2021 Proceedings of the
National Association of Insurance Commissioners

2021 Fall National Meeting
December 13 – 16, 2021

Held at the
Hilton San Diego Bayfront & Omni San Diego
San Diego, California
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Information about statutory accounting principles and the procedures necessary for filing financial annual statements and conducting risk-based capital calculations.

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Studies, reports, handbooks and regulatory research conducted by NAIC members on a variety of insurance related topics.

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Important answers to common questions about auto, home, health and life insurance — as well as buyer’s guides on annuities, long-term care insurance and Medicare supplement plans.

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CERTIFICATE OF INCORPORATION OF
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
a Nonstock Corporation

I. Name

The name of the Corporation is: National Association of Insurance Commissioners (NAIC).

II. Duration

The period of duration of the NAIC is perpetual.

III. Registered Office and Agent

The NAIC’s Registered Office in the State of Delaware is to be located at: 1209 Orange St., in the City of Wilmington, Zip Code 19801. The registered agent in charge thereof is The Corporation Trust Company.

IV. Authority to Issue Stock

The NAIC shall have no authority to issue capital stock.

V. Incorporators

The name and address of the incorporator are as follows:
Catherine J. Weatherford
National Association of Insurance Commissioners
120 W. 12th St., Suite 1100
Kansas City, MO 64106

VI. Purpose

The NAIC is organized exclusively for charitable and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue law), including without limitation, to assist state insurance regulators, individually and collectively, in serving the public interest and achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost-effective manner, consistent with the wishes of its members:

(a) Protect the public interest, promote competitive markets and facilitate the fair and equitable treatment of insurance consumers;

(b) Promote, in the public interest, the reliability, solvency and financial solidity of insurance institutions; and

(c) Support and improve state regulation of insurance.

VII. Restrictions

A. No substantial part of the activities of the Corporation shall be the carrying of propaganda, or otherwise attempting to influence legislation except as otherwise permitted by Section 501(h) of the Code and in any corresponding laws of the State of Delaware, and the Corporation shall not participate in or intervene in including the publishing or distribution of statements concerning any political campaign on behalf of or in opposition to any candidate for public office.

B. For any period for which the Corporation may be considered a private foundation, as defined in Section 509(a), the Corporation shall be subject to the following restrictions and prohibitions:

1. The Corporation shall not engage in any act of self-dealing as defined in section 4941(d) of the Code.

2. The Corporations shall make distributions for each taxable year at such time and in such manner so as not to become subject to the tax on undistributed income imposed by section 4942 of the Code.

3. The Corporation shall not retain any excess business holdings as defined in section 4943(c) of the Code.

4. The Corporation shall not make any investments in such manner as to subject it to tax under section 4944 of the Code.

5. The Corporation shall not make any taxable expenditures as defined in section 4945(d) of the Code.
VIII. Membership

The NAIC shall have one class of members consisting of the Commissioners, Directors, Superintendents, or other officials who by law are charged with the principal responsibility of supervising the business of insurance within each State, territory, or insular possession of the United States. Members only shall be eligible to hold office in and serve on the Executive Committee, Committees and Subcommittees of the NAIC. However, a member may be represented on a Committee or Subcommittee by the member’s duly authorized representative as defined in the Bylaws. Only one official from each State, territory or insular possession shall be a member and each member shall be limited to one vote. Any insurance supervisory official of a foreign government or any subdivision thereof, which has been diplomatically recognized by the United States government, may attend and participate in all meetings of this Congress but shall not be a member and shall not have the power to vote.

IX. Activities

The NAIC is a nonprofit charitable and educational organization and no part of the net earnings or property for the corporation will inure to the benefit of, or be distributable to its members, directors, officers or other private individuals, except that the NAIC shall be authorized and empowered to pay reasonable compensation for services rendered by employees and contractors, and to make payments and distributions in furtherance of the purposes set forth in Article VI hereof.

X. Powers

The NAIC shall have all of the powers conferred by the Delaware General Corporation Law for non-profit corporations, except that, any other provision of the Certificate to the contrary notwithstanding, the NAIC shall neither have nor exercise any power, nor carry on any other activities not permitted: (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue law); or (b) by a corporation contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code of 1986, as amended, (or the corresponding provision of any future United States Internal Revenue law).

XI. Immunity

All officers and members of the Executive Committee shall be immune from personal liability for any civil damages arising from acts performed in their official capacity, and shall not be compensated for their services as an officer or member of the Executive Committee on a salary or a prorated equivalent basis. The immunity shall extend to such actions for which the member of the Executive Committee or officer would not otherwise be liable, but for the Executive Committee member’s or officer’s affiliation with the NAIC. This immunity shall not apply to intentional conduct, wanton or willful conduct or gross negligence. Nothing herein shall be construed to create or abolish an immunity in favor of the NAIC itself. Nothing herein shall be construed to abolish any immunities held by the state officials pursuant to their individual state’s law.

XII. Exculpation and Indemnification

A member of the Executive Committee shall not be liable to the NAIC or its members for monetary damages for breach of fiduciary duty as a member of the Executive Committee, provided that this provision shall not eliminate or limit the liability of a member of the Executive Committee for any breach of the duty of loyalty to the NAIC or its members, for acts or omissions not in good faith, or which involve intentional misconduct or a knowing violation of law, or for any transaction from which the member of the Executive Committee involved derived an improper personal benefit. Any amendment, modification or repeal of the foregoing sentence shall not adversely affect any right or protection of a member of the Executive Committee of the Corporation hereunder in respect of any act or omission occurring prior to the time of such amendment, modification, or repeal. If the Delaware General Corporation Law hereafter is amended to authorize the further elimination or limitation of the liability of the members of the Executive Committee, then the liability of a member of the Executive Committee, in addition to the limitation provided herein, shall be limited to the fullest extent permitted by the amended Delaware General Corporation Law.

The NAIC shall indemnify to the full extent authorized or permitted by the laws of the State of Delaware, as now in effect or as hereafter amended, any person made or threatened to be made a party to any threatened, pending or completed action, suit or proceeding (whether civil, criminal, administrative or investigative, including an action by or in the right of the NAIC) by reason of the fact that the person is or was a member of the Executive Committee, officer, member, committee member, employee or agent of the NAIC or serves any other enterprise as such at the request of the NAIC.
The foregoing right of indemnification shall not be deemed exclusive of any other rights to which such person may be entitled apart from this Article XII. The foregoing right of indemnification shall continue as to a person who has ceased to be a member of the Executive Committee, officer, member, committee member, employee or agent and shall inure to the benefit of the heirs, the executors and administrators of such a person.

XIII. Dissolution

In the event of the dissolution of the NAIC, the Executive Committee shall, after paying or making provision for the payment of all of the liabilities of the NAIC, dispose of all the assets of the NAIC equitably to any state government which is represented as a member of the NAIC at the time of dissolution, provided that the assets are distributed upon the condition that they be used primarily and effectively to implement the public purpose of the NAIC, or to one or more such organizations organized and operated exclusively for religious, charitable, education, scientific, or literary purposes or similar purposes as shall at the time qualify: (a) as an exempt organization under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue law); and (b) as an organization contributions to which are deductible under Section 170(c) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue law), as the Executive Committee shall determine.

XIV. Bylaws

The Bylaws of the NAIC may prescribe the powers and duties of the several officers, members of the Executive Committee and members and such rules as may be necessary for the work of the NAIC provided they are in conformity with the Certificate of Incorporation.

XV. Amendments

This Certificate of Incorporation may be altered or amended at any meeting of the full membership (Plenary Session) of the NAIC by an affirmative vote of two-thirds of the members qualified to vote, or their authorized representatives, provided that previous notice of the proposed amendment has been mailed to all members by direction of the Executive Committee at least thirty (30) days prior to the meeting.

IN WITNESS WHEREOF, this Certificate of Incorporation has been signed this 4th day of October 1999.

/signature/
Catherine J. Weatherford, Incorporator

ADOPTED 1999, Proc. Third Quarter
BYLAWS OF THE
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

ARTICLE I Name, Organization and Location

The name of this corporation is NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC). The NAIC is organized under the General Corporation Law of the State of Delaware. The NAIC may have one (1) or more office locations within or without the State of Delaware as the Executive Committee may from time to time determine.

ARTICLE II Membership

The Membership of the NAIC shall be comprised of those persons designated as members in the Certificate of Incorporation. Each member of the NAIC shall have the power to vote and otherwise participate in the affairs of the NAIC as set forth herein or as required by applicable law. This power may be exercised through a duly authorized representative who shall be a person officially affiliated with the member’s department and who is wholly or principally employed by said department.

The organization may charge members an annual assessment, the amount of which shall be determined by the Executive Committee. Members failing to pay all NAIC assessments on a timely basis shall be placed in an inactive status. Members in an inactive status shall not have any voting rights and shall be denied membership on NAIC committees and task forces, access to mailings and services of the NAIC Offices, as well as access to zone examination processes and other benefits of membership in the NAIC.

The NAIC’s receipt of full payment from the inactive member of all current and past due assessments shall serve to immediately remove them from inactive status.

The Membership of the NAIC shall be subject to a conflict of interest policy and disclosure form as adopted by the members.

The Executive Committee is empowered to reinstate, in part or in whole, an inactive member’s participation on the committees and task forces, access to mailings and services of the NAIC Offices and satellite offices, as well as access to zone examination processes, and other benefits of membership in the NAIC upon good cause shown as determined by the Executive Committee.

ARTICLE III Officers

The officers of the NAIC shall be a President, a President-Elect, a Vice President, and a Secretary-Treasurer. Annual officer elections shall be held at the last regular National Meeting of each calendar year or at such other plenary session as agreed to by the members. The voting membership, by secret ballot, shall elect officers as provided in these Bylaws. Officers’ terms shall be for one year, beginning on January 1 following their election. The officers shall hold office until their death, resignation, removal or the election and qualification of their successors, whichever occurs first. Any Officer may resign at any time by giving notice thereof in writing to the President of the NAIC. Any such resignation will take effect upon delivery if no date is specified, or as of its date, unless some other date is specified therein, in which event it will be effective as of that date. The acceptance of that resignation will not be necessary to make it effective.

If an interim vacancy occurs in the office of President, the President-Elect shall cease to hold his or her office effective immediately and shall assume the office of President. If an interim vacancy occurs in any one or more of the other officer positions, an interim election shall be held to fill the vacancy. No member may hold any office for more than two consecutive years. Notwithstanding the foregoing, at no time shall more than two officer positions be filled by members of the same Zone during the same term. Any officer may be removed from office by the affirmative vote of two-thirds (2/3) of the members, but only after a resolution for removal is adopted by two-thirds (2/3) of the Executive Committee whenever, in their judgment, the best interests of the NAIC would be served thereby.

The President shall serve as Chairman of the Executive Committee and shall preside at all special and regular meetings of the members. The President shall serve as the leader of the organization and its principal spokesperson. The President shall work closely with the Executive Committee to establish and achieve the strategic, business and operational goals of the organization; ensure appropriate policies and procedures for the organization are implemented and followed; and protect the integrity as well as the resources of the organization. After a member completes his or her term or terms as President, he or she shall not be able to hold another officer position for a period of twelve (12) months from the date such member completes his or her term or terms as President, which shall be referred to as a "waiting period"; provided however, the Executive Committee may waive the twelve month waiting period if warranted by exigent circumstances.
The President-Elect shall serve as Vice-Chairman of the Executive Committee. In the absence of the President at a duly convened meeting of the Executive Committee or at a regular or special meeting of the members, the President-Elect shall preside over such meeting to the extent of the President’s absence. The President-Elect shall perform such other duties and tasks as may be assigned by the President. Where the President does not run for re-election, the President-Elect shall become President at the conclusion of the President’s term of office.

The Vice President, in the absence of the President and President-Elect at a duly convened meeting of the Executive Committee or at a regular or special meeting of the members, shall preside over such meeting to the extent of the President’s and the President-Elect’s absence; and shall perform such other duties as may be assigned by the President or President-Elect, or in the absence thereof, by the Executive Committee.

The Secretary-Treasurer shall assist the President and, as applicable, the President-Elect or the Vice President in the conduct of meetings of the Executive Committee and members. For member meetings, the Secretary-Treasurer shall call the roll of the membership and certify the presence of a quorum and shall receive, validate and maintain all proxies for elections held at member meetings. The Secretary-Treasurer shall also recommend to the Executive Committee such policies and procedures to maintain the history and continuity of the NAIC. The Secretary-Treasurer shall also assist the President and President-Elect in all matters relating to the budget, accounting, expenditure and revenue practices of the NAIC; including, but not limited to reviewing the financial information of the organization and consulting with NAIC management, independent auditors, and other necessary parties regarding the financial operations and condition of the organization.

**ARTICLE IV Executive Committee**

The business and affairs of the NAIC shall be managed by and under the direction of the Executive Committee. The Executive Committee shall be made up entirely of members of the NAIC. The Executive Committee shall consist of the following members: the officers of the NAIC; the most recent past president; the twelve (12) members of the zones as provided for in Article V of these Bylaws. The members of the Executive Committee shall be subject to a conflict of interest policy as adopted by the members. Any Executive Committee member may resign at any time by giving notice thereof in writing to the members of the NAIC. Resignation as an Executive Committee member also operates as resignation as a Zone officer. Any such resignation will take effect upon delivery if no date is specified, or as of its date, unless some other date is specified therein, in which event it will be effective as of that date. The acceptance of that resignation will not be necessary to make it effective.

1. The Executive Committee shall have the authority and responsibility to:

   (a) manage the affairs of the NAIC in a manner consistent with the Certificate of Incorporation and Bylaws;

   (b) make recommendations to achieve the goals of the NAIC based upon either its own initiative or the recommendations of the Standing Committees or Subcommittees reporting to it, for consideration and action by the members at any NAIC Plenary Session;

   (c) create and terminate one or more Task Forces reporting to it to the extent needed and appropriate;

   (d) establish and allocate, from time to time, functions and responsibilities to be performed by each Zone;

   (e) to the extent needed and appropriate, oversee NAIC Offices to assist the NAIC and the individual members in achieving the goals of the NAIC;

   (f) submit to the NAIC at each National Meeting, during which a Plenary Session is held, its report and recommendations concerning the reports of the Standing Committees. All Standing Committee reports shall be included as part of the Executive Committee report;

   (g) plan, implement and coordinate communications and activities with other state, federal and local government organizations in order to advance the goals of the NAIC and promote understanding of state insurance regulation.
2. Duties and Operations of the Executive Committee.

(a) The Executive Committee shall hold at least two (2) regular meetings annually at a designated time and place. Special meetings may be held when called by the President, or by at least three (3) members of the Executive Committee in writing. In any case, the Executive Committee shall meet at least once per calendar month. At least five (5) days notice shall be given of all regular and special meetings. Meetings may be held in person or by means of conference telephone or other communication equipment by means of which all persons participating in the meeting can hear each other, and such participation in a meeting shall constitute presence in person at such meeting in accordance with applicable laws. The presiding member of the Executive Committee shall only cast his or her vote in order to break a tie vote. In addition, the Executive Committee may act by written consent as provided by law.

(b) The Executive Committee may, with the concurrence of two-thirds of the members of the Executive Committee, establish rules for its conduct that shall not conflict with the Certificate of Incorporation and Bylaws. Such rules may be changed only by a concurrence of two-thirds of the members of the Executive Committee after twenty-four (24) hours notice to all members of the Executive Committee.

(c) Any action required or permitted to be taken at any meeting of the Executive Committee or any committee thereof may be taken without a meeting if all members of the Executive Committee or such committee, as the case may be, consent thereto in writing in accordance with applicable law.

(d) The Executive Committee shall cause to be kept minutes of its meeting and have information of any action of a general character taken by it published to members qualified to vote.

(e) NAIC OFFICES

(i) The Executive Committee shall oversee an Executive Office and a Central Office with management and staff personnel and appropriate resources for performance of duties and assigned responsibilities. Additional satellite offices may be established as needed. The Executive Committee shall have the authority to select, employ and terminate a Chief Executive Officer who shall not be a member of the NAIC and who shall have the primary responsibility for the internal management and functioning of the NAIC Offices within the direction of the Executive Committee, as well as other duties assigned by the Executive Committee through execution of an Employment Agreement or other authorization. The Chief Executive Officer appointed by the Executive Committee pursuant to this section shall not be considered an officer for purposes of Article III hereof and shall not be a member of the Executive Committee. The Executive Committee, through the Internal Administration (EX1) Subcommittee, shall provide oversight and direction to the Chief Executive Officer regarding Office operations.

(ii) Consistent with the purposes of the NAIC, the role of the NAIC Offices is to: (1) provide services to the NAIC through support to the NAIC Committees, Subcommittees, Task Forces or otherwise; (2) provide services to individual State insurance departments; and (3) develop recommendations for consideration as to NAIC policy and administrative decisions of the NAIC.

(iii) In performing its role, subject to the oversight and direction specified in (paragraph i) the NAIC Offices may engage in a variety of functions including but not limited to the following: research; analysis; information gathering and dissemination; library services; data collection; data base building and maintenance; report generation and dissemination; government liaison; non-regulatory liaison; securities valuation; administration; litigation; legislative and regulatory drafting; and educational development.

(iv) The Chief Executive Officer shall prepare an annual budget, related to the priorities of the NAIC, for the NAIC Offices to be submitted through the EX1 Subcommittee to the Executive Committee, which shall make its recommendations to the members of the NAIC for action at the next Plenary Session of the NAIC.
3. Internal Administration (EX1) Subcommittee

The Internal Administration (EX1) Subcommittee shall be a Subcommittee reporting to the Executive Committee. Appointments of the Chair and Vice Chair of the Executive Subcommittee and members other than those specifically designated herein shall be made by the President and President-Elect.

This Subcommittee shall be comprised of the President, President-Elect, Vice President, the Secretary-Treasurer, the most recent past President, and three (3) other members of the Executive Committee. The presiding member of the Subcommittee shall only cast his or her vote in order to break a tie vote.

The Internal Administration (EX1) Subcommittee shall:

(a) Exercise such powers and authority as may be delegated to it by the Executive Committee.

(b) Generally oversee the NAIC Offices including, without limitation: (i) periodically monitor operations of the NAIC Offices, (ii) review and revise the budget of the NAIC, hold an annual hearing to receive public comments on the budget of the NAIC, and submit the revised budget to the Executive Committee, (iii) approve emergency expenditures which vary from the adopted budget and promptly certify its action in writing to the Executive Committee, (iv) evaluate the Chief Executive Officer and make appropriate recommendations to the Executive Committee, (v) assist the Chief Executive Officer in resolving competing demands for NAIC resources, (vi) review compensation of all senior management and (vii) quarterly prepare a report containing the current budget and expenditures which the Secretary-Treasurer shall present to the Executive Committee.

4. Audit Committee

The Executive Committee shall appoint an Audit Committee made up of at least four (4) members of the NAIC, including at least one member from each zone, in addition to the NAIC Secretary-Treasurer. The NAIC Secretary-Treasurer shall chair the Audit Committee. The Audit Committee shall report to the Executive Committee without any NAIC employees being present. The Audit Committee shall be directly responsible for the appointment, compensation, and oversight of the independent certified public accountant employed to conduct the audit. The Audit Committee shall also have the power, to the extent permitted by law, to: (i) initiate or review the results of an audit or investigation into the business affairs of the NAIC; (ii) review the NAIC’s financial accounts and reports; (iii) conduct pre-audit and post-audit reviews with NAIC staff, members and independent auditors; and (iv) exercise such other powers and authority as delegated to it by the Executive Committee.

ARTICLE V Zones

To accomplish the purposes of the NAIC in a timely and efficient manner, the United States, its territories and insular possessions shall be divided into four Zones. Each Zone shall consist of a group of at least eight States, located in the same geographical area, with each State being contiguous to at least one other State in the group so far as practicable, plus any territory or insular possession that may be deemed expedient, all as determined by majority of the Executive Committee. Members of each Zone shall annually elect a Chairman, a Vice Chairman and a Secretary from among themselves prior to or during the last regular National Meeting of each calendar year or at such time as agreed to by the Zone members. The Chairman, Vice Chairman and Secretary of each Zone shall be members of the Executive Committee with terms of office corresponding to that of the officers. Each Zone shall perform such functions as are designated by the Executive Committee of the NAIC or by the members of the NAIC as a whole or by the members of the Zone. Each Zone may hold Zone Meetings for such purposes as may be deemed appropriate by members of the Zone.

ARTICLE VI Standing Committees and Task Forces

1. General

The Standing Committees shall not be subcommittees of the Executive Committee and shall have no power or authority for the management of the business and affairs of the NAIC. Each Standing Committee shall be composed of not more than 15 members, including a Chair and one or more Vice Chairs, appointed by the President and President-Elect, and such appointments shall remain effective until the succeeding President and President-Elect appoint members for the following year. Standing Committees shall meet at least twice a year at National Meetings and may meet more often at the call of the Chair as required to complete its assignments from the Executive Committee in a timely manner.
The Executive Committee shall make all assignments of subject matter to the Standing Committees and shall require coordination between Committees and Task Forces of the subject matter if more than one Committee or Task Force is affected. The format of the Committee reports shall be prescribed by the Executive Committee. All appointments or elections of members of the NAIC to any office or Committee of the NAIC shall be deemed the appointment or election of a particular member and shall not automatically pass to a successor in office.

2. Specific Duties

The Standing Committees of the NAIC, their duties and responsibilities shall be as follows:

(a) Life Insurance and Annuities (A) Committee: This Standing Committee shall consider issues relating to life insurance and annuities.

(b) Health Insurance and Managed Care (B) Committee: This Standing Committee shall consider issues relating to health and accident insurance and managed care.

(c) Property and Casualty Insurance (C) Committee: This Standing Committee shall consider issues relating to personal and commercial lines of property and casualty insurance, worker’s compensation insurance, statistical information, surplus lines, and casualty actuarial matters.

(d) Market Regulation and Consumer Affairs (D) Committee: This Standing Committee shall consider issues involving market conduct in the insurance industry; competition in insurance markets; the qualifications and conduct of agents and brokers; market conduct examination practices; the control and management of insurance institutions; consumer services of State insurance departments; and consumer participation in NAIC activities.

(e) Financial Condition (E) Committee: This Standing Committee shall consider both administrative and substantive issues as they relate to accounting practices and procedures; blanks; valuation of securities; the Insurance Regulatory Information System (IRIS), as it relates to solvency and profitability; the call, monitoring and concluding report of Zone Examinations; and financial examinations and examiner training.

(f) Financial Regulation Standards and Accreditation (F) Committee: This Standing Committee shall consider both administrative and substantive issues as they relate to administration and enforcement of the NAIC Accreditation Program, including without limitation, consideration of standards and revisions of standards for accreditation, interpretation of standards, evaluation and interpretation of states’ laws and regulations, and departments’ practices, procedures and organizations as they relate to compliance with standards, examination of members for compliance with standards, development and oversight of procedures for examination of members for compliance with standards, qualification and selection of individuals to perform the examination of members for compliance with standards, and decisions regarding whether to accredit members.

(g) International Insurance Relations (G) Committee. This Standing Committee shall have the responsibility for issues relating to international insurance.

3. Task Forces

The Executive Committee, its Subcommittee and the Standing Committees may establish one or more Task Forces, subject to approval of the Executive Committee. The parent Committee or Subcommittee, subject to approval of the Executive Committee, may vote to discontinue a Task Force once its charge has been completed.

Vacancies in the positions of Chair or Vice Chair of any Task Force shall be filled by the parent Committee or Subcommittee from within or outside the present Task Force membership; provided, however, that the chief insurance regulatory official of the state of the former Chair or Vice Chair shall become a member of the Task Force. A vacancy in the position of member shall be filled by the chief insurance regulatory official of the vacating member’s state.

If an existing Task Force is dealing with insurance issues that require continuing study, the Executive Committee may adopt the recommendation of the parent Committee or Subcommittee that the Task Force be designated a Standing Task Force. A Standing Task Force shall continue in effect until terminated by the Executive Committee.
ARTICLE VII Meetings of the Membership

1. Regular Meetings.

The NAIC shall hold at least two (2) regular meetings of the members (“National Meetings”) each calendar year. Notice, stating the place, day and hour and any special purposes of the National Meeting, shall be delivered by the Executive Committee not less than ten (10) calendar days nor more than sixty (60) calendar days before the date on which the National Meeting is to be held, either personally, by mail or by other lawful means, to each member entitled to be present and vote at such meeting.

2. Special Meetings.

Special meetings of the members may be called by any five (5) members of the Executive Committee by giving all members notice of such meeting at least ten (10) but not more than sixty (60) days prior thereto, or by any twenty (20) members of the NAIC by giving all members notice of such meeting at least thirty (30) but not more than sixty (60) days prior thereto. Notice of the special meeting shall state the place, day and hour of the special meeting and the purpose or purposes for which the special meeting is called, and shall be delivered by the persons calling the meeting within the applicable time period set forth herein, either personally, by mail or by other lawful means, to each member entitled to be present and vote at such meeting.

3. Waiver of Notice; Postponement.

Member meetings may be held without notice if all members entitled to notice are present (except when members entitled to notice attend the meeting for the express purpose of objecting, at the beginning of the meeting, because the meeting is allegedly not lawfully called or convened), or if notice is waived by those not present. Any previously scheduled meeting of the members may be postponed by the Executive Committee (or members calling a special meeting, as the case may be) upon notice to members, in person or writing, given at least two (2) days prior to the date previously scheduled for such meeting.

4. Quorum.

Except as otherwise provided by law or by the Certificate of Incorporation, the presence, by person or proxy, of a majority of the members shall constitute a quorum at a member meeting, a meeting of a Standing Committee, Task Force or a working group. The chairman of the meeting may adjourn the meeting from time to time, whether or not there is such a quorum. The members present at a duly called member meeting at which a quorum is present may continue to transact business until adjournment, notwithstanding the withdrawal of enough members to leave less than a quorum.

5. Any meeting of the NAIC may be held in executive session as defined in the NAIC policy on open meetings. Any member may attend and participate in any meeting of the NAIC or any meeting of a Standing Committee or Task Force whether or not such member has the right to vote. All National Meetings shall provide for a Plenary Session of the NAIC as a whole in order to consider and take action upon the matters submitted to the NAIC.

ARTICLE VIII Elections

1. The election of officers of the NAIC shall be scheduled for the plenary session of the last National Meeting of the calendar year or at such other plenary session as agreed to by the members.

2. At the beginning of such Plenary Session, the Secretary-Treasurer shall ascertain and announce the presence of a quorum.

3. Upon the determination of a quorum, the chair shall briefly review the provisions of the Certificate of Incorporation and Bylaws in regard to voting.

4. The President shall ask for and announce all proxies. Proxies shall be held by the Secretary-Treasurer or a designee throughout the election session. Proxies shall be valid, subject to their term, until superseded by the member and shall be governed by ARTICLE IX of the Bylaws.

5. Every individual voting by proxy must meet the requirements of Article II of the Bylaws of the NAIC which requires that such a person be “...officially affiliated with the member’s (the member delegating authority to vote) department, and is wholly or principally employed by said department.”
6. Prior to opening the nominations for office, the Chair shall appoint three (3) members of the NAIC to act as voting inspectors. The voting inspectors shall distribute, collect, count and/or verify ballots, and report their findings to the Secretary-Treasurer. If a voting inspector is nominated for an office and does not withdraw as a candidate, he or she shall not be a voting inspector for the election of the office to which he or she is nominated and the chair shall appoint another voting inspector in his or her place.

7. The Chair shall announce the opening of nominations for offices in the following order:

   (a) President. Provided, however, where the President does not run for re-election, the President-Elect shall become President at the conclusion of the President’s term of office. In those cases where the President runs for re-election or where a vacancy exists because the President-Elect fails or is otherwise unable to assume the Presidency, this office will be subject to an election.

   (b) President-Elect.

   (c) Vice President.

   (d) Secretary-Treasurer.

8. Only members or duly authorized proxyholders may make nominations.

9. One nominating speech, not to exceed three (3) minutes in duration, shall be allowed for each nominee.

10. After nominations are closed for each office, each nominee must indicate whether he or she accepts the nomination and, if he or she accepts, shall be permitted to address the membership for a period of up to seven (7) minutes. Such addresses shall be given in the order by which the nominations were made.

11. The votes of members, in person or by proxy, constituting a majority of the quorum present at the meeting shall be necessary for election to such office. If no candidate receives a majority, the two candidates with the most votes will participate in a run-off election. The candidate with the most votes in the run-off election shall win such election.

12. Voting need not be by written ballot, unless otherwise required by these Bylaws, the Certificate of Incorporation, or applicable law.

**ARTICLE IX Proxies; Waiver of Notice**

Where the delegation of power to vote or participate in the membership of the NAIC is required by ARTICLE II of these Bylaws to be in writing, such delegation must be effected by proxy. All proxies must be dated, give specific authority to a named individual who meets the requirements of ARTICLE II for duly authorized representatives, and meet any other applicable legal requirement. Documents such as electronic transmission, telegrams, mailgrams, etc. are acceptable as proxies if they otherwise meet the requirements contained herein and applicable law. Proxies should be maintained by NAIC Central Office staff. Notwithstanding the foregoing, a member may not vote by proxy in a meeting of the Executive Committee, Financial Regulation Standards and Accreditation (F) Committee in a vote concerning a state-specific item, Government Relations Leadership Council, or International Insurance Relations Leadership Group, or any respective subcommittees.

Whenever any notice is required to be given to any member (for a meeting of members or the Executive Committee) under the provisions of the Certificate of Incorporation, these Bylaws or applicable law, a written waiver, signed by the person entitled to notice, or a waiver by electronic transmission by person entitled to notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice. Neither the business to be transacted at, nor the purpose of, any annual or special meeting of the members or any committee, subcommittee or task force need be specified in any waiver of notice of such meeting.

Unless otherwise restricted by the Certificate of Incorporation or these Bylaws, Members may participate in a meeting by means of conference telephone or by any means by which all persons participating in the meeting are able to communicate with one another, and such participation shall constitute presence in person at the meeting.

Any notice required under these Bylaws may be provided by mail, facsimile, or electronic transmission.
ARTICLE X Procedures; Books and Records

The Executive Committee shall adopt policies and procedures for the conduct of meetings. In the event such policies and procedures conflict with the NAIC’s Certificate of Incorporation or Bylaws, the Certificate of Incorporation and Bylaws shall govern.

The books and records of the NAIC may be kept outside the State of Delaware at such place or places as may from time to time be designated by the Internal Administration Subcommittee (EX1) of the Executive Committee.

ARTICLE XI Amendments

These Bylaws may be altered or repealed and new Bylaws may be adopted at any regular or special meeting of the members by an affirmative vote, in person or by proxy, of a majority of the members entitled to vote at such meeting; provided, however, that any proposed alteration (except to correct typographical or grammatical errors or article, section or paragraph cross-references caused by other alterations, repeals, or adoptions) or repeal of, or the adoption of any Bylaw inconsistent with, Article II [Membership], Article VII, Paragraph 2 [Special Meetings of Members] and Paragraph 4 [Quorum], Article VIII [Elections], or this Article XI [Amendments] of these Bylaws (the “Supermajority Bylaws”) by the members shall require the affirmative vote, in person or by proxy, of at least two-thirds (2/3) of the members entitled to vote at such meeting and provided, further, that in the case of any such member action at a special meeting of members, notice of the proposed alteration, repeal or adoption of the new Bylaw or Bylaws must be contained in the notice of such special meeting. Corrections for typographical or grammatical errors or to article, section or paragraph cross-references caused by other alterations, repeals or adoption, shall only be made if approved by the affirmative vote of at least two-thirds (2/3) of the Executive Committee.

Adopted October 1999, see 1999 Proc., Third Quarter page 7
Amended November 2002, see 2002 Proc., Fourth Quarter page 25
Amended June 2003, see 2003 Proc., Second Quarter page 28
Amended March 2004, see 2004 Proc., First Quarter page 119
Amended December 2004, see 2004 Proc., Fourth Quarter page 58
Amended March 2009, see 2009 Proc., First Quarter pages 3–67
Amended September 2009, see 2009 Proc., Third Quarter
Amended October 2011, see Proc., Summer 2011
Amended December 2015, see Proc., Spring 2016
The NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories. NAIC members are the elected and appointed state government officials who, along with their departments and staff, regulate the conduct of insurance companies and agents in their respective state or territory. The NAIC is committed to conducting its business openly. This policy statement applies to meetings of NAIC committees, subcommittees, task forces and working groups. It does not apply to Roundtable discussions, zone meetings, commissioners’ conferences, and other like meetings of the members. Applicable meetings will be open unless the discussion or action contemplated will include:

1. Potential or pending litigation or administrative proceedings which may involve the NAIC, any NAIC member, or their staffs, in any capacity involving their official or prescribed duties, requests for briefs of amicus curiae, or legal advice;

2. Pending investigations which may involve either the NAIC or any member in any capacity;

3. Specific companies, entities or individuals, including, but not limited to, collaborative financial and market conduct examinations and analysis;

4. Internal or administrative matters of the NAIC or any NAIC member, including budget, personnel and contractual matters, and including consideration of internal administration of the NAIC, including, but not limited to, by the Internal Administration (EX1) Subcommittee or any subgroup appointed thereunder;

5. Voting on the election of officers of the NAIC;

6. Consultations with NAIC staff members related to NAIC technical guidance, including, but not limited to, Annual and Quarterly Statement Blanks and Instructions, the Accounting Practices and Procedures Manual, and similar materials;

7. Consideration of individual state insurance department’s compliance with NAIC financial regulation standards by the Financial Regulation Standards and Accreditation (F) Committee or any subgroup appointed thereunder;

8. Consideration of strategic planning issues relating to federal legislative and regulatory matters or international regulatory matters; or

9. Any other subject required to be kept confidential under any Memorandum of Understanding or other agreement, state or federal law or under any judicial or administrative order.

Because not all situations requiring a regulator to regulator discussion can be anticipated at the time a meeting is scheduled, a meeting convened in open session can move into regulator to regulator session on motion by the chair or other member approved by a majority of the members present. Public notice will be provided of all applicable meetings. The reason for holding a meeting in regulator only session will be announced when the meeting notice is published, at the beginning of any regulator only session, and when an open meeting goes into regulator only session.

This revised policy statement shall take effect upon adoption by the membership.

[NOTE: (Effective Jan. 1, 1996, conference call meetings are included in the application of the policy statement, by action of the NAIC on June 4, 1995). This policy statement was originally adopted by the NAIC membership during the 1994 Fall National Meeting in Minneapolis, Minnesota, Sept. 18–20, 1994.]

Revisions Adopted by the NAIC Membership, April 1, 2014
2021 COMMITTEE STRUCTURE

Plenary

Executive Committee

(EX1) Subcommittee

Internal Administration

Information Systems Task Force

(A) Committee

Life Insurance and Annuities

Life Actuarial Task Force

(B) Committee

Health Insurance and Managed Care

Health Actuarial Task Force

Regulatory Framework Task Force

Senior Issues Task Force

(C) Committee

Property and Casualty Insurance

Casualty Actuarial and Statistical Task Force

Surplus Lines Task Force

Title Insurance Task Force

Workers’ Compensation Task Force

(D) Committee

Market Regulation and Consumer Affairs

Antifraud Task Force

Market Information Systems Task Force

Producer Licensing Task Force

(E) Committee

Financial Condition

Accounting Practices and Procedures Task Force

Capital Adequacy Task Force

Examination Oversight Task Force

Financial Stability Task Force

Receivership and Insolvency Task Force

Reinsurance Task Force

Risk Retention Group Task Force

Valuation of Securities Task Force

(F) Committee

Financial Regulation Standards and Accreditation

(G) Committee

International Insurance Relations

NAIC/Consumer Liaison Committee

NAIC/American Indian and Alaska Native Liaison Committee

Updated January 25, 2021
## APPOINTED and DISBANDED GROUPS

### Current and Previous Year

### APPOINTED SINCE JANUARY 2021

<table>
<thead>
<tr>
<th>Group Name</th>
<th>Effective Date</th>
<th>NAIC Support Staff</th>
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<tbody>
<tr>
<td>E-Commerce (EX) Working Group</td>
<td>04/14/2021</td>
<td>Denise Matthews</td>
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<tr>
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<td>08/16/2021</td>
<td>Greg Welker</td>
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<tr>
<td>Index-Linked Variable Annuity (A) Subgroup</td>
<td>07/01/2021</td>
<td>Reggie Mazyck</td>
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<tr>
<td>Long-Term Care Insurance Restructuring (E) Subgroup</td>
<td>04/07/2021</td>
<td>Dan Daveline</td>
</tr>
<tr>
<td>NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group</td>
<td>04/13/2021</td>
<td>Aaron Brandenburg</td>
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<tr>
<td>Receiver’s Handbook (E) Subgroup</td>
<td>04/13/2021</td>
<td>Sherry Flippo</td>
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### RENAMED SINCE JANUARY 2021

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<th>NAIC Support Staff</th>
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<tbody>
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<td>Big Data and Artificial Intelligence (EX) Working Group</td>
<td>12/09/2020</td>
<td>Tim Mullen/Denise Matthews</td>
</tr>
<tr>
<td>Financial Stability (E) Task Force</td>
<td>01/08/2021</td>
<td>Tim Nauheimer</td>
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<tr>
<td>Liquidity Assessment (E) Subgroup</td>
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<td>08/14/2021</td>
<td>Tim Nauheimer</td>
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<tr>
<td>Mutual Recognition of Jurisdictions (E) Working Group</td>
<td>03/08/2021</td>
<td>Dan Schelp</td>
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### DISBANDED SINCE JANUARY 2021

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<th>Group Name</th>
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<th>NAIC Support Staff</th>
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<tr>
<td>Annuity Disclosure (A) Working Group</td>
<td>08/17/2021</td>
<td>Jennifer Cook</td>
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<tr>
<td>Biographical Third-Party Review (E) Subgroup</td>
<td>04/13/2021</td>
<td>Crystal Brown</td>
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<tr>
<td>Retirement Security (A) Working Group</td>
<td>04/12/2021</td>
<td>Jennifer Cook</td>
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### DISBANDED IN 2020

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<th>NAIC Support Staff</th>
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<tbody>
<tr>
<td>Climate Risk and Resilience (C) Working Group</td>
<td>12/09/2020</td>
<td>Anne Obersteadt</td>
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<tr>
<td>Health Reserves (B) Subgroup</td>
<td>12/09/2020</td>
<td>Eric King</td>
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<tr>
<td>Health Maintenance Organization (HMO) Issues (B) Subgroup</td>
<td>12/09/2020</td>
<td>Jolie Matthews</td>
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<tr>
<td>Investment Risk-Based Capital (E) Working Group</td>
<td>08/14/2020</td>
<td>Jane Barr</td>
</tr>
<tr>
<td>Lender-Placed Insurance Model Act (C) Working Group</td>
<td>12/09/2020</td>
<td>Aaron Brandenburg</td>
</tr>
<tr>
<td>Long-Term Care Insurance (E/B) Task Force</td>
<td>08/14/2020</td>
<td>Dan Daveline</td>
</tr>
<tr>
<td>NAIC/Industry Liaison Committee</td>
<td>08/14/2020</td>
<td>Ethan Sonnichsen</td>
</tr>
<tr>
<td>NAIC/State Government Liaison Committee</td>
<td>08/14/2020</td>
<td>Ethan Sonnichsen</td>
</tr>
<tr>
<td>Receivership Large Deductible Workers’ Compensation (E) Working Group</td>
<td>12/09/2020</td>
<td>Sherry Flippo</td>
</tr>
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**Updated October 14, 2021**

© 2021 National Association of Insurance Commissioners
# 2021 Members by Zone

## Northeast Zone
- Jessica K. Altman, Chair  
  Pennsylvania  
- Gary D. Anderson, Vice Chair  
  Massachusetts  
- Kathleen A. Birrane, Secretary  
  Maryland  
- Andrew N. Mais  
  Connecticut  
- Trinidad Navarro  
  Delaware  
- Karima M. Woods  
  District of Columbia  
- Eric A. Cioppa  
  Maine  
- Chris Nicolopoulos  
  New Hampshire  
- Marlene Caride  
  New Jersey  
- Adrienne A. Harris  
  New York  
- Elizabeth Kelleher Dwyer  
  Rhode Island  
- Michael S. Pieciak  
  Vermont

## Southeast Zone
- Jim L. Ridling, Chair  
  Alabama  
- Mike Chaney, Vice Chair  
  Mississippi  
- James J. Donelon, Secretary  
  Louisiana  
- Alan McClain  
  Arkansas  
- David Almapi  
  Florida  
- John F. King  
  Georgia  
- Sharon P. Clark  
  Kentucky  
- Mike Causey  
  North Carolina  
- Raymond G. Farmer  
  Puerto Rico  
- Carter Lawrence  
  South Carolina  
- Tregenza A. Roach  
  Tennessee  
- Scott A. White  
  Virgin Islands  
- Allan L. McVey  
  Virginia  
- Jim L. Ridling, Chair  
  West Virginia

## Midwest Zone
- Larry D. Deiter, Chair  
  South Dakota  
- Glen Mulready, Vice Chair  
  Oklahoma  
- Doug Ommen, Secretary  
  Iowa  
- Dana Popish Severinghaus  
  Illinois  
- Amy L. Beard  
  Indiana  
- Vicki Schmidt  
  Kansas  
- Anita G. Fox  
  Michigan  
- Grace Arnold  
  Minnesota  
- Chlora Lindley-Myers  
  Missouri  
- Eric Dunning  
  Nebraska  
- Jon Godfread  
  North Dakota  
- Judith L. French  
  Ohio  
- Mark Afable  
  Wisconsin

## Western Zone
- Lori K. Wing-Heier, Chair  
  Alaska  
- Michael Conway, Vice Chair  
  Colorado  
- Andrew R. Stolfi, Secretary  
  Oregon  
- Peni Itula Sapini Teo  
  American Samoa  
- Evan G. Daniels  
  Arizona  
- Ricardo Lara  
  California  
- Michelle B. Santos  
  Guam  
- Colin M. Hayashida  
  Hawaii  
- Dean L. Cameron  
  Idaho  
- Troy Downing  
  Montana  
- Edward M. Deleon Guerrero  
  N. Mariana Islands  
- Barbara D. Richardson  
  Nevada  
- Russell Toal  
  New Mexico  
- Cassie Brown  
  Texas  
- Jonathan T. Pike  
  Utah  
- Mike Kreidler  
  Washington  
- Jeff Rude  
  Wyoming

*Updated December 9, 2021*
# 2021 Executive (EX) Committee

David Altmaier, President  
Florida  
Dean L. Cameron, President-Elect  
Idaho  
Chlora Lindley-Myers, Vice President  
Missouri  
Andrew N. Mais, Secretary-Treasurer  
Connecticut  

Most Recent Past President  
Raymond G. Farmer  
South Carolina  

## Northeast Zone

Jessica K. Altman, Chair  
Pennsylvania  
Gary D. Anderson, Vice Chair  
Massachusetts  
Kathleen A. Birrane, Secretary  
Maryland  

## Southeast Zone

Jim L. Ridling, Chair  
Alabama  
Mike Chaney, Vice Chair  
Mississippi  
James J. Donelon, Secretary  
Louisiana  

## Midwest Zone

Larry D. Deiter, Chair  
South Dakota  
Glen Mulready, Vice Chair  
Oklahoma  
Doug Ommen, Secretary  
Iowa  

## Western Zone

Lori K. Wing-Heier, Chair  
Alaska  
Michael Conway, Vice Chair  
Colorado  
Andrew R. Stolfi, Secretary  
Oregon  

NAIC Support Staff: Andrew J. Beal/Kay Noonan  

*Updated January 25, 2021*
CLIMATE AND RESILIENCY (EX) TASK FORCE
of the Executive (EX) Committee

Ricardo Lara, Co-Chair
Raymond G. Farmer, Co-Chair
Colin M. Hayashida, Co-Vice Chair
James J. Donelon, Co-Vice Chair
Kathleen A. Birrane, Co-Vice Chair
Mark Afable, Co-Vice Chair
Andrew R. Stolfi, Co-Vice Chair
Jim L. Ridling
Lori K. Wing-Heier
Michael Conway
Andrew N. Mais
Trinidad Navarro
Karima M. Woods
David Altmaier
Amy L. Beard
Eric A. Cioppa
Gary D. Anderson
Anita G. Fox
Grace Arnold
Eric Dunning
Barbara D. Richardson
Marlene Caride
Russell Toal
Adrienne A. Harris
Jon Godfread
Judith L. French
Jessica K. Altman
Elizabeth Kelleher Dwyer
Michael S. Pieciak
Scott A. White
Mike Kreidler
Allan L. McVey
Jeff Rude

California
South Carolina
Hawaii
Louisiana
Maryland
Wisconsin
Oregon
Alabama
Alaska
Colorado
Connecticut
Delaware
District of Columbia
Florida
Indiana
Maine
Massachusetts
Michigan
Minnesota
Nebraska
Nevada
New Jersey
New Mexico
New York
North Dakota
Ohio
Pennsylvania
Rhode Island
Vermont
Virginia
Washington
West Virginia
Wyoming

NAIC Support Staff: Jennifer Gardner
GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL
of the Executive (EX) Committee

David Altmaier, Chair
Dean L. Cameron, Vice Chair
Ricardo Lara
Andrew N. Mais
John F. King
Sharon P. Clark
Gary D. Anderson
Anita G. Fox
Chlora Lindley-Myers
Jon Godfread
Glen Mulready
Jessica K. Altman
Raymond G. Farmer
Mike Kreidler
Jeff Rude

Florida
Idaho
California
Connecticut
Georgia
Kentucky
Massachusetts
Michigan
Missouri
North Dakota
Oklahoma
Pennsylvania
South Carolina
Washington
Wyoming

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

INNOVATION AND TECHNOLOGY (EX) TASK FORCE
of the Executive (EX) Committee

Jon Godfread, Chair
Elizabeth Kelleher Dwyer, Vice Chair
Jim L. Ridling
Lori K. Wing-Heier
Peni Itula Sapini Teo
Evan G. Daniels
Alan McClain
Ricardo Lara
Michael Conway
Andrew N. Mais
Trinidad Navarro
Karima M. Woods
David Altmaier
Colin M. Hayashida
Dean L. Cameron
Dana Popish Severinghaus
Amy L. Beard
Doug Ommen
Vicki Schmidt
Sharon P. Clark
James J. Donelon
Eric A. Cioppa
Kathleen A. Birrane
Gary D. Anderson
Anita G. Fox

North Dakota
Rhode Island
Alabama
Alaska
American Samoa
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan

Grace Arnold
Mike Chaney
Chlora Lindley-Myers
Troy Downing
Edward M. Deleon Guerrero
Eric Dunning
Barbara D. Richardson
Chris Nicolopoulos
Marlene Caride
Russell Toal
Mike Causey
Judith L. French
Glen Mulready
Andrew R. Stolfi
Jessica K. Altman
Raymond G. Farmer
Larry D. Deiter
Carter Lawrence
Cassie Brown
Jonathan T. Pike
Michael S. Pieciak
Scott A. White
Mike Kreidler
Allan L. McVey
Mark Afable

Minnesota
Mississippi
Missouri
Montana
N. Mariana Islands
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
North Carolina
Ohio
Oklahoma
Oregon
Pennsylvania
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin

NAIC Support Staff: Scott Morris/Denise Matthews
INNOVATION AND TECHNOLOGY (EX) TASK FORCE (Continued)

Big Data and Artificial Intelligence (EX) Working Group
of the Innovation and Technology (EX) Task Force

Doug Ommen, Chair
Elizabeth Kelleher Dwyer, Co-Vice Chair
Mark Afable, Co-Vice Chair
Daniel Davis/Jimmy Gunn
Lori K. Wing-Heier/Katie Hegland/Sian Ng-Ashcraft
Ken Allen
Mike Conway/Peg Brown
Andrew N. Mais
Frank Pyle
Karima M. Woods
Rebecca Smid/Mike Yaworsky
Judy Mottar
Holly Williams Lambert
Satish Akula
Tom Travis
Benjamin Yardley
Kathleen A. Birrane/Robert Baron/Ron Coleman
Karen Dennis
Matthew Vatter/Phil Vigliaturo
Cynthia Amann
Barbara D. Richardson
Christian Citarella
Marlene Caride
Keith Briggs/Kathy Shortt
Jon Godfread/Chris Aufenthie
Judith L. French/Lori Barron
Teresa Green
Andrew R. Stolfi
Shannen Logue/Michael McKenney
Michael Wise
Carter Lawrence
J’ne Byckovski/Rachel Cloyd
Tanji J. Northrup/Reed Stringham
Michael S. Pieciak/Kevin Gaffney
Scott A. White/Eric Lowe
Eric Slavich/John Haworth
Allan L. McVey

Iowa
Rhode Island
Wisconsin
Alabama
Alaska
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Illinois
Indiana
Kentucky
Louisiana
Maine
Maryland
Michigan
Minnesota
Missouri
Nevada
New Hampshire
New Jersey
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
South Carolina
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia

NAIC Support Staff: Tim Mullen/Denise Matthews
INNOVATION AND TECHNOLOGY (EX) TASK FORCE (Continued)

E-Commerce (EX) Working Group
_of the Innovation and Technology (EX) Task Force_

Kathleen A. Birrane/Robert Baron, Chair
Jully Pae
Andrew N. Mais/George Bradner
Dana Sheppard
Heather Droge
Tom Travis
Cynthia Amann
Martin Swanson
Chris Aufenthie
Judith L. French/Lori Barron
Shannen Logue
Elizabeth Kelleher Dwyer/Matt Gendron
Justin Baisch

Maryland
California
Connecticut
District of Columbia
Kansas
Louisiana
Missouri
Nebraska
North Dakota
Ohio
Pennsylvania
Rhode Island
Washington

NAIC Support Staff: Denise Matthews/Casey McGraw

Speed to Market (EX) Working Group
_of the Innovation and Technology (EX) Task Force_

Rebecca Nichols, Chair
Maureen Motter, Vice Chair
Jimmy Gunn
Wally Thomas/Katie Hegland
Jimmy Harris
Shirley Taylor
Trinidad Navarro/Frank Pyle
Robert Nkojo
Dean L. Cameron
Julie Rachford
Heather Droge
Tammy Lohmann
Camille Anderson-Weddle
Edward M. Deleon Guerrero
Frank Cardamone
Russell Toal
Ted Hamby
Jon Godfrey
Cuc Nguyen/Glen Mulready
Andrew R. Stolfi
Mark Worman/Theresa Rubio
Tanji J. Northrup
Lichiou Lee
Allan L. McVey
Barry Haney

Virginia
Ohio
Alabama
Alaska
Arkansas
Colorado
Delaware
District of Columbia
Idaho
Illinois
Kansas
Minnesota
Missouri
N. Mariana Islands
New Hampshire
New Mexico
North Carolina
North Dakota
Oklahoma
Oregon
Texas
Utah
Washington
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# LONG-TERM CARE INSURANCE (EX) TASK FORCE

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NAIC Support Staff: Sherry Stevens
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NAIC Support Staff: Eric King
### REGULATORY FRAMEWORK (B) TASK FORCE
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NAIC Support Staff: Jolie H. Matthews/Jennifer R. Cook
REGULATORY FRAMEWORK (B) TASK FORCE (Continued)

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# Advisory Organization Examination Oversight (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee

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NAIC Support Staff: Ginny Ewing/Randy Helder
# PRODUCER LICENSING (D) TASK FORCE

*of the Market Regulation and Consumer Affairs (D) Committee*

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<td>Elizabeth Kelleher Dwyer</td>
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<tr>
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NAIC Support Staff: Dan Daveline

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<table>
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</tbody>
</table>

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NAIC Support Staff: Jane Barr
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NAIC Support Staff: Dan Daveline/Casey McGraw

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NAIC Support Staff: Dan Daveline
# FINANCIAL CONDITION (E) COMMITTEE (Continued)

## Restructuring Mechanisms (E) Subgroup

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<td>Amy Garcia</td>
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<tr>
<td>Amy Malm</td>
<td>Wisconsin</td>
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NAIC Support Staff: Dan Daveline/Robin Marcotte

## Risk-Focused Surveillance (E) Working Group

of the Financial Condition (E) Committee

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<td>William Arfanis/Kathy Belfi</td>
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<td>John Jacobson/Steve Drutz</td>
<td>Washington</td>
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NAIC Support Staff: Pat Allison
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<td>Jeff Rude</td>
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of the Financial Condition (E) Committee

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Andrew N. Mais
Sharon P. Clark
Troy Downing
Barbara D. Richardson
Russell Toal
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District of Columbia
Connecticut
Kentucky
Montana
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New Mexico
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of the Financial Condition (E) Committee

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Adrienne A. Harris
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Jonathan T. Pike
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Alaska
California
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Louisiana
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Massachusetts
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Andrew N. Mais                 Connecticut
Trinidad Navarro               Delaware
Karima M. Woods                District of Columbia
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Kathleen A. Birrane            Maryland
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Grace Arnold                   Minnesota
Mike Chaney                    Mississippi
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Eric Dunning                   Nebraska
Barbara D. Richardson          Nevada
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Mike Causey                    North Carolina
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Judith L. French               Ohio
Glen Mulready                  Oklahoma
Jessica K. Altman              Pennsylvania
Cassie Brown                   Texas
Jonathan T. Pike               Utah
Tregenza A. Roach              Virgin Islands
Scott A. White                 Virginia
Mike Kreidler                  Washington
Mark Afable                    Wisconsin

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of the NAIC/Consumer Liaison Committee

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Jon Godfread
Glen Mulready
Andrew R. Stolfi
Larry D. Deiter
Mike Kreidler

Alaska
Wyoming
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Delaware
Idaho
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Montana
N. Mariana Islands
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Oregon
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Washington

NAIC Support Staff: Lois E. Alexander
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### ALASKA—Appointed, at the pleasure of the Commissioner of Commerce, Community, and Economic Development

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### AMERICAN SAMOA—Appointed, at the pleasure of the Governor

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### NAIC MEMBER TENURE LIST

#### AMERICAN SAMOA—Continued

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#### ARIZONA—Appointed, at the pleasure of the Governor; subject to confirmation by the Senate

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### NAIC MEMBER TENURE LIST

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### ARKANSAS—Appointed, at the pleasure of the Governor with the advice and consent of the Senate

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### NAIC Member Tenure List

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### NAIC MEMBER TENURE LIST

#### CALIFORNIA—Continued

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#### COLORADO—Appointed, at the pleasure of the Governor; subject to confirmation by the Senate

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© 2021 National Association of Insurance Commissioners
## NAIC Member Tenure List

### Delaware—Elected; 4-Year Term

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<th>State/Member Title</th>
<th>Member Name</th>
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<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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### District of Columbia—Appointed, at the pleasure of the Mayor; confirmed by the Council of District Columbia

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<td>4/28/1931</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Thomas M. Baldwin, Jr.</td>
<td>9/16/1924</td>
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<tr>
<td>Acting Superintendent of Insurance</td>
<td>Thomas M. Baldwin, Jr.</td>
<td>3/29/1924</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Burt A. Miller</td>
<td>6/22/1922</td>
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<td>Lewis A. Griffith</td>
<td>6/4/1919</td>
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<td>Lee B. Mosher</td>
<td>11/14/1917</td>
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<td>Charles F. Nesbit</td>
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<td>Daniel E. Curry</td>
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<td>Thomas E. Drake (Died July 23, 1910)</td>
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<tr>
<td>Assessor of the District</td>
<td>Hopewell H. Darnelle</td>
<td>12/1/1899</td>
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<td>Assessor of the District</td>
<td>Matthew Trimble</td>
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<tr>
<td>Assessor of the District</td>
<td>Roger Williams</td>
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<td>3/16/1890</td>
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<td>Assessor of the District</td>
<td>Roswell A. Fish</td>
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<td>3/19/1889</td>
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<td>Treasurer and Assessor</td>
<td>Robert P. Dodge (Died May 21, 1887)</td>
<td>7/11/1876</td>
<td>5/21/1887</td>
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<tr>
<td>Treasurer of the District</td>
<td>James S. Wilson</td>
<td>12/1/1873</td>
<td>7/11/1876</td>
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<tr>
<td>Treasurer of the District</td>
<td>John T. Johnson</td>
<td>10/18/1871</td>
<td>11/29/1873</td>
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<tr>
<td>Insurance Commissioner</td>
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### NAIC MEMBER TENURE LIST

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<th>MOS. SERVED</th>
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<td><strong>FLORIDA—Continued</strong></td>
<td>J. Edwin Larson <em>(Died Jan. 24, 1965)</em></td>
<td>1/7/1941</td>
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<td>William V. Knott</td>
<td>9/28/1928</td>
<td>1/7/1941</td>
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<td>State Treasurer</td>
<td>William V. Knott</td>
<td>3/1/1903</td>
<td>2/19/1912</td>
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<td>State Treasurer</td>
<td>James B. Whitfield</td>
<td>6/19/1897</td>
<td>3/1/1903</td>
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<td>State Treasurer</td>
<td>Clarence B. Collins</td>
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<td>6/19/1897</td>
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<td>State Treasurer</td>
<td>Eduardo J. Triay</td>
<td>12/31/1891</td>
<td>1/3/1893</td>
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<td>State Treasurer</td>
<td>Edward S. Crill</td>
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<td>1/8/1889</td>
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<td>State Treasurer</td>
<td>Henry A. L’Engle</td>
<td>2/1/1881</td>
<td>2/19/1885</td>
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<td>State Treasurer</td>
<td>Walter H. Gwynn</td>
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<td>State Treasurer</td>
<td>Charles H. Foster</td>
<td>1/16/1873</td>
<td>1/9/1877</td>
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<td>State Treasurer</td>
<td>Simon B. Conover</td>
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<th><strong>FLORIDA [Department of Financial Services]—Elected; 4-Year Term</strong></th>
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<tr>
<td>Chief Financial Officer</td>
<td>Jimmy T. Patronis, Jr. <em>(Appointed June 25, 2017; Elected Nov. 6, 2018)</em></td>
<td>6/30/2017</td>
<td>incumbent</td>
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<tr>
<td>Chief Financial Officer</td>
<td>Jeffrey H. &quot;Jeff&quot; Atwater</td>
<td>1/4/2011</td>
<td>6/30/2017</td>
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<tr>
<td>Chief Financial Officer</td>
<td>Adelaide Alexander ‘Alex’ Sink</td>
<td>1/2/2007</td>
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<th><strong>GEORGIA—Elected; 4-Year Term</strong></th>
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<tr>
<td>Insurance Commissioner</td>
<td>John F. King <em>(Appointed June 12, 2019)</em></td>
<td>7/1/2019</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Position Vacant</td>
<td>5/16/2019</td>
<td>7/1/2019</td>
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<td>Jim Beck <em>(Suspended May 16, 2019)</em></td>
<td>1/14/2019</td>
<td>5/16/2019</td>
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<td>Insurance Commissioner</td>
<td>Ralph T. Hudgens</td>
<td>1/10/2011</td>
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<tr>
<td>Insurance Commissioner</td>
<td>John Oxendine</td>
<td>1/20/1995</td>
<td>1/1/2011</td>
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<td>Insurance Commissioner</td>
<td>Tim Ryles</td>
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<td>1/20/1995</td>
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<td>Ins. Cmrs./Comptroller General</td>
<td>Johnnie L. Caldwell</td>
<td>1/12/1971</td>
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<td>Ins. Cmrs./Comptroller-General</td>
<td>James L. Bentley</td>
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<td>Zachariah D. ‘Zack’ Cravey</td>
<td>1/1/1947</td>
<td>1/1/1963</td>
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<td>Ins. Cmrs./Comptroller-General</td>
<td>C. Downing Musgrove</td>
<td>6/7/1940</td>
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<td>Ins. Cmrs./Comptroller-General</td>
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<td>1/12/1937</td>
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<td>Glenn B. Carreker</td>
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<td>William A. Wright <em>(Died Sept. 13, 1929)</em></td>
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<td>Washington L. Goldsmith</td>
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<td>Comptroller-General</td>
<td>Madison Bell</td>
<td>5/24/1871</td>
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# NAIC MEMBER TENURE LIST

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<thead>
<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tr>
<td><strong>GUAM—Appointed, at the pleasure of the Governor</strong></td>
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<tr>
<td>Cmsr. of Banking and Insurance</td>
<td>Michelle B. Santos</td>
<td>12/7/2020</td>
<td>incumbent</td>
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<tr>
<td>Director of Rev. &amp; Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>Dafne M. Shimizu</td>
<td>1/7/2019</td>
<td>12/7/2020</td>
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<td>Director of Rev. &amp; Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
<td>John P. Camacho</td>
<td>2/5/2018</td>
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<td>Director of Rev. &amp; Taxation/Acting Cmsr. of Banking &amp; Insurance</td>
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<td>Acting Director of Revenue and Taxation/Acting Insurance Cmsr.</td>
<td>George V. Cruz</td>
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<td>Director of Revenue and Taxation/Insurance Commissioner</td>
<td>Joaquin G. Blaz</td>
<td>1/1/1988</td>
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<td>Acting Director of Revenue and Taxation/Acting Insurance Cmsr.</td>
<td>J.C. Carr Bettis</td>
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<td>Director of Revenue and Taxation/Insurance Commissioner</td>
<td>David J. ‘Dave’ Santos</td>
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<td>Director of Revenue and Taxation/Insurance Commissioner</td>
<td>Jose R. Rivera</td>
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<td>Director of Revenue and Taxation/Insurance Commissioner</td>
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<td>George W. Ingling (Died March 26, 1979)</td>
<td>3/6/1961</td>
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<td><strong>HAWAII—Appointed, at the pleasure of the Director of Commerce and Consumer Affairs; approved by the Governor</strong></td>
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### NAIC MEMBER TENURE LIST

#### HAWAI‘I—Continued

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#### IDAHO—Appointed; 4-year term, subject to earlier removal by the Governor

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### NAIC MEMBER TENURE LIST

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<td><strong>Insurance Commissioner</strong></td>
<td>Leo O’Connell</td>
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## NAIC Member Tenure List

### Illinois—Continued

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<td>Joseph S. Gerber</td>
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<td>Justin T. McCarthy</td>
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| Director of Insurance              | Harry B. Hershey            | 1/17/1949 | 9/1/1950  | 1           | 8           |
| Director of Insurance              | Nellis P. Parkinson         | 4/4/1945  | 1/17/1949 | 3           | 9           |
| Acting Director of Insurance       | Nellis P. Parkinson         | 4/15/1944 | 4/4/1945  | 1           | 0           |
| Director of Insurance              | Paul F. Jones               | 1/15/1941 | 4/15/1944 | 3           | 3           |
| Director of Insurance              | C. Hayden Davis             | 11/7/1940 | 1/15/1941 | 0           | 2           |
| Director of Insurance              | Ernest Palmer               | 7/1/1933  | 11/7/1940 | 6           | 4           |
| Insurance Superintendent           | Ernest Palmer               | 1/23/1933 | 7/1/1933  | 0           | 6           |
| Insurance Superintendent           | Harry W. Hanson             | 7/1/1930  | 1/23/1933 | 2           | 6           |
| Insurance Superintendent           | George W. Huskinson         | 1/26/1927 | 7/1/1930  | 3           | 6           |
| Director of Trade and Commerce     | H. U. Bailey                | 1/27/1926 | 1/26/1927 | 1           | 0           |
| Director of Trade and Commerce     | Clifford C. Ireland         | 11/15/1923| 1/27/1926 | 2           | 2           |
| Insurance Superintendent           | Thomas J. Houston          | 8/8/1921  | 11/15/1923| 2           | 3           |
| Insurance Superintendent           | Frederick W. ‘Fred’ Potter  | 5/15/1917 | 8/8/1921  | 4           | 3           |
| Insurance Superintendent           | Rufus M. Potts              | 8/11/1913 | 5/15/1917 | 3           | 9           |
| Insurance Superintendent           | Frederick W. ‘Fred’ Potter  | 1/1/1907  | 8/11/1913 | 6           | 7           |
| Insurance Superintendent           | William R. Vredenburgh      | 5/2/1903  | 1/1/1907  | 3           | 8           |
| Insurance Superintendent           | Henry Yates (Died May 1, 1903) | 5/6/1901 | 5/1/1903  | 2           | 0           |
| Insurance Superintendent           | James R. B. Van Cleave      | 5/1/1897  | 5/6/1901  | 4           | 0           |
| Insurance Superintendent           | Bradford K. Durfee          | 7/13/1893 | 5/1/1907  | 3           | 10          |
| Auditor of State                   | David P. Gore               | 1/10/1893 | 7/13/1893 | 0           | 6           |
| Auditor of State                   | Charles W. Pavely           | 1/14/1889 | 1/10/1893 | 4           | 0           |
| Auditor of State                   | Charles P. Swigert          | 1/10/1881 | 1/14/1889 | 8           | 0           |
| Auditor of State                   | Thomas B. Needles           | 1/8/1877  | 1/10/1881 | 4           | 0           |
| Auditor of State                   | Charles E. Lippencott       | 5/24/1871 | 1/8/1877  | 5           | 8           |

### Indiana—Appointed, at the Pleasure of the Governor

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<th>State/Member Title</th>
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| Acting Commissioner of Insurance   | James D. ‘Jim’ Atterholt     | 1/10/2005 | 2/22/2005 | 0           | 1           |
| Interim Commissioner of Insurance  | Amy E. Strati                | 7/15/2004 | 1/10/2005 | 0           | 6           |
| Commissioner of Insurance          | Sarah Ann ‘Sally’ McCarty    | 6/26/1997 | 7/15/2004 | 7           | 1           |
| Commissioner of Insurance          | John J. Quinn                | 4/16/1997 | 6/26/1997 | 0           | 2           |

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## NAIC Member Tenure List

<table>
<thead>
<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
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### IOWA—Appointed, at the Pleasure of the Governor; 4-Year Term

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## NAIC Member Tenure List

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## Kansas—Elected: 4-Year Term

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### NAIC Member Tenure List

**Kansas—Continued**

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**Kentucky—Appointed, at the Pleasure of the Governor**

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<td>Sharon P. Clark</td>
<td>1/6/2020</td>
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<td>Commissioner of Insurance</td>
<td>Nancy G. Atkins</td>
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<td>Laura Douglas</td>
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<td>Suetta Dickinson</td>
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<td>Elizabeth Wright</td>
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### KENTUCKY—Continued

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<td>Commissioner of Insurance</td>
<td>Sherman Goodpaster</td>
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<td>Commissioner of Insurance</td>
<td>J. Dan Talbott</td>
<td>1/31/1936</td>
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<td>Gemill B. Senff</td>
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<td>Commissioner of Insurance</td>
<td>Bush W. Allin</td>
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<td>Commissioner of Insurance</td>
<td>Leslie C. Norman</td>
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<tr>
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<td>Bedford Leslie</td>
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<td>Gustavus W. Smith</td>
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### LOUISIANA—Elected; 4-Year Term

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<th>Yrs. Served</th>
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<td>Acting Insurance Commissioner</td>
<td>Darrell Cobb</td>
<td>8/1/1991</td>
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<td>Insurance Commissioner</td>
<td>Dudley A. Guglielmo</td>
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<td>Rufus D. Hayes</td>
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<td>Secretary of State/Insurance Cmr.</td>
<td>James A. Gremillion</td>
<td>6/24/1940</td>
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<td>Eugene A. Conway</td>
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<tr>
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<td>Secretary of State/Insurance Cmr.</td>
<td>Alvin E. Hebert (Died March 9, 1915)</td>
<td>7/23/1912</td>
<td>3/9/1915</td>
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<td>E. J. O'Brien</td>
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<td>Edward Everett</td>
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<td>Deputy Insurance Commissioner</td>
<td>John J. McCann</td>
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<td>John T. Michel</td>
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<td>Simeon Toby</td>
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<td>Oscar Orroyo</td>
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<td>William A. Strong</td>
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<td>Richard Gaines</td>
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<tr>
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### MAINE—Appointed; 5-Year Term

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<td>Mila Kofman</td>
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<td>Eric A. Cioppa</td>
<td>1/14/2007</td>
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<td>Jeri E. Brown</td>
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<td>Everard B. Stevens</td>
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<td>Frank M. Hogerty, Jr.</td>
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<td>Commissioner of Insurance</td>
<td>J. Wallace Blunt</td>
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<td>Commissioner of Insurance</td>
<td>Stephen W. Carr</td>
<td>12/26/1893</td>
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## NAIC Member Tenure List

### MAINE—Continued

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<td>Frank E. Nye</td>
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<td>Joseph B. Peaks</td>
<td>3/1/1883</td>
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### MARYLAND—Appointed, at the Pleasure of the Governor; 4-Year Term

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<tr>
<td>Commissioner of Insurance</td>
<td>Kathleen A. Birrane</td>
<td>5/18/2020</td>
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<td>1/22/2015</td>
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<td>Therese M. Goldsmith</td>
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<td>Elizabeth &quot;Beth&quot; Sammis</td>
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<td>Peggy J. Watson</td>
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<td>Charles A. Wailes (Died Jan. 31, 1876)</td>
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### Massachusetts—Appointed, at the Discretion of the Governor

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<tr>
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<td>Gary D. Anderson</td>
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<td>Julius L. Clarke</td>
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<tr>
<td>MIChIGAn—Appointed, at the Pleasure of the Governor; 4-Year Term</td>
<td>Anita G. Fox</td>
<td>1/14/2019</td>
<td>incumbent</td>
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<tr>
<td>Acting Director, DIFS</td>
<td>Judith A. ‘Judy’ Weaver</td>
<td>12/28/2018</td>
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## NAIC Member Tenure List

### Michigan—Continued

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### Minnesota—Appointed, at the Pleasure of the Governor; Confirmed by the Senate

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## NAIC Member Tenure List

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### Missouri—Appointed, at the Pleasure of the Governor; Confirmed by the Senate

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<th>Yrs. Served</th>
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## NAIC MEMBER TENURE LIST

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### NAIC MEMBER TENURE LIST

#### MONTANA—Elected; 4-Year Term

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<th>End Date</th>
<th>Yrs. Served</th>
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<td>Troy Downing (Elected Nov. 3, 2020)</td>
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<td>1/5/2009</td>
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#### NEBRASKA—Appointed, at the Pleasure of the Governor

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| NEVADA—Appointed, at the Pleasure of the Director of the Department of Business and Industry | | | |
|---------------------------|--------------------------|-----------|----------|-------------|-------------|
| Insurance Commissioner    | Barbara D. Richardson    | 3/7/2016  | incumbent |             |             |
| Acting Insurance Commissioner | Amy L. Parks           | 7/7/2015  | 3/7/2016 | 0           | 8           |
| Insurance Commissioner    | Scott J. Kipper         | 10/24/2011 | 7/2/2015 | 3           | 9           |
| Acting Insurance Commissioner | Amy L. Parks           | 8/12/2011 | 10/24/2011 | 0          | 2           |
| Insurance Commissioner    | Brett J. Barratt        | 7/7/2010  | 7/1/2011 | 1           | 0           |
| Acting Insurance Commissioner | Betty Baker            | 9/1/2008  | 12/29/2008 | 0          | 3           |
| Insurance Commissioner    | Alice Molasky-Arman      | 1/6/1995  | 9/1/2008  | 13          | 8           |
| Insurance Commissioner    | Alessandro A. ‘Al’ Iuppa | 1/1/1990  | 2/1/1991  | 1           | 1           |
| Insurance Commissioner    | David A. Gates          | 7/6/1984  | 1/1/1990  | 5           | 6           |
| Insurance Commissioner    | Kevin Sullivan          | 1/3/1983  | 7/6/1984  | 1           | 6           |
| Insurance Commissioner    | Patsy Redmond           | 5/12/1981 | 1/3/1983  | 1           | 8           |
| Insurance Commissioner    | Donald W. ‘Don’ Heath   | 1/1/1979  | 5/12/1981 | 2           | 4           |
## NAIC MEMBER TENURE LIST

### NEVADA—Continued

<table>
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<tr>
<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tbody>
<tr>
<td>Insurance Commissioner</td>
<td>James L. ‘Jim’ Wadhams</td>
<td>6/1/1978</td>
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### NEW HAMPSHIRE—Appointed, 5-Year Term; Nominated by the Governor; Approved by the Executive Council

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<td>Christopher R. ‘Chris’ Nicolopoulos</td>
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<td>Alexander K. ‘Alex’ Feldvebel</td>
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## NAIC Member Tenure List

**NEW JERSEY—Appointed, at the Pleasure of the Governor**

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<tr>
<td>Acting Insurance Commissioner</td>
<td>Kenneth D. Merin</td>
<td>4/1/1984</td>
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<tr>
<td>Insurance Commissioner</td>
<td>Joseph F. Murphy</td>
<td>2/1/1982</td>
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<td>Acting Insurance Commissioner</td>
<td>John G. Foley</td>
<td>1/1/1982</td>
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<td>James J. Sheeran</td>
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<td>Insurance Commissioner</td>
<td>Richard C. McDonough</td>
<td>2/14/1972</td>
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<td>Horace J. Bryant</td>
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<td>Warren N. Gaffney</td>
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<td>Christopher A. Gough</td>
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<td>Cmsr. of Banking and Insurance</td>
<td>William E. Tuttle, Jr. (Died Feb. 11, 1923)</td>
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<td>George M. La Monte</td>
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<td>Vivian M. Lewis</td>
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<td>David O. Watkins</td>
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<td>William Bettie</td>
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<td>Cmrs. of Banking and Insurance</td>
<td>George B. M. Harvey</td>
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<td>Secretary of State</td>
<td>Henry C. Kelsey</td>
<td>5/24/1871</td>
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<tr>
<th><strong>NEW MEXICO—Appointed, by the Insurance Nominating Committee; 4-Year Term</strong></th>
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<tbody>
<tr>
<td>Superintendent of Insurance</td>
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<td>Interim Superintendent of Insurance</td>
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<td>Bank Examiner of State</td>
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<td>Superintendent of Insurance and Corporation Commission</td>
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### NEW MEXICO—Continued

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<th>End Date</th>
<th>Yrs. Served</th>
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<td>Territorial Auditor</td>
<td>Trinidad Alarid</td>
<td>8/15/1888</td>
<td>3/18/1891</td>
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### NEW YORK—Appointed, at the Pleasure of the Governor

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<th>State/Member Title</th>
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<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tbody>
<tr>
<td>Acting Superintendent of Fin. Svcs.</td>
<td>Adrienne A. Harris</td>
<td>9/13/2021</td>
<td>Incumbent</td>
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<tr>
<td>Acting Superintendent of Fin. Svcs.</td>
<td>Shirin Emami</td>
<td>8/25/2021</td>
<td>9/12/2021</td>
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</tr>
<tr>
<td>Superintendent of Financial Services</td>
<td>Linda A. Lacewell</td>
<td>6/21/2019</td>
<td>8/24/2021</td>
<td>2</td>
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<tr>
<td>Superintendent of Financial Services</td>
<td>Maria T. Vullo</td>
<td>6/15/2016</td>
<td>2/1/2019</td>
<td>2</td>
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<tr>
<td>Acting Superintendent of Fin. Svcs.</td>
<td>Maria T. Vullo</td>
<td>2/22/2016</td>
<td>6/15/2016</td>
<td>0</td>
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<tr>
<td>Acting Superintendent of Fin. Svcs.</td>
<td>Shirin Emami</td>
<td>12/1/2015</td>
<td>2/22/2016</td>
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<tr>
<td>Acting Superintendent of Fin. Svcs.</td>
<td>Anthony J. Albanese</td>
<td>6/18/2015</td>
<td>11/30/2015</td>
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<tr>
<td>Acting Superintendent of Insurance</td>
<td>James J. Wrynn</td>
<td>8/20/2009</td>
<td>9/11/2009</td>
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<tr>
<td>Acting Superintendent of Insurance</td>
<td>Kermit J. Brooks</td>
<td>7/4/2009</td>
<td>8/19/2009</td>
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<tr>
<td>Acting Superintendent of Insurance</td>
<td>Louis W. 'Lou' Pietroluongo</td>
<td>1/1/2007</td>
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<td>Acting Superintendent of Insurance</td>
<td>Howard D. Mills III</td>
<td>1/18/2005</td>
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<td>Gregory V. ‘Greg’ Serio</td>
<td>4/5/2001</td>
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<td>Albert B. Lewis</td>
<td>1/5/1978</td>
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<tr>
<td>Superintendent of Insurance</td>
<td>Thomas A. Harnett</td>
<td>6/24/1975</td>
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<tr>
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<td>Lawrence W. Keepnews</td>
<td>3/18/1975</td>
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<td>Lawrence O. Monin</td>
<td>3/10/1975</td>
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<td>Superintendent of Insurance</td>
<td>Benjamin R. Schenck</td>
<td>1/1/1971</td>
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<td>Henry Root Stern, Jr.</td>
<td>1/28/1964</td>
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<tr>
<td>Acting Superintendent of Insurance</td>
<td>Samuel C. Cantor</td>
<td>10/3/1963</td>
<td>1/27/1964</td>
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<td>Thomas Thacher</td>
<td>1/27/1959</td>
<td>10/2/1963</td>
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<td>Superintendent of Insurance</td>
<td>Julius S. Wikler</td>
<td>3/17/1958</td>
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<td>Adelbert G. Straub, Jr.</td>
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<td>Alfred J. Bohlinger</td>
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<tr>
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<td>Louis H. Pink</td>
<td>5/10/1935</td>
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<td>Henry A. Thellosson</td>
<td>2/17/1931</td>
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<td>Albert Conway</td>
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<td>Francis R. Stoddard, Jr.</td>
<td>12/1/1921</td>
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<td>Jesse S. Phillips</td>
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<td>Frank Hasbrouck</td>
<td>3/27/1914</td>
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<td>William Temple Emmet</td>
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<td>William H. Hotchkiss</td>
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<td>Otto Kelsey</td>
<td>5/17/1906</td>
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<td>Francis Hendricks</td>
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<td>Robert A. Maxwell</td>
<td>1/1/1886</td>
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<td>John A. McCall, Jr.</td>
<td>4/23/1883</td>
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<td>Charles G. Fairman</td>
<td>4/27/1880</td>
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<td>John F. Smyth</td>
<td>2/21/1877</td>
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<td>George B. Church</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>Mike Causey (Elected Nov. 8, 2016; Re-elected Nov. 3, 2020)</td>
<td>1/1/2017</td>
<td>incumbent</td>
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<tr>
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<td>G. Wayne Goodwin</td>
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<tr>
<td>Commissioner of Insurance</td>
<td>John Randolph Ingram</td>
<td>1/10/1973</td>
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<td>Jon Godfred (Elected Nov. 8, 2016; Re-elected Nov. 3, 2020)</td>
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<td>James A. ‘Jim’ Poolman</td>
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### NAIC MEMBER TENURE LIST

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### NORTHERN MARIANA ISLANDS—Appointed, Concurrent with Current Governor

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<td>Mark O. Rabauliman</td>
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<td>Sixto K. Igisomar</td>
<td>1/24/2012</td>
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<td>Secretary of Commerce</td>
<td>Michael J. Ada</td>
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<td>Michael J. Ada</td>
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<td>James A. Santos</td>
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### OHIO—Appointed, at the Pleasure of the Governor; Confirmed by the Senate

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<td>Judith L. ‘Judi’ French</td>
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<td>Interim Director of Insurance</td>
<td>Tynesia Dorsey</td>
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<td>Jillian E. Froment</td>
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<td>Mary Taylor</td>
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<td>Mary Jo Hudson</td>
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<td>Director of Insurance</td>
<td>Ann H. Womer Benjamin</td>
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<td>Holly Saelens</td>
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### NAIC MEMBER TENURE LIST

#### OHIO—Continued

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#### OKLAHOMA—Elected; 4-Year Term

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<th>Mos. Served</th>
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# NAIC Member Tenure List

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| **OREGON—Appointed, Indefinite** | | | | | |
| Director, Department of Consumer and Business Services (DCBS) / Insurance Commissioner | Andrew R. Stolfi | 4/7/2020 | incumbent |
| Insurance Commissioner | Andrew R. Stolfi | 2/1/2018 | 4/7/2020 | 2 | 2 |
| Acting Director, DCBS / Insurance Commissioner | Cameron Smith | 12/21/2017 | 1/31/2018 | 0 | 2 |
| Acting Director, DCBS / Insurance Commissioner | Jean Straight | 9/1/2017 | 12/20/2017 | 0 | 3 |
| Insurance Commissioner / Chief Actuary | Laura N. Cali Robison | 7/15/2013 | 8/31/2017 | 4 | 1 |
| Insurance Commissioner | Louis D. Savage | 5/1/2012 | 7/15/2013 | 1 | 2 |
| Acting Insurance Commissioner | Louis D. Savage | 11/1/2011 | 5/1/2012 | 0 | 6 |
| Acting Insurance Administrator | Teresa D. Miller | 10/1/2008 | 7/8/2009 | 0 | 9 |
| Insurance Administrator | Scott J. Kipper | 12/1/2007 | 10/1/2008 | 0 | 10 |
| Acting Insurance Administrator | Carl Lundberg | 7/1/2007 | 12/1/2007 | 0 | 5 |
| Insurance Administrator (named NAIC member rep. by Dir. Neidig) | Joel S. Ario | 12/1/2000 | 7/1/2007 | 7 | 3 |
| Acting Director, DCBS / Insurance Commissioners | Mary C. Neidig | 3/1/2000 | 4/27/2000 | 0 | 1 |
| Acting Director, DCBS / Insurance Commissioners | Deborah Lincoln | 3/1/2000 | 3/1/2000 | 0 | 1 |
| Acting Director, DCBS / Insurance Commissioners | Mike Greenfield | 7/1/1998 | 3/1/2000 | 1 | 8 |
| Acting Director, DCBS / Insurance Commissioners | Deborah Lincoln | 3/1/1998 | 7/1/1998 | 0 | 4 |
| Acting Director, DCBS / Insurance Commissioners | Kerry Barnett | 12/1/1993 | 12/31/1997 | 4 | 0 |
### NAIC Member Tenure List

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<th>State/Member Title</th>
<th>Member Name</th>
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<th>End Date</th>
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### Pennsylvania—Appointed, at the Pleasure of the Governor; Confirmed by the Senate

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#### PUERTO RICO—Appointed, Indefinite

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### NAIC MEMBER TENURE LIST

#### PUERTO RICO—Continued

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<td>Hector R. Ball</td>
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#### RHODE ISLAND—Appointed, at the Discretion of the Director of Business Regulation

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<td>Deputy Director/Insurance and Banking</td>
<td>Elizabeth ‘Beth’ Kelleher Dwyer</td>
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<td>Maurice C. Paradis</td>
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#### SOUTH CAROLINA—Appointed, at the Will of the Governor

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South Dakota—Appointed, at the Pleasure of the Secretary of the Department of Labor and Regulation

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<th>Member Name</th>
<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
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TENNESSEE—Appointed, at the Discretion of the Governor

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### TEXAS—Appointed; 2-Year Term

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### NAIC Member Tenure List

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<th>End Date</th>
<th>Yrs. Served</th>
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<td>Robert B. Cousins, Jr.</td>
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<td>James L. Chapman</td>
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<td>Charles S. Tingey</td>
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<td>James T. Hammond</td>
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## NAIC MEMBER TENURE LIST

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<td>Elijah Sells</td>
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### VERMONT—Appointed, Biannually by the Governor with Senate Consent

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<tr>
<td>Commissioner, Department of Financial Regulation (DFR)</td>
<td>Michael S. ‘Mike’ Pieciak (Reappointed Dec. 22, 2016; Reappointed March 1, 2019)</td>
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<td>Commissioner, DFR</td>
<td>Susan L. Donegan</td>
<td>11/13/2012</td>
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<td>Stephen W. ‘Steve’ Kimbell</td>
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<td>Michael F. ‘Mike’ Bertrand</td>
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<td>Paulette J. Thabault</td>
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<td>Gretchen Babcock</td>
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<td>George A. Chaffee</td>
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<td>Cmsr. of Banking and Insurance</td>
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<td>Cmsr. of Banking and Insurance</td>
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<td>Donald A. Hemenway</td>
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<td>Cmsr. of Banking and Insurance</td>
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<td>Guy W. Bailey</td>
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<td>Walter F. Scott</td>
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<td>Edward H. Deavitt</td>
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<td>F. L. Fleetwood</td>
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© 2021 National Association of Insurance Commissioners
# NAIC Member Tenure List

## Vermont—Continued

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<th>Mos. Served</th>
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## Virgin Islands—Elected: 4-Year Term

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<td>Lt. Governor/Ins. Commissioner</td>
<td>Tregenza A. Roach (Elected Nov. 20, 2018)</td>
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<td>Lt. Governor/Ins. Commissioner</td>
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<td>Gwendolyn ‘Gwen’ Hall Brady</td>
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## Virginia—Appointed, at the Pleasure of the State Corporation Commission

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<td>Scott A White</td>
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<td>Commissioner of Insurance</td>
<td>George A. Bowles (Died June 1, 1956)</td>
<td>4/14/1932</td>
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<td>Re-elected Nov. 2, 2004; Re-elected Nov. 4, 2008; Re-elected Nov. 6, 2012; Re-elected Nov. 8, 2016; Re-Elected Nov. 3, 2020)</td>
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## NAIC Member Tenure List

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<th>State/Member Title</th>
<th>Member Name</th>
<th>Beg. Date</th>
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<th>Yrs. Served</th>
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<td><strong>WEST VIRGINIA—Continued</strong></td>
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<td>7/1/1947</td>
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<td><strong>WISCONSIN—Appointed, at the Pleasure of the Governor</strong></td>
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<td>Incumbent</td>
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<td>Theodore K. 'Ted' Nickel</td>
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<td>Ann J. Haney</td>
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<td>Harold R. Wilde, Jr.</td>
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<td>Paul J. Ragan</td>
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<td>Alfred Van DeZande</td>
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<td>Platt Whitman</td>
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<td>Michael J. ‘Mike’ Cleary</td>
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<td>Insurance Commissioner</td>
<td>Emil Giljohann</td>
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<td>William A. Fricke</td>
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<td>Wilbur M. Root</td>
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<td>Insurance Commissioner</td>
<td>Philip Cheek, Jr.</td>
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### NAIC Member Tenure List

#### Wisconsin—Continued

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<tr>
<th>State/Member Title</th>
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<th>Beg. Date</th>
<th>End Date</th>
<th>Yrs. Served</th>
<th>Mos. Served</th>
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<tr>
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<td>Philip L. Spooner, Jr.</td>
<td>4/1/1878</td>
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<td>Secretary of State</td>
<td>Hans B. Warner</td>
<td>1/7/1878</td>
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<td>Secretary of State</td>
<td>Peter Doyle</td>
<td>1/5/1874</td>
<td>1/7/1878</td>
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<td>Secretary of State</td>
<td>Llewelyn Breese</td>
<td>5/24/1871</td>
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#### Wyoming—Appointed, at the Pleasure of the Governor

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<th>Mos. Served</th>
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<tr>
<td>Insurance Commissioner</td>
<td>Jeffrey P. ’Jeff’ Rude</td>
<td>9/19/2019</td>
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<tr>
<td>Interim Insurance Commissioner</td>
<td>Jeffrey P. ’Jeff’ Rude</td>
<td>6/19/2019</td>
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<td>Thomas C. ’Tom’ Vines</td>
<td>4/16/2012</td>
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<td>Kenneth G. ’Ken’ Vines</td>
<td>2/21/2003</td>
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<td>10/16/2002</td>
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<td>Kenneth Erickson</td>
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<td>Ralph Thomas</td>
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<td>1/1/1971</td>
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Updated: 4/1/2022

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## NAIC MEETING RECORD

The following is a record of officers and list of national meeting locations at which the NAIC has met since its organization.

<table>
<thead>
<tr>
<th>Mtg</th>
<th>Date</th>
<th>Meeting Site</th>
<th>President</th>
<th>Vice-President</th>
<th>Secretary / Secretary-Treasurer</th>
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<td>5/24–6/2/1871</td>
<td>New York, NY</td>
<td>George W. Miller, NY</td>
<td>Llewelyn Breese, WI</td>
<td>Henry S. Olcott, NY</td>
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<td>10/18–30/1871</td>
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<td>George W. Miller, NY</td>
<td>Llewelyn Breese, WI</td>
<td>Henry S. Olcott, NY</td>
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<td>10/–12/1872</td>
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<td>Henry S. Olcott, NY</td>
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<td>Boston, MA</td>
<td>Llewelyn Breese, WI</td>
<td>John W. Foard, CA</td>
<td>Oliver Pillsbury, NH</td>
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<td>9/2–5/1874</td>
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<td>Orlow W. Chapman, NY</td>
<td>Samuel H. Row, MI</td>
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<td>9/20–25/1875</td>
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<td>Orlow W. Chapman, NY</td>
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<td>Orrin T. Welch, KS</td>
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<td>John A. McCall Jr., NY</td>
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<td>Charles P. Swigert, IL</td>
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<td>Charles H. Moore, OH</td>
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<td>John A. McCall Jr., NY</td>
<td>Eugene Pringle, MI</td>
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<td>Niagara Falls, NY</td>
<td>Oliver Pillsbury, NH</td>
<td>Samuel H. Cross, RI</td>
<td>Jacob A. McEwen, OH</td>
</tr>
<tr>
<td>19</td>
<td>8/15–16/1888</td>
<td>Madison, WI</td>
<td>Philip Cheek Jr., WI</td>
<td>Orsamus R. Fyler, CT</td>
<td>Jacob A. McEwen, OH</td>
</tr>
<tr>
<td>20</td>
<td>9/4–5/1889</td>
<td>Denver, CO</td>
<td>Orsamus R. Fyler, CT</td>
<td>Samuel E. Kemp, OH</td>
<td>George B. Luper, PA</td>
</tr>
<tr>
<td>21</td>
<td>8/20–21/1890</td>
<td>Cleveland, OH</td>
<td>George S. Merrill, MA</td>
<td>Samuel E. Kemp, OH</td>
<td>George B. Luper, PA</td>
</tr>
<tr>
<td>22</td>
<td>9/30–10/2/1891</td>
<td>St. Louis, MO</td>
<td>Christopher P. Elberbe, MO</td>
<td>George B. Luper, PA</td>
<td>John J. Brinkerhoff, IL</td>
</tr>
<tr>
<td>24</td>
<td>9/12–13/1893</td>
<td>Chicago, IL</td>
<td>John C. Linehan, NH</td>
<td>Christopher H. Smith, MN</td>
<td>John J. Brinkerhoff, IL</td>
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<tr>
<td>26</td>
<td>9/17–18/1895</td>
<td>Mackinac Island, MI</td>
<td>Bradford K. Durfee, IL</td>
<td>William M. Hahn, OH</td>
<td>Frederick L. 'Fred' Cutting, MA</td>
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<tr>
<td>28</td>
<td>9/7–8/1897</td>
<td>Old Point Comfort, VA</td>
<td>Stephen W. Carr, ME</td>
<td>Stephen W. Carr, ME</td>
<td>John J. Brinkerhoff, IL</td>
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<tr>
<td>29</td>
<td>9/1898</td>
<td>Milwaukee, WI</td>
<td>Stephen W. Carr, ME</td>
<td>William A. Fricke, WI</td>
<td>John J. Brinkerhoff, IL</td>
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<tr>
<td>30</td>
<td>9/1899</td>
<td>Detroit, MI</td>
<td>Edward T. Orear, MO</td>
<td>Milo D. Campbell, MI</td>
<td>John J. Brinkerhoff, IL</td>
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<tr>
<td>31</td>
<td>9/1900</td>
<td>Hartford, CT</td>
<td>Edward T. Orear, MO</td>
<td>W. S. Matthews, OH</td>
<td>John J. Brinkerhoff, IL</td>
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<tr>
<td>32</td>
<td>9/1901</td>
<td>Buffalo, NY</td>
<td>William H. Hart, IN</td>
<td>Edwin L. Scofield, CT</td>
<td>John J. Brinkerhoff, IL</td>
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<tr>
<td>33</td>
<td>9/1902</td>
<td>Columbus, OH</td>
<td>William H. Hart, IN</td>
<td>Fred A. Howland, VT</td>
<td>John J. Brinkerhoff, IL</td>
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<tr>
<td>34</td>
<td>9/1903</td>
<td>Baltimore, MD</td>
<td>Arthur I. Vorys, OH</td>
<td>John L. Bacon, VT</td>
<td>John J. Brinkerhoff, IL</td>
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<tr>
<td>35</td>
<td>9/1904</td>
<td>Indianapolis, IN</td>
<td>John L. Bacon, VT</td>
<td>Samual H. Row, MI</td>
<td>John J. Brinkerhoff, IL</td>
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<tr>
<td>36</td>
<td>9/1905</td>
<td>Breton Woods, NH</td>
<td>Frederick L. 'Fred' Cutting, MA</td>
<td>James V. Barry, MI</td>
<td>John J. Brinkerhoff, IL</td>
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<tr>
<td>37</td>
<td>10/1906</td>
<td>Washington, DC</td>
<td>James V. Barry, MI</td>
<td>Theron Upson, CT</td>
<td>John J. Brinkerhoff, IL</td>
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<tr>
<td>38</td>
<td>9/1907</td>
<td>Richmond, VA</td>
<td>George H. Adams, NH</td>
<td>Reau E. Folk, TN</td>
<td>John J. Brinkerhoff, IL</td>
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<tr>
<td>39</td>
<td>8/1908</td>
<td>Detroit, MI</td>
<td>Reau E. Folk, TN</td>
<td>Beryl F. Carroll, IA</td>
<td>John J. Brinkerhoff, IL</td>
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<tr>
<td>40</td>
<td>8/1909</td>
<td>Colorado Springs, CO</td>
<td>Benjamin F. Crouse, MD</td>
<td>Fred W. Potter, IL</td>
<td>John A. Hartigan, MN</td>
</tr>
<tr>
<td>41</td>
<td>9/1910</td>
<td>Mobile, AL</td>
<td>John A. Hartigan, MN</td>
<td>Eugene J. McGivney, LA</td>
<td>Harry R. Cunningham, MT</td>
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<tr>
<td>42</td>
<td>8/1911</td>
<td>Milwaukee, WI</td>
<td>Joseph L. Button, VA</td>
<td>Theodore H. Macdonald, CT</td>
<td>Harry R. Cunningham, MT</td>
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<tr>
<td>43</td>
<td>7/1912</td>
<td>Spokane, WA</td>
<td>Fred W. Potter, IL</td>
<td>Frank H. Hardison, MA</td>
<td>Fitz Hugh McMaster, SC</td>
</tr>
<tr>
<td>44</td>
<td>7/1913</td>
<td>Burlington, VT</td>
<td>Frank H. Hardison, MA</td>
<td>1st James R. Young, NC</td>
<td>Fitz Hugh McMaster, SC</td>
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<tr>
<td>45</td>
<td>9/1914</td>
<td>Asheville, NC</td>
<td>James R. Young, NC</td>
<td>2nd Willard Done, UT</td>
<td>Fitz Hugh McMaster, SC</td>
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<tr>
<td>46</td>
<td>9/1915</td>
<td>Del Monte, CA</td>
<td>John S. Darst, WV</td>
<td>1st Willard Done, UT</td>
<td>Fitz Hugh McMaster, SC</td>
</tr>
<tr>
<td>47</td>
<td>9/1916</td>
<td>Richmond, VA</td>
<td>Burton Mansfield, CT</td>
<td>2nd John T. Winship, MI</td>
<td>Fitz Hugh McMaster, SC</td>
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<tr>
<td>48</td>
<td>8/1917</td>
<td>St. Paul, MN</td>
<td>Jesse S. Phillips, NY</td>
<td>2nd W. C. Taylor, ND</td>
<td>Fitz Hugh McMaster, SC</td>
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<td>49</td>
<td>9/1918</td>
<td>Denver, CO</td>
<td>Michael J. 'Mike' Cleary, WI</td>
<td>1st John T. Winship, MI</td>
<td>Joseph L. Button, VA</td>
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<td>50</td>
<td>9/1919</td>
<td>Hartford, CT</td>
<td>Claude W. Fairchild, CO</td>
<td>1st Joseph G. Brown, VT</td>
<td>Joseph L. Button, VA</td>
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<tr>
<td>51</td>
<td>9/1920</td>
<td>Beverly Hills, CA</td>
<td>Joseph G. Brown, VT</td>
<td>2nd Frank H. Ellsworth, MI</td>
<td>Joseph L. Button, VA</td>
</tr>
<tr>
<td>Date</td>
<td>Meeting Site</td>
<td>President</td>
<td>Vice-President</td>
<td>Secretary / Secretary-Treasurer</td>
<td></td>
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<tr>
<td>9/1921</td>
<td>Louisville, KY</td>
<td>Alfred L. Harty, MO</td>
<td>1st Thomas B. Donaldson, PA</td>
<td>Joseph L. Button, VA</td>
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<td>1st John C. Luning, FL</td>
<td>Joseph L. Button, VA</td>
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<tr>
<td>9/1922</td>
<td>Swampscott, MA</td>
<td>Thomas B. Donaldson, PA</td>
<td>1st H. O. Fishback, WA</td>
<td>Joseph L. Button, VA</td>
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<tr>
<td>8/1923</td>
<td>Minneapolis, MN</td>
<td>Herbert O. Fishback, WA</td>
<td>1st John C. Luning, FL</td>
<td>Joseph L. Button, VA</td>
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<td>7/1924</td>
<td>Seattle, WA</td>
<td>Herbert O. Fishback, WA</td>
<td>1st John C. Luning, FL</td>
<td>Joseph L. Button, VA</td>
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<tr>
<td>9/1925</td>
<td>San Antonio, TX</td>
<td>John C. Luning, FL</td>
<td>1st Samuel W. McCulloch, PA</td>
<td>Joseph L. Button, VA</td>
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<tr>
<td>11/1926</td>
<td>Los Angeles, CA</td>
<td>Harry L. Conn, OH</td>
<td>1st T. M. Henry, MA</td>
<td>Joseph L. Button, VA</td>
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<td>9/1927</td>
<td>Cincinnati, OH</td>
<td>Albert S. Caldwell, TN</td>
<td>1st Thomas M. Baldwin, Jr., DC</td>
<td>Joseph L. Button, TN</td>
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<td>5/1956</td>
<td>Hartford, CT</td>
<td>Howard P. Dunham, CT</td>
<td>1st Clarence C. Wysong, IN</td>
<td>Albert S. Caldwell, TN</td>
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<tr>
<td>9/1930</td>
<td>Portland, OR</td>
<td>Jess G. Read, OK1</td>
<td>1st Charles C. Wysong, IN</td>
<td>Albert S. Caldwell, TN</td>
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<tr>
<td>10/1932</td>
<td>Dallas, TX</td>
<td>Charles D. Livingston, MI</td>
<td>1st William A. Tarver, TX</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1933</td>
<td>Chicago, IL</td>
<td>Garfield W. Brown, MN2</td>
<td>1st William A. Tarver, TX</td>
<td>Albert S. Caldwell, TN</td>
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<tr>
<td>12/1934</td>
<td>St. Petersburg, FL</td>
<td>Garfield W. Brown, MN</td>
<td>1st Daniel C. ‘Dan’ Boney, NC22</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1936</td>
<td>St. Paul, MN</td>
<td>William A. Sullivan, WA</td>
<td>1st William A. Tarver, TX</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1937</td>
<td>Philadelphia, PA</td>
<td>Ernest Palmer, IL</td>
<td>2nd William A. Tarver, TX</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1938</td>
<td>Quebec, Canada</td>
<td>George A. Bowles, WA</td>
<td>2nd George S. Van-Schaick, NY22</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1939</td>
<td>San Francisco, CA</td>
<td>Frank N. Julian, AL</td>
<td>2nd George S. Van-Schaick, NY22</td>
<td>Albert S. Caldwell, TN</td>
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<tr>
<td>6/1940</td>
<td>Hartford, CT</td>
<td>C. Clarence Nelson, UT</td>
<td>1st John C. Blackall, CT24</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1941</td>
<td>Detroit, MI</td>
<td>John C. Blackall, CT</td>
<td>1st John C. Blackall, CT24</td>
<td>Albert S. Caldwell, TN</td>
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<tr>
<td>6/1943</td>
<td>Boston, MA</td>
<td>John Sharp Williams III, MS</td>
<td>2nd John Sharp Williams III, MS</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1944</td>
<td>Chicago, IL</td>
<td>Charles F. J. Harrington, MA</td>
<td>2nd Newell R. Johnson, MN</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1946</td>
<td>Portland, OR</td>
<td>James M. McCormack, TN</td>
<td>2nd Newell R. Johnson, MN</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1948</td>
<td>Philadelphia, PA</td>
<td>Seth B. Thompson, OR</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1949</td>
<td>Seattle, WA</td>
<td>J. Edwin Larson, FL</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1950</td>
<td>Quebec, Canada</td>
<td>David A. Forbes, MI</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1951</td>
<td>Swampscott, MA</td>
<td>W. Ellery Allyn, CT</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1952</td>
<td>Chicago, IL</td>
<td>Frank Sullivan, KS</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>12/1952</td>
<td>New York, NY</td>
<td>Wade O. Martin Jr., LA</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1953</td>
<td>San Francisco, CA</td>
<td>Wade O. Martin Jr., LA</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>11/1953</td>
<td>Miami Beach, FL</td>
<td>D. D. ‘Pat’ Murphy, SC</td>
<td>2nd Seth B. Thompson, OR</td>
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<td>8/1954</td>
<td>Detroit, MI</td>
<td>D. D. ‘Pat’ Murphy, SC</td>
<td>2nd Seth B. Thompson, OR</td>
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<td>11/1954</td>
<td>New York, NY</td>
<td>Donald Knowlton, NH</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>5/1955</td>
<td>Los Angeles, CA</td>
<td>Donald Knowlton, NH</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>11/1955</td>
<td>New York, NY</td>
<td>C. Lawrence Leggett, MO</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>5/1956</td>
<td>St. Louis, MO</td>
<td>C. Lawrence Leggett, MO</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>12/1956</td>
<td>Miami Beach, FL</td>
<td>Robert B. Taylor, OR</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<tr>
<td>6/1957</td>
<td>Atlantic City, NJ</td>
<td>Robert B. Taylor, OR</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>12/1957</td>
<td>New York, NY</td>
<td>Joseph A. Navarre, MI</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<tr>
<td>6/1958</td>
<td>Chicago, IL</td>
<td>Joseph A. Navarre, MI</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<tr>
<td>12/1958</td>
<td>New Orleans, LA</td>
<td>Arch E. Northington, TN</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>6/1959</td>
<td>Boston, MA</td>
<td>Paul A. Hammel, NV</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>11/1959</td>
<td>Miami Beach, FL</td>
<td>Paul A. Hammel, NV</td>
<td>2nd Seth B. Thompson, OR</td>
<td>Albert S. Caldwell, TN</td>
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<td>Mtg</td>
<td>Date</td>
<td>Meeting Site</td>
<td>President</td>
<td>Vice-President</td>
<td>Secretary / Secretary-Treasurer</td>
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<td>124</td>
<td>12/1987</td>
<td>Phoenix, AZ</td>
<td>Edward J. Muhl, MD</td>
<td>John E. Washburn, IL</td>
<td>W. Fletcher Bell, KS</td>
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<td>125</td>
<td>3/1988</td>
<td>Santa Fe, NM</td>
<td>John E. Washburn, IL</td>
<td>David A. Gates, NV</td>
<td>W. Fletcher Bell, KS</td>
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<td>126</td>
<td>6/1988</td>
<td>New York, NY</td>
<td>John E. Washburn, IL</td>
<td>David A. Gates, NV</td>
<td>W. Fletcher Bell, KS</td>
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<td>127</td>
<td>9/1988</td>
<td>Mackinac Island, MI</td>
<td>John E. Washburn, IL</td>
<td>David A. Gates, NV</td>
<td>W. Fletcher Bell, KS</td>
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<td>128</td>
<td>12/1988</td>
<td>New Orleans, LA</td>
<td>John E. Washburn, IL</td>
<td>David A. Gates, NV</td>
<td>W. Fletcher Bell, KS</td>
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<tr>
<td>129</td>
<td>3/1989</td>
<td>Little Rock, AR</td>
<td>John E. Washburn, IL</td>
<td>David A. Gates, NV</td>
<td>W. Fletcher Bell, KS</td>
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<tr>
<td>130</td>
<td>6/1989</td>
<td>Cincinnati, OH</td>
<td>Thomas J. Sheehan, OH</td>
<td>Earl R. Pomeroy, ND</td>
<td>W. Fletcher Bell, KS</td>
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<td>9/1989</td>
<td>Wilmington, DE</td>
<td>David A. Gates, NV</td>
<td>Earl R. Pomeroy, ND</td>
<td>W. Fletcher Bell, KS</td>
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<td>12/1989</td>
<td>Las Vegas, NV</td>
<td>David A. Gates, NV</td>
<td>Earl R. Pomeroy, ND</td>
<td>W. Fletcher Bell, KS</td>
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<td>133</td>
<td>3/1990</td>
<td>Salt Lake City, UT</td>
<td>David A. Gates, NV</td>
<td>Earl R. Pomeroy, ND</td>
<td>W. Fletcher Bell, KS</td>
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<td>134</td>
<td>6/1990</td>
<td>Baltimore, MD</td>
<td>John E. Washburn, NC</td>
<td>David A. Gates, NV</td>
<td>W. Fletcher Bell, KS</td>
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<td>140</td>
<td>12/1991</td>
<td>Houston, TX</td>
<td>James E. ‘Jim’ Long, NC</td>
<td>William H. ‘Bill’ McCartney, NE</td>
<td>Robin Campaniano, Hi</td>
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<tr>
<td>143</td>
<td>9/1992</td>
<td>Cincinnati, OH</td>
<td>William H. ‘Bill’ McCartney, NE</td>
<td>Steve T. Foster, VA</td>
<td>David J. Walsh, AK</td>
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<td>144</td>
<td>12/1992</td>
<td>Atlanta, GA</td>
<td>William H. ‘Bill’ McCartney, NE</td>
<td>Steve T. Foster, VA</td>
<td>David J. Walsh, AK</td>
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<td>145</td>
<td>3/1993</td>
<td>Nashville, TN</td>
<td>Steven T. Foster, VA</td>
<td>Steven T. Foster, VA</td>
<td>David J. Walsh, AK</td>
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<tr>
<td>146</td>
<td>6/1993</td>
<td>Chicago, IL</td>
<td>Steven T. Foster, VA</td>
<td>David J. Walsh, AK</td>
<td>David J. Lyons, IA</td>
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<tr>
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<td>Boston, MA</td>
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<td>Chicago, IL</td>
<td>Kathleen Sebelius, KS</td>
<td>Therese M. ‘Terri’ Vaughn, IA</td>
<td>Therese M. ‘Terri’ Vaughn, IA</td>
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<th>Mtg</th>
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<th>Meeting Site</th>
<th>President</th>
<th>Vice-President</th>
<th>Secretary / Secretary-Treasurer</th>
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<td>9/2004</td>
<td>Anchorage, AK</td>
<td>M. Diane Koken, PA(^{39})</td>
<td>Joel S. Ario, OR(^{39})</td>
<td>Alessandro A. ‘Al’ Iuppa, ME(^{39})</td>
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<td>180</td>
<td>12/2004</td>
<td>New Orleans, LA (^{40})</td>
<td>M. Diane Koken, PA</td>
<td>Joel Ario, OR</td>
<td>Alessandro A. ‘Al’ Iuppa, ME</td>
</tr>
</tbody>
</table>

\(^{39}\) Indicates a specific state.
2. Aug. 21, 1890: Charles B. Allan (Nebraska deputy auditor) was elected Secretary for the 1891 Convention; however, he resigned before the Convention assembled. Sept. 30, 1891: John J. Brinkerhoff (Illinois actuary) was elected Secretary for the 1891 Convention.
3. Sept. 18, 1895: William M. Hahn (OH) was elected President for the 1896 Convention and James R. Waddill (MO) was elected Vice-President; however, Superintendent Hahn was out of office effective June 3, 1886. Sept. 22, 1896: Superintendent Waddill was elected President for the 1896 Convention and Stephen W. Carr (ME) was chosen to act as Vice-President.

4. Sept. 23, 1896: James R. Waddill (MO) was elected President for the 1897 Convention and Stephen W. Carr (ME) was elected Vice-President; however, Mr. Waddill was out of office effective March 1, 1897. Sept. 7, 1897: Commissioner Carr was elected President for the 1897 Convention. It is unknown who acted as Vice-President.

5. Sept. 23, 1896: Frederick L. ‘Fred’ Cutting (MA) was elected Secretary for the 1897 Convention; however, he was out of office at the date of the Convention. Sept. 7, 1897: John J. Brinkerhoff (Illinois actuary) was elected Secretary for the 1897 Convention.

6. Sept. 7, 1897: Frederick L. ‘Fred’ Cutting (MA) was elected Secretary for the 1898 Convention; however, he declined the offer. Sept. 13, 1898: John J. Brinkerhoff (Illinois actuary) was elected Secretary for the 1898 Convention.

7. Sept. 15, 1898: Elmer H. Dearth (MN) was elected President for the 1899 Convention; however, he was out of office at the date of the Convention. Sept. 5, 1899: Edward T. Orear (MO) was elected President for the 1899 Convention.

8. Sept. 20, 1900: John A. O’Shaughnessy (MN) was elected President for the 1901 Convention; however, he was out of office at the date of the Convention. September 1901: William H. Hart (IN) was elected President for the 1901 Convention.

9. Sept. 29, 1910: Theodore H. Macdonald (CT) was elected Vice-President for the 1911 Convention; however, he was out of office at the date of the Convention. It is unknown who acted as Vice-President.

10. Aug. 25, 1911: Harry R. Cunningham (MT) was elected Secretary for the 1912 Convention; however, he resigned before the Convention assembled. March 1912: Fitz Hugh McMaster (SC) was elected Secretary for the 1912 Convention.

11. Aug. 1, 1913: Willard Done (UT) was elected First Vice-President for the 1914 Convention; however, he resigned before the Convention assembled. It is unknown who acted as First Vice-President.

12. Aug. 31, 1917: Emory H. English (IA) was elected President for the 1918 Convention; Robert J. Merrill (NH) was elected First Vice-President; and Michael J. Cleary (WI) was elected Second Vice-President. November 1917: Mr. Merrill resigned as First Vice-President. Dec. 6, 1917: Mr. Cleary was elected First Vice-President for the 1918 Convention and Walter K. Chorn (MO) was elected Second Vice-President. Jan. 1, 1918: Mr. English resigned as President and Mr. Cleary was elected President for the 1918 Convention by the Executive (EX) Committee. It is unknown who acted as First Vice-President.

13. Aug. 31, 1917: Fitz Hugh McMaster (SC) was elected Secretary for the 1918 Convention; however, he resigned before the Convention assembled. Dec. 6, 1917: Joseph L. Buxton (VA) was elected Secretary for the 1918 Convention.

14. Sept. 12, 1919: John B. Sanborn (MN) was elected Second Vice-President for the 1920 Convention; however, he resigned before the Convention assembled. June 1920: Alfred L. Harty (MO) was chosen to act as Second Vice-President for the 1920 Convention.

15. Sept. 3, 1920: Frank H. Ellsworth (MI) was elected President for the 1921 Convention; Alfred L. Harty (MO) was elected First Vice-President; and Thomas B. Donaldson (PA) was elected Second Vice-President. Commissioner Ellsworth resigned effective April 30, 1921, as NAIC President and Michigan Insurance Commissioner. June 27, 1921: Superintendent Harty was elected President for the 1921 Convention by the Executive (EX) Committee; Commissioner Donaldson was elected First Vice-President; and Platt Whitman (WI) was elected Second Vice-President.

16. Sept. 8, 1922: Platt Whitman (WI) was elected President for the 1923 Convention; Herbert O. Fishback (WA) was elected First Vice-President; and John C. Luning (FL) was elected Second Vice-President. July 1, 1923: Commissioner Whitman resigned as President; Commissioner Fishback was elected President for the 1923 Convention by the Executive (EX) Committee; and Mr. Luning was elected First Vice-President by the Executive (EX) Committee. It is unknown who acted as Second Vice-President.
17. Sept. 18, 1925: William R. C. Kendrick (IA) was elected President for the 1926 Convention. January 1926: Commissioner Kendrick resigned as NAIC President and Harry L. Conn (OH) was elected President for the 1926 Convention. Commissioner Kendrick remained as Iowa Insurance Commissioner until March 1, 1926.

18. Nov. 19, 1926: Harry L. Conn (OH) was elected President for the 1927 Convention and Albert S. Caldwell (TN) was elected First Vice-President. April 15, 1927: Superintendent Conn resigned as NAIC President and Ohio Insurance Superintendent. May 3, 1927: Commissioner Caldwell was elected President for the 1927 Convention and James A. Beha (NY) was elected First Vice-President.

19. Sept. 26, 1928: Charles R. Detrick (CA) was elected President for the 1929 Convention; James A. Beha (NY) was elected First Vice-President; and Howard P. Dunham (CT) was elected Second Vice-President. Jan. 1, 1929: Superintendent Beha resigned as NAIC First Vice-President and New York Insurance Superintendent. Commissioner Dunham was elected First Vice-President for the 1929 Convention. April 24, 1929: Commissioner Detrick resigned as NAIC President and California Insurance Commissioner. Commissioner Dunham was elected President for the 1929 Convention; Clarence C. Wysong (IN) was elected First Vice-President; and Jess G. Read (OK) was elected Second Vice-President.

20. Sept. 19, 1929: Joseph L. Button (VA) was elected Secretary for the 1930 Convention; however, he resigned effective Oct. 15, 1929, as NAIC Secretary and Virginia Commissioner of Insurance and Banking. Dec. 10, 1929: Albert S. Caldwell (TN) was elected Secretary for the 1930 Convention.

21. Sept. 9, 1930: Clarence C. Wysong (IN) was elected President for the 1931 Convention; Jess G. Read (OK) was elected First Vice-President; and Clare A. Lee (OR) was elected Second Vice-President. January 1931: Commissioner Wysong resigned effective Jan. 1, 1931, as NAIC President and Indiana Insurance Commissioner; Commissioner Lee was no longer serving as Second Vice-President; and Commissioner Read was elected President by the Executive (EX) Committee for the 1931 Convention. June 17, 1931: Charles D. Livingston (MI) was elected First Vice-President by the Executive (EX) Committee for the 1931 Convention and William A. Tarver (TX) was elected Second Vice-President by the Executive (EX) Committee.

22. Oct. 20, 1932: William A. Tarver (TX) was elected President for the 1933 Convention; Garfield W. Brown (MN) was elected First Vice-President; and Daniel C. ‘Dan’ Boney (NC) was elected Second Vice-President. Commissioner Tarver resigned effective Feb. 10, 1933, as NAIC President and Texas Life Insurance Commissioner. Commissioner Brown was elected President for the 1933 Convention; Commissioner Boney was chosen to act as First Vice-President and George S. Van Schaick (NY) was chosen to act as Second Vice-President.

23. July 1935: It is unclear why no one acted as First Vice-President or Second Vice-President for the 1935 Convention.

24. June 23, 1939: J. Balch Moor (DC) was elected Vice-President; however, he died July 22, 1939, before the 1940 Convention assembled. John C. Blackall (CT) was elected Vice-President by the Executive (EX) Committee to fill the unexpired term.

25. June 6, 1945: Edward L. Scheufler (MO) was elected Vice-President for the 1946 Convention; however, he resigned effective Oct. 15, 1945, as NAIC Vice-President and Missouri Insurance Superintendent. Dec. 3, 1945: Robert E. Dineen (NY) was elected Vice-President by the Executive (EX) Committee for the 1946 Convention.

26. June 11, 1946: Jess G. Read (OK) was elected Secretary for the 1947 Convention; however, he died July 20, 1946. Sept. 4, 1946: Nellis P. Parkinson (IL) was elected Secretary by the Executive (EX) Committee to fill the unexpired term.

27. June 1953: George B. Butler (TX) was elected Vice-President; however, he died Sept. 28, 1953. It is unknown who acted as Vice-President for the November 1953 Convention. Nov. 30, 1953: Donald Knowlton (NH) was elected Vice-President by the Executive (EX) Committee to fill the unexpired term.

28. May 1956: George A. Bowles (VA) was elected Secretary; however, he died June 1, 1956. Paul A. Hammel (NV) was elected Secretary to fill the unexpired term.

29. June 1958: Arch E. Northington (TN) was elected President; however, he resigned effective Dec. 23, 1958, as NAIC President and Tennessee Insurance Commissioner. January 1959: Paul A. Hammel (NV) was elected President and Sam N. Beery (CO) was elected Vice-President by the Executive (EX) Committee to fill the unexpired term.

30. June 1962: Joseph S. Gerber (IL) was elected Vice-President; however, he resigned effective Jan. 29, 1963, as NAIC Vice-President and Illinois Insurance Director. The office of Vice-President was vacant for the June 1963 Convention.
31. June 1968: Charles R. Howell (NJ) was elected President; however, he resigned effective Feb. 28, 1969, as NAIC President and New Jersey Commissioner of Banking and Insurance. Ned Price (TX) was elected by the Executive (EX) Committee to fill the unexpired term.


33. A constitutional amendment moved NAIC officer elections from June to December (commencing December 1974), President Johnnie L. Caldwell (GA) served a six-month term.

34. Kenneth E. ‘Ken’ DeShetler (OH) was elected President; however, he resigned effective Jan. 13, 1975, as NAIC President and Ohio Insurance Director. William H. Huff, III (IA) was elected by the Executive (EX) Committee to fill the unexpired term.

35. H. Peter ‘Pete’ Hudson (IN) was elected President; however, he resigned as NAIC President and Indiana Insurance Commissioner effective Nov. 15, 1979. It is unknown who presided over the December 1979 Convention.

36. John W. Lindsay resigned effective Sept. 3, 1981, as NAIC Vice-President and South Carolina Insurance Commissioner. Johnnie L. Caldwell (GA) was elected by the Executive (EX) Committee to fill the unexpired term.

37. David J. Lyons resigned effective June 17, 1994, as NAIC Vice President but remained as Iowa Insurance Commissioner until July 31, 1994. A special interim Plenary election was held June 12, 1994: Arkansas Insurance Commissioner Lee Douglass was elected Vice President to serve June 17, 1994, to Dec. 31, 1994.

38. September 2001: NAIC members unanimously agreed that the 2001 Fall National Meeting should be canceled in the wake of the tragic events that occurred Sept. 11, 2001. The meeting had been scheduled for Sept. 22–25, 2001, at the Marriott and Westin Copley Place hotels in Boston, Massachusetts.

39. Ernst N. ‘Ernie’ Csiszar resigned effective Aug. 18, 2004, as NAIC President and South Carolina Director of Insurance. Approximately two weeks later, James A. ‘Jim’ Poolman resigned as NAIC Vice President but remained as North Dakota Insurance Commissioner. A special interim Plenary election was held Sept. 13, 2004, during the Fall National Meeting in Anchorage, Alaska: Pennsylvania Insurance Commissioner M. Diane Koken was elected President; Oregon Insurance Administrator Joel S. Ario was elected Vice President; and Maine Insurance Superintendent Alessandro A. ‘Al’ Iuppa was elected Secretary-Treasurer to serve from Sept. 13, 2004, to Dec. 31, 2004.

40. December 2004: NAIC members voted at its 2004 Winter National Meeting to adopt amendments to the NAIC Bylaws, which included the creation of a President-Elect position as an NAIC officer.

41. September 2005: NAIC members agreed to cancel the 2005 Fall National Meeting due to the devastation caused by Hurricane Katrina on Aug. 29, 2005. The meeting had been scheduled for Sept. 10–13, 2005, at the Sheraton hotel in New Orleans, Louisiana.

42. Eric P. Serna resigned effective June 14, 2006, as NAIC Secretary-Treasurer and New Mexico Superintendent of Insurance. A special Plenary interim election was held during the 2006 Summer National Meeting: New Hampshire Insurance Commissioner Roger A. Sevigny was elected Secretary-Treasurer to serve from June 14, 2006, to Dec. 31, 2006.

43. Michael T. McRaith resigned effective May 31, 2011, as NAIC Secretary-Treasurer and Illinois Director of Insurance. A special Plenary interim election was held via conference call May 16, 2011: North Dakota Insurance Commissioner Adam Hamm was elected Secretary-Treasurer to serve from May 31, 2011, to Dec. 31, 2011.


45. Michael F. ‘Mike’ Consedine resigned effective Jan. 20, 2015, as NAIC President-Elect and Pennsylvania Insurance Commissioner. A special Plenary interim election was held via conference call Feb. 8, 2015: Missouri Insurance Director John M. Huff was elected President-Elect to serve from Feb. 8, 2015, to Dec. 31, 2015.
Sharon P. Clark resigned effective Jan. 11, 2016, as NAIC President-Elect and Kentucky Insurance Commissioner. A special Plenary interim election was held in Bonita Springs, Florida, on Feb. 7, 2016: Wisconsin Insurance Commissioner Theodore K. ‘Ted’ Nickel was elected President-Elect; Tennessee Insurance Commissioner Julie Mix McPeak was elected Vice President; and Maine Insurance Superintendent Eric A. Cioppa was elected Secretary-Treasurer to serve from Feb. 7, 2016, to Dec. 31, 2017.

David C. Mattax, NAIC Secretary-Treasurer and Texas Insurance Commissioner, died in office April 13, 2017. A special Plenary interim election was held via conference call on May 12, 2017: South Carolina Insurance Director Raymond G. Farmer was elected Secretary-Treasurer to serve from May 12, 2017, to Dec. 31, 2017.

Gordon I. Ito resigned effective Dec. 31, 2018, as NAIC Vice President and Hawaii Insurance Commissioner. A special Plenary interim election was held in La Quinta, California, on Feb. 4, 2019: Florida Insurance Commissioner David Altmaier was elected Vice President to serve from Feb. 4, 2019, to Dec. 31, 2019.

March 11, 2020: Due to concerns about the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2020 Spring National Meeting in a virtual format. However, on March 23, 2020, the NAIC officers decided to suspend holding any further sessions of the virtual Spring National Meeting to allow NAIC members and staff more time to focus on the health emergency. The meeting had been scheduled for March 21–24, 2020, at the Phoenix Convention Center and the Sheraton Grand and Hyatt Regency hotels in Phoenix, Arizona.

June 10, 2020: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2020 Summer National Meeting in a virtual format. The meeting had been scheduled for Aug. 8–11, 2020, at the Minneapolis Convention Center and the Hilton and Hyatt Regency hotels in Minneapolis, Minnesota.

Sept. 21, 2020: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2020 Fall National Meeting in a virtual format. The meeting had been scheduled for Nov. 14–17, 2020, at the JW Marriott hotel in Indianapolis, Indiana.

Feb. 24, 2021: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2021 Spring National Meeting in a virtual format. The meeting had been scheduled for April 10–13, 2021, at the Gaylord Texan Hotel and Convention Center in Grapevine, Texas.

June 1, 2021: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2021 Summer National Meeting in a hybrid format. In-person meetings took place for NAIC members and interested parties as capacity allowed. Meetings were live-streamed for participants who attended virtually.

Oct. 27, 2021: Given the ongoing health challenges associated with holding large in-person meetings in the midst of the COVID-19 pandemic, the NAIC officers—in consultation with the NAIC membership—decided to hold the 2021 Fall National Meeting in a hybrid format. In-person meetings took place for NAIC members and interested parties as capacity allowed. Meetings were live-streamed for participants who attended virtually.

Updated: 10/27/2021

https://naiconline.sharepoint.com/teams/MemberServicesExecutive/Shared Documents/Commissioner/Meeting_Officer_Record/08-Meeting_Officer_Record.docx
NAIC MODEL LAWS, REGULATIONS AND GUIDELINES

The following is a listing of NAIC model laws, regulations, and guidelines referenced in the Proceedings of the 2021 Fall National Meeting.

Administrative Supervision Model Act (#558)
10-416

Annual Financial Reporting Model Regulation (#205)
2-16, 3-59, 10-13, 10-299

Annuity Disclosure Model Regulation (#245)
3-165, 6-21

Assumption Reinsurance Model Act (#803)
10-329, 10-347, 10-348, 10-352, 10-353, 10-427, 10-482, 10-546

Coordination of Benefits Model Regulation (#120)
7-141, 7-145

Corporate Governance Annual Disclosure Model Act (#305)
3-54, 9-4, 9-75, 9-78, 9-80, 9-81, 9-84, 10-819, 10-825, 10-830, 10-836

Corporate Governance Annual Disclosure Model Regulation (#306)
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Credit for Reinsurance Model Law (#785)
2-24, 3-8, 3-68, 3-126, 3-139, 3-141, 3-150, 3-151, 3-152, 3-166, 10-3, 10-24, 10-255, 10-256, 10-263, 10-267, 10-272, 10-287, 10-568, 10-580, 10-582, 10-591, 10-592, 10-1074, 10-1075, 10-1076, 10-1078, 10-1080, 10-1089, 10-1090, 10-1092, 10-1094, 10-1103, 10-1104, 10-1107

Credit for Reinsurance Model Regulation (#786)
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Criminal Sanctions for Failure to Report Impairment Model Bill (#510)
10-416

Disclosure of Material Transactions Model Act (#285)
10-345

Group Health Insurance Standards Model Act (#100)
7-144, 7-145

Guideline for Administration of Large Deductible Policies in Receivership (#1980)
10-1066, 10-1071
Guideline for Definition of Reciprocal State in Receivership Laws (#1985)  
10-1066, 10-1071

Health Benefit Plan Network Access and Adequacy Model Act (#74)  
9-34

Health Care Professional Credentialing Verification Model Act (#70)  
9-42

Health Carrier External Review Model Act (#75)  
9-76

Health Carrier Governance Procedure Model Act (#72)  
9-76, 9-81

Health Carrier Prescription Drug Benefit Management Model Act (#22)  
7-147

Health Information Privacy Model Act (#55)  
2-12, 3-6, 9-5, 9-52, 9-54, 9-55, 9-56, 9-66, 9-72, 9-74, 9-92

Health Insurance Reserves Model Regulation (#10)  
4-110, 4-150, 4-234

Health Maintenance Organization Model Act (#430)  
2-13, 3-165, 9-11, 9-76, 9-80, 9-81, 9-84, 9-85

Insurance Data Security Model Law (#668)  
3-12, 3-14, 4-53, 5-3, 6-14, 9-62, 9-72, 9-74, 9-114, 10-1017, 10-1029

Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450)  
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CALL TO ORDER

The 233rd session of the National Association of Insurance Commissioners (NAIC) will now come to order. Good afternoon, I’m NAIC President and Florida’s Commissioner of the Office of Insurance Regulation, David Altmaier. I am honored to open the NAIC Fall National Meeting.

INTRODUCTION OF HEAD TABLE

I’d like to introduce the members of our head table. Please hold your applause until the end, unless you are joining us virtually, in which case you should feel free to applaud at any time.

Honorable Ricardo Lara, Meeting Host and California Insurance Commissioner
Honorable James J. Donelon, NAIC Past President and Louisiana Insurance Commissioner
Honorable Eric A. Cioppa, NAIC Past President and Maine Insurance Superintendent
Honorable Raymond G. Farmer, NAIC Most Recent Past President and South Carolina Insurance Director
Honorable Dean L. Cameron, NAIC President-Elect and Idaho Insurance Director
Honorable Chlora Lindley-Myers, NAIC Vice President and Missouri Insurance Director
Honorable Andrew N. Mais, NAIC Secretary-Treasurer and Connecticut Insurance Commissioner
Andrew J. Beal, NAIC Chief Operating Officer (COO) and Chief Legal Officer (CLO)
Michael F. Consedine, NAIC Chief Executive Officer (CEO)

Please welcome the members of our NAIC Fall National Meeting head table.

New Member Video

Please join me in welcoming our newest members in this short video. [New Member Video Plays.] Let’s welcome the new members with a round of applause.

Introduction of Special Guests

We are pleased to welcome guests from the Federal Emergency Management Agency (FEMA), the U.S. Department of the Treasury (Treasury Department), the Federal Insurance Office (FIO), and legislators from across the country.

Introduction of Host Commissioner

It is my pleasure to introduce the commissioner of the California Department of Insurance, Ricardo Lara.

Commissioner Lara was elected by the state of California Jan. 7, 2019. Prior to becoming the insurance commissioner, he served in the California State Senate representing the 33rd Senate district. Before that, he served in the California State Assembly representing the 50th Assembly district. Commissioner Lara, welcome and thank you for serving as our host.

Host Commissioner’s Remarks

It is my pleasure to welcome all of you to San Diego for our 2021 NAIC Fall National Meeting; and for those of you who are joining virtually, I hope that you will get to experience beautiful California soon. Before I begin, I just want to thank all the hotel workers for making our conference possible. These men and women were some of the hardest hit workers during the pandemic.
We have gone through so much together—a global pandemic, economic shutdowns, civil unrest, and climate-intensified natural disasters. Today our thoughts are with families in Kentucky, Arkansas, Missouri, Tennessee, and Illinois who suffered deadly tornadoes this weekend. To our colleagues in these states, you have our sympathy and support as people start on the long road to recovery.

As my mom always says, “no hay mal que por bien no venga,” which translates to “every cloud has a silver lining.” When lives are lost during a natural disaster, that cloud comes with a heavy darkness. For me, the silver lining presents itself in how we consistently respond to that darkness and that we have stuck together, learned together, and kept focus on our collective mission: to protect consumers. When we met in Arizona, I was inspired by the unanimous dedication our members still hold dear through our 150 years of existence. We renewed our commitment to a simple but often elusive tenet of good governance: objective, nonpartisan policymaking. At the NAIC, we work together in partnerships that may seem uncommon in other public agencies and offices. For example, California and South Carolina: together we co-chair the Climate and Resiliency (EX) Task Force and have been able to find agreement on several issues. Maybe it’s that we both come from places that, despite our differences, love our beaches and our seafood; but let’s be real, it’s Director Farmer’s southern charm. Whatever it is, I challenge you to find that type of pairing among any other public officeholders.

As an organization, think of the geographic diversity of our recent past leaders: Montana; Missouri; Wisconsin; Tennessee; Maine; South Carolina; Florida; and now another great western state, Director Cameron from Idaho, who will lead us in 2022 as we continue to build on our foundation. Even when the issues are tough, we find common ground and we move forward. It is our diversity of laws and leaders, in fact, that rejuvenates our efforts to overcome complex obstacles. This is a strength of our state-based insurance regulatory approach, and we reinforce it through the work we do. We find ways to collaborate and merge many streams of thought into solutions for our shared challenges. I want to take a moment to thank the staff of the NAIC, who work hard all year to prepare for these meetings and drive forward our common vision. They have done remarkable work throughout the pandemic; let’s have a round of applause for our NAIC staff.

As a proud Californian and a San Diego State University Aztec, I am honored that the NAIC has chosen San Diego for this important event. My time as an undergrad student here brought perspective to my life experiences and motivated me to act and fight for equity and justice. California is home to 40 million people; i.e., 12% of the U.S. population. More than a quarter of California residents are immigrants, and nearly one in four households has a native-born U.S. citizen with at least one immigrant parent. That includes this dude, born and raised in East L.A. It’s only in the U.S. that my story is even possible—the first openly LGBTQ person to be elected to statewide office in our state’s history and the first Latino commissioner from the Golden State—and that is why, despite our faults, this is the greatest country on Earth.

I hope you all get a chance while you’re here—masked up of course—to experience one of the most ethnically and culturally diverse cities in the nation where nearly 41% of the population speak multiple languages. That proud heritage shapes who we are and why fairness and opportunity are at the center of the California dream. Like all of you, I have dedicated myself to public service. My focus is on those in need and those who have historically experienced systemic discrimination and racial or ethnic bias. The pandemic and civil unrest we witnessed both in 2020 and beyond have made plain for all to see the inequities that exist in our society. As insurance leaders, and as a national body, this is a challenge we must all take on; I am grateful to all the workstream co-chairs serving on the Special (EX) Committee on Race and Insurance for leading our work in this area.

Collectively, we face several types of climate change impacts. As you look to the west and talk with San Diegans, you will hear about the challenges of sea level rise and coastal flooding. Over the past 30 years—i.e., the common timeframe for a mortgage—every single county in California has been under a governor-declared flooding emergency. These are not unique challenges to California. All our coastal states and—as we all have recently witnessed—our Midwest face such threats, made worse by tornadoes, hurricanes in the east, and atmospheric rivers in the west. This has been a year of record-setting fires and record-setting temperatures right here in California and across the Western U.S.: 121° in Los Angeles County; 123° in the Coachella Valley and Palm Springs; and 130° in Death Valley, the hottest world temperature ever on record. Insurance is going to be critical to how we protect our communities after a disaster, and it also matters before a disaster happens. How we bring down these shared risks is essential to maintaining affordable and available insurance. I am particularly proud that, for the first time, the NAIC hosted a forum at the United Nations (UN) Climate Change Conference in Scotland to talk about our NAIC approach to climate resilience on the global stage. Insurance regulators must help address climate risks, and it is essential that the NAIC assert ourselves and demonstrate that we are the leader in this space.
As insurance regulators, we start with three powerful tools at our disposal: our regulatory actions, our advocacy for new protections with our state legislatures, and our engagement with consumers and businesses.

- **Regulatory Actions**

Our regulatory authority helps protect the public and build consistency in the insurance marketplace. Like many of you, I have taken executive actions in 2020 to expedite protections for consumers throughout the pandemic and used my authority to mandate insurance companies’ return over-collection of premium. My actions have saved California drivers more than $2.4 billion and counting through returned premiums for private passenger automobile (PPA) insurance alone.

- **Legislative Advocacy**

We work with our state legislatures on changes to statute that can clarify, strengthen, and create consumer protections. Currently, I am partnering with members of the California State Legislature to create a statewide early warning system for extreme heat waves to protect our most vulnerable residents and help calculate the costs of this threat. I often say, “diversity means business.” Over the past three years, we have gone from millions invested in affordable housing, small business pandemic relief, and green projects to billions through the California Department of Insurance’s (DOI’s) insurer investment program. This translates to new jobs, new homes, and new business opportunities exemplifying how insurance companies can do good and invest in our diverse communities.

- **Engagement with Residents and Businesses**

Engaging with the communities, we have the honor to serve as essential. After experiencing our deadly wildfires, I visited more than 36 counties and met with more than 10,000 people to hear first-hand from them. I have met with our farmers and wine-growers—essential businesses for our state’s economy and workforce—to learn about the challenges they are facing from wildfires. Our NAIC national meetings also give us the ability to hear from our consumer liaison representatives about what they are observing to heed their recommendations and take inspiration from the direct evidence of the challenges they face.

California might be the largest department in the country, but let me be clear: we are an equal partner with each and every one of you. Our DOI staff dedicate their time to NAIC committee work, rolling up their sleeves, getting into the details, and showing their commitment to this great organization. I am grateful for their dedication to our state and to you; and under my leadership, we hold paramount the value of building bridges and mutual respect toward our fellow member states and territories. Our outgoing president and my friend, David Altmaier, understands what I mean. David, you welcomed me as a new commissioner nearly three years ago, and I am deeply grateful. You model the values that are at the heart of this organization: the objective, nonpartisan policymaking that makes a difference for consumers.

As the NAIC celebrates 150 years, let us carry this nonpartisan unity forward and foster fair-minded policies. After all, it is our commitment to building consensus and consumer protection for all that will be our foundation in the years to come. We have a lot of work to do, and it is work worth doing. Bienvenidos a San Diego. Now let’s get down to business!

**David Altmaier’s Remarks**

Thank you, Commissioner Lara, and thank you again for hosting our Fall National Meeting. We are looking forward to our time here in San Diego, a city famous for its white sand beaches and beautiful weather. It is frequently referred to as “America’s Finest City,” and in my opinion, any city within close proximity of a Legoland should be considered among America’s finest cities.

Before I begin, I’d also like to acknowledge the retirement of Commissioner Mark Afable of Wisconsin. Commissioner Afable, thank you for all your contributions to the NAIC. Since your first day with us, you have proven yourself to be a compassionate thought-leader in areas such as race and insurance, innovation and technology, and pre-disaster mitigation. We appreciate your dedicated service and wish you all the best.
2021 Robert Dineen Award Recipients

As we come to the end of our year-long celebration of the NAIC’s 150-year anniversary, I would like to welcome you all to the NAIC Fall National Meeting. It is the NAIC’s 233rd national meeting, and I know I speak for many when I say it’s great to be back in person (and virtually) again.

I am especially pleased that two of this year’s Robert Dineen Award honorees are here in San Diego and that I will be able to recognize their achievements in person.

In June 1989, the NAIC established the Robert Dineen Award in honor of the founder of the NAIC’s Support and Services Office. The award honors a staff member of an insurance department who has made an outstanding contribution to state insurance regulation and regularly performs activities that advance the insurance regulatory profession.

This year, we will be honoring three Robert Dineen Award winners. When I call your name, please step up the podium to receive your award:

The first is Doug Slape, Chief Deputy Commissioner for the Texas Department of Insurance.

For more than 30 years, Mr. Slape has worked to improve solvency regulation and provided a powerful and reasoned voice to maintain the integrity of Texas’ state-based system of regulation. His service includes leadership positions in many NAIC groups. While chair of the NAIC’s Captive and Special Purpose Vehicle Use (E) Subgroup, he supported the writing of the NAIC’s first white paper on the use of captives in the U.S. Following the 2008 financial crisis, he was instrumental in developing enhancements to the solvency regulation framework, which have been included in the Accreditation Program. Among his achievements, he led an initiative at the Texas DOI to automate the review of quarterly financial filings to address the complexity of the risk-focused supervision process that was quickly evolving. This process is recognized in the NAIC’s Financial Analysis Handbook, and many other states have followed Texas’ approach.

Our second honoree is Judy Weaver, Senior Deputy Director at the Michigan Department of Insurance and Financial Services.

Ms. Weaver has served Michigan for more than 30 years. During her career, she has served as a field examiner examining insurance companies and worked in financial analysis, examination, company licensing and receivership of insurers, and market regulation of managed care entities. She has also served as deputy director and chief examiner. Her financial expertise and regulatory discipline have allowed her to contribute key insights across the financial arena and to several NAIC committees, including chairing the Financial Analysis Solvency Tools (E) Working Group and the Financial Analysis (E) Working Group. Congratulations on this well-deserved recognition.

Our last honoree is Nancy Cross, Statutory Compliance Director for the Mississippi Insurance Department.

Ms. Cross joined the Mississippi DOI in December 1958 as the administrative assistant to the deputy commissioner. She has served under four different insurance commissioners and has risen through the ranks to become the statutory compliance director, where she is responsible for issuing new and renewing licenses for all insurance companies, health maintenance organizations, societies, and associations doing business in Mississippi.

Nancy could not join us in San Diego this week. However, the Mississippi DOI provided us with this video.

Congratulations to all this year’s Robert Dineen Award Winners.

PRESIDENTIAL ADDRESS

David Altmaier, NAIC President

Good afternoon, I’m NAIC President and Florida’s Commissioner of the Office of Insurance Regulation, David Altmaier. I am honored to open the NAIC Fall National Meeting here in beautiful San Diego. Every NAIC meeting is an opportunity for stakeholders within the insurance sector to engage on matters critical to consumers all across our country, and to that end, we’re glad to welcome several of our federal partners, as well as state legislative partners to San Diego.
Before I go on, I’d like to take a moment to recognize several of my fellow colleagues who are responding to disasters in their states. We woke up Saturday morning to the devastating news of the impacts from storms and tornadoes across several states, including my home state of Kentucky. Events of this nature underscore the importance of our resiliency efforts and all we do to protect consumers. I am grateful for partnerships such as the ones made here to support one another in times like these.

As we come to the end of our year-long celebration of the NAIC’s 150-year anniversary, I would like to welcome you all to the NAIC Fall National Meeting. It is the NAIC’s 233rd national meeting, and I know I speak for many when I say it’s great to be back in person (and virtually) again.

Over the course of 150 years, the NAIC has navigated a tremendous amount of change, and its ability to adapt is remarkable in so many ways. We have shown time and time again that the source of strength of our state-based system is the connection between our members, particularly in challenging times. One thing is clear: the grit and perseverance of the NAIC and its members are as strong today as they ever were. These enduring characteristics helped lead us through so many challenges and guided the industry through an ever-evolving landscape. The NAIC’s history is well documented. For your enjoyment, and perhaps education, there’s a well-produced 150th anniversary timeline, video, and 150 years’ worth of meeting minutes that can be found on naic.org.

Let’s turn to our accomplishments and challenges in 2021.

We’ve been working very hard to respond to a global pandemic and the impacts of COVID-19 for nearly two years now. It has remained priority one for the NAIC as an important reminder to stay vigilant around these ever-evolving risks; but for a moment, let’s consider the big picture. There are many lessons and takeaways from what the COVID-19 pandemic has presented to us from a regulatory standpoint. Two are top of mind. The first is that no matter how much preparation we do ahead of time, we always need to be prepared to pivot to meet the next challenge. Second, even consumed by what feels to be a never-ending string of crisis situations, we remain focused on our fundamental objectives of consumer protection and market solvency.

That’s why thinking outside the box is so critical; but before I talk about what the sector has done well, I’d like to take a moment to acknowledge the toll the COVID-19 pandemic has had everywhere.

The number of U.S. citizens who perished from the pandemic this year surpassed 2020 numbers in November. We’ve seen an impact on communities and businesses as well. While we should be proud of our resiliency, we cannot ignore the pain that this pandemic has inflicted. We also realize that the pandemic may still deliver unexpected twists and turns ahead, but as availability of the vaccine and treatments continue to roll-out, we have cause for real optimism. The feeling that we’ve turned a corner was reflected in the engagement of NAIC members.

While 2020 was an obstacle course of cancelled meetings and evolving priorities, in 2021, our membership came together in person for the first time in over a year to discuss important regulatory issues like long-term care insurance (LTCI), the use of big data, rising cyber risks, and the impact of climate and race in exacerbating a protection gap for under-served communities.

The NAIC also held its first hybrid national meeting in August of this year in Columbus, OH. I think it’s fair to say based on the feedback we received, we set the bar when it comes to large-scale hybrid events, and our thanks again to Ohio Director Judith L. French for serving as our host. We look forward to returning one day to Columbus to fully experience what was an amazing venue. That meeting served as a great opportunity for us to continue our discussion on NAIC priorities and listen to industry and consumer advocate concerns.

In response to feedback we received, I am excited that this fall we have been able to expand our national meeting to include more working groups and task forces. So, let’s return to those two key historical lessons and apply them to our year. I’ll let our work speak for itself. We continue to adapt proactively to changing market conditions.

At this meeting, NAIC members will vote to create the first letter committee since 2004. It is important for members to stay current with the latest innovations and technological advancements. The Innovation, Cybersecurity, and Technology (H) Committee will elevate and unify our long-standing engagement in these areas to ensure that the NAIC continues to aggressively protect consumers while reducing barriers to positive innovation. One of the most significant areas of focus for
the new Committee will be on the industry’s use of data, particularly in the context of complex rating and underwriting models. Protecting the consumer’s data and privacy and ensuring the sector’s appropriate and ethical use of that data is a critical responsibility that all our members take seriously. We look forward to engaging with each other and stakeholders on these important issues in the future.

Another example of our ability to adapt and maintain focus on our core mission of protecting consumers is the work we are doing as part of our Special (EX) Committee on Race and Insurance formed in 2020. During the recent Summer National Meeting, we adopted new charges for the Special Committee and delved deeper into workstream deliverables. You will start to see some of that work emerging at this meeting. As our esteemed Most Recent Past President, Director Farmer observed when we started this journey a year ago that it is the duty of the insurance sector to address these issues while promoting diversity. We are committed to continuing the journey and completing our work, but this work will take time. I invite all interested parties to work with us to deliver on this commitment to consumers.

Let’s switch our focus on our work this year to some of the fundamentals critical to our state-based system. LTCI continues to present challenges for state insurance regulators as we look for ways to balance the tension between solvency regulation and consumer protection. The Long-Term Care Insurance (EX) Task Force is close to finalizing the development of a regulatory framework for a multistate rate review process. Additionally, it appointed a multistate rate review actuarial team, which completed its first regulator-only pilot project.

Other NAIC groups continue to make progress in achieving their goals related to long-term care (LTC), including: the Senior Issues (B) Task Force appointed the Long-Term Care Insurance Model Update (B) Working Group with the charge to examine the Long-Term Care Insurance Model Act (#640) and Long-Term Care Insurance Model Regulation (#641); the Valuation Analysis (E) Working Group conducted its third year of reviewing filings related to Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51); and the Long-Term Care Actuarial (B) Working Group and its subgroups made progress on actuarial issues, addressing reserving standards and reporting requirements.

Another important area of focus for us is climate risks and mitigation. From our earliest days, NAIC members have responded to climate-driven natural catastrophes—both before and after disaster strikes. We play a crucial role in understanding the risks themselves and ensuring that companies are appropriately accounting for those risks. State insurance regulators are on the front lines of natural catastrophe preparedness and response, protecting policyholders and maintaining well-functioning insurance markets. The NAIC and state insurance regulators are addressing climate-related risks through the three main pillars of insurance regulation: financial risk analysis, insurance market availability and affordability, and consumer education and outreach.

Last month, the NAIC released a report on how the state-based insurance regulatory system is adaptable to emerging risks. The report summarizes past, present, and future programs and actions by the NAIC and state insurance regulators to help the insurance industry respond to increasing natural hazards, including flooding, wildfires, and extreme weather. Thanks to the coordination of Commissioner Lara, state insurance regulators participated as panelists during the recent COP26 Sustainable Insurance Series hosted by the UN Environment Programme’s (UNEP’s) Principles for Sustainable Insurance (PSI) Initiative.

I was fortunate to join Commissioner Lara, Maryland Insurance Commissioner Kathleen A. Birrane, Director Farmer, Washington Commissioner Mike Kreidler, and Commissioner Mais as panelists at this event. Our discussion focused on how U.S. insurance regulators are taking action.

We continue to work with our counterparts both domestically and internationally on the critical work of addressing climate risks and the protection gap. One year ago, the NAIC finalized and adopted the Group Capital Calculation (GCC), an effort I am very proud of. The GCC provides an additional analytical tool for state insurance regulators that complements other analytical mechanisms in place and helps quantify risk across the insurance group and gain a clear picture for the allocation of capital.

Over the course of 2021, we continued implementing post-financial crisis reforms, in particular, those focused on enhancing group supervision and addressing potential systemic risk in the insurance sector at an international level. At the same time, we took up a new generation of issues facing regulators across the globe, many of which mirror our domestic focus. As regulators of the largest single market in the world, it is critical for NAIC members to provide their perspective on these issues and ensure that any standard setting takes into account our viewpoints. As a result, the NAIC, group-wide supervisors across
several states, and a variety of volunteer insurers actively contribute to this work by providing data and input. This is particularly important in assessing the comparability of the Aggregation Method to the International Association of Insurance Supervisors (IAIS) insurance capital standard (ICS).

This year marked a landmark anniversary for us: an incredible 150 years of NAIC members working collaboratively to protect consumers and ensure fair, competitive, and healthy markets. In 2022, we’ll continue to respond to whatever issues come our way. A state insurance regulator’s job is never done.

As I prepare to pass the torch to Director Cameron and shift to the role of immediate past president, we will continue the tradition of finding ways to work together to advance solutions that help foster a robust and responsive insurance sector that provides consumers with safe and reliable insurance products. As we continue the journey, let me leave you with something from our start—that first meeting 150 years ago—in fact some of the closing remarks of essentially the first NAIC president. Here is how he characterized our state-based system, recognizing the momentous opportunity afforded by the creation of the NAIC:

This system of insurance is like a vast machine. Let the parts be constructed by independent artisans without any reference to the labors of each other, and you have no warrant that they will fit together and work in harmony or produce any kind of useful result; but let the artificers come together and unite their skill. Let the different parts be made for each other, and by connecting links be made to work together, and you will have a perfect machine. Let this method be applied to a common system of insurance supervision for the whole country, and we shall have a system like the mechanism of the clock, where every little wheel works in harmony with all the others, a system which shall move with regularity, the certainty, and the efficiency of the pendulum. When we accomplish this result, then, and not till then, will we see the reward of the efforts which we have bestowed in this first meeting to bring about this result.

I think it’s fair to say we have achieved, to a large degree, the vision set out by those first members; and while there is more work to do, we certainly continue to abide by the notion that we are stronger when we are connected, and we are better when we act in harmony. It has been a unique privilege and personal honor for me to have contributed in some small way to this grand design and legacy, as has every one of you sitting around the table. We are part of something larger than ourselves, and the work we do will extend well beyond our time here. Thank you for the opportunity to be a part of it.

Farmer Award

At the NAIC, we don’t hand out green or yellow blazers to mark achievements like they do in professional golf or football, respectively, to mark exceptional performance. However, we do celebrate a leader’s accomplishments with the NAIC’s President’s Award for Distinguished NAIC Leadership, otherwise known as the President’s Award.

The President’s Award was first announced at the 2008 Fall National Meeting. At that time, it was awarded to Commissioner Jim Long. This award was also given out in 2010 when Commissioner Alfred Gross was the recipient, followed by Commissioner Sandy Praeger in 2014, Superintendent Joseph Torti III in 2015, and the last time we gave the President’s Award to Commissioner Roger Sevigny in 2017.

Today, it is my distinct honor to present the President’s Award for Distinguished NAIC Leadership for the last time.

For his commitment as we navigated through a global pandemic; for his proactive stance on inclusion within the insurance industry; for the support he provided in standing up the Special (EX) Committee on Race and Insurance and co-chairing the Climate and Resiliency (EX) Task Force; and his leadership in the areas of technology, data, privacy, and cybersecurity. For his service on the Financial Stability Oversight Council (FSOC) and his work on the Reinsurance (E) Task Force, Long-Term Care Insurance (EX) Task Force, Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, Regulatory Framework (B) Task Force, Casualty Actuarial and Statistical (C) Task Force, Surplus Lines (C) Task Force, Title Insurance (C) Task Force, Workers’ Compensation (C) Task Force, Antifraud (D) Task Force, Market Regulation Certification (D) Working Group, Producer Licensing (D) Task Force, Financial Condition (E) Committee, Capital Adequacy (E) Task Force, Receivership and Insolvency (E) Task Force, Restructuring Mechanisms (E) Working Group, and Risk Retention Group (E) Task Force. Before the session times out, let’s just say that in short for consistently providing 53 years of exceptional leadership and service advancing consumer protection and regulation in the insurance industry.
I present the President’s Award for Distinguished NAIC Leadership to the Honorable Raymond G. Farmer, South Carolina Department of Insurance Director, 2020 NAIC President, and 2021 Immediate Past NAIC President. [Applause]

Congratulations Director Farmer. Please come up and receive the award.

As the president of the NAIC, I would like to make the following proclamation.

Whereas the NAIC lauds exemplary leadership, we will no longer recognize exceptional leadership with the presentation of the President’s Award for Distinguished NAIC Leadership.

Therefore, I, David Altmaier, President of the NAIC, on this 13th day of December of the year 2021, do hereby proclaim the Raymond G. Farmer Award for Exceptional Leadership to be the name of the award presented for exceptional NAIC leadership from this day forward.

THANK YOU/GIFT PRESENTATION

[Director Cameron thanked Director Altmaier].

ADJOURNMENT

Thank you. I look forward to meeting with state insurance regulators, industry leaders, and interested parties as we discuss the work being done at the NAIC. With that, I officially conclude this opening session of the 233rd meeting of the NAIC.
Synopsis of the NAIC Committee, Subcommittee and Task Force Meetings

2021 Fall National Meeting

December 11–16, 2021

TO: Members of the NAIC and Interested Parties
FROM: The Staff of the NAIC

Committee Action

NAIC staff have reviewed the committee, subcommittee, and task force reports and highlighted the actions taken by the committee groups during the 2021 Fall National Meeting. The purpose of this report is to provide NAIC members, state insurance regulators, and interested parties with a summary of these meeting reports.

EXECUTIVE (EX) COMMITTEE AND PLENARY (Joint Session)

December 16, 2021

1. Adopted the report of the Executive (EX) Committee. See the Committee listing for details.
2. Adopted the establishment of the Innovation, Cybersecurity, and Technology (H) Committee and its charges.
3. Adopted by consent the committee, subcommittee, and task force minutes of the Summer National Meeting.
4. Adopted the NAIC 2022 proposed budget.
5. Adopted the NAIC 2022 proposed committee charges.
6. Received the report of the Life Insurance and Annuities (A) Committee. See the Committee listing for details.
7. Received the report of the Health Insurance and Managed Care (B) Committee. See the Committee listing for details.
8. Received the report of the Property and Casualty Insurance (C) Committee. See the Committee listing for details.
9. Received the report of the Market Regulation and Consumer Affairs (D) Committee. See the Committee listing for details.
10. Received the report of the Financial Condition (E) Committee. See the Committee listing for details.
11. Received the report of the Financial Regulation Standards and Accreditation (F) Committee. See the Committee listing for details.
12. Received the report of the International Insurance Relations (G) Committee. See the Committee listing for details.
13. Adopted the 2022 Generally Recognized Expense Table (GRET).
15. Adopted the travel insurance Market Conduct Annual Statement (MCAS) blank.
16. Adopted the short-term limited-duration (STLD) MCAS blank.
17. Adopted the Regulatory Information Retrieval System (RIRS) coding structure.
20. Adopted exposure of the 2020 revisions to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) as an update to the accreditation standards.
21. Received a status report on state implementation of NAIC-adopted model laws and regulations.
22. Received the results of the 2022 zone officer elections:
   A. Midwest Zone: Commissioner Glen Mulready, Chair (OK); Commissioner Doug Ommen, Vice Chair (IA); and Director Anita G. Fox, Secretary (MI).
   B. Northeast Zone: Commissioner Gary D. Anderson, Chair (MA); Commissioner Kathleen A. Birrane, Vice Chair (MD); and Commissioner Trinidad Navarro, Secretary (DE).
   C. Southeast Zone: Commissioner Scott A. White, Chair (VA); Commissioner Carter Lawrence, Vice Chair (TN); and Commissioner James J. Donelon, Secretary (LA).
   D. Western Zone: Director Lori K. Wing-Heier, Chair (AK); Commissioner Michael Conway, Vice Chair (CO); and Commissioner Andrew R. Stolfi, Secretary (OR).
23. Elected the 2022 NAIC officers: Director Dean L. Cameron (ID), President; Director Chlora Lindley-Myers (MO), President-Elect; Commissioner Andrew N. Mais (CT), Vice President; and Commissioner Jon Godfread (ND), Secretary-Treasurer.
EXECUTIVE (EX) COMMITTEE
December 14, 2021

1. Adopted the report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, which met Dec. 12 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings. During this meeting, the Committee and Subcommittee took the following action:
   A. Adopted its Dec. 7, Oct. 26, and Summer National Meeting minutes, which included the following action:
      i. Approved the proposed NAIC 2022 budget and recommended that it be considered by the full membership during the joint meeting of the Executive (EX) Committee and Plenary during the Fall National Meeting.
      ii. Held a public hearing on the NAIC 2022 proposed budget with interested parties.
      iii. Approved exposure of the NAIC 2022 proposed budget for a public comment period.
      iv. Approved the 2021 NAIC Staffing Request Fiscal.
   B. Adopted the report of the Audit Committee, including its Dec. 7 minutes. During this meeting, the Committee took the following action:
      i. Received an overview of the Oct. 31 financial statements.
      ii. Received an update on the 2021 financial audit and the 2021/2022 Service Organization Control (SOC) 1 and SOC 2 audits.
      iii. Received an update on database filing fee payments and the Zone financials.
      iv. Received an update on the Enterprise Resource Planning (ERP) project.
      v. Received an update on the Operating Reserve Analysis project.
   C. Adopted the report of the Internal Administration (EX1) Subcommittee, including its Nov. 22 minutes. During this meeting, the Subcommittee took the following action:
      i. Received the Sept. 30 Long-Term Investment Portfolio and Defined Benefit Pension Plan Portfolio reports.
      ii. Adopted a recommendation to increase the liability driven investment (LDI) percentage for the Defined Benefit Plan portfolio.
   D. Received the joint chief executive officer/chief operating officer (CEO/COO) report.
   E. Received an update on the System for Electronic Rates & Forms Filing (SERFF) modernization project.
   F. Received a cybersecurity update.

2. Adopted the report of the Executive (EX) Committee, which met Dec. 7, Oct. 26, and Oct. 12 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During these meetings, the Committee took the following action:
   A. Approved the NAIC 2022 proposed budget and recommended that it be considered by the full membership during the joint meeting of the Executive (EX) Committee and Plenary during the Fall National Meeting.
   B. Approved the 2021 NAIC Staffing Request Fiscal.
   C. Approved the exposure of the NAIC 2022 proposed budget for public review and comment.
   D. Approved the exposure of the 2021 NAIC Staffing Request Fiscal for public comment.
   E. Reappointed Commissioner Andrew N. Mais (CT) to the International Association of Insurance Supervisors (IAIS) Executive Committee for a two-year term.

3. Adopted the report of the Climate and Resiliency (EX) Task Force. See the Task Force listing for details.
5. Adopted the report of the Innovation and Technology (EX) Task Force. See the Task Force listing for details.
6. Adopted the report of the Long-Term Care Insurance (EX) Task Force. See the Task Force listing for details.
7. Adopted the report of the Special (EX) Committee on Race and Insurance. See the Committee listing for details.
8. Adopted its 2022 proposed charges.
9. Received a status report on the NAIC State Ahead strategic plan implementation.
10. Received a status report on model law development efforts for amendments to: 1) the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171); 2) the Life Insurance Disclosure Model Regulation (#580); 3) the Mortgage Guaranty Insurance Model Act (#630); 4) the Nonadmitted Insurance Model Act (#870); and 5) the Pet Insurance Model Act.
11. Received a report from the National Insurance Producer Registry (NIPR).
12. Received a report from the Interstate Insurance Product Regulation Commission (Compact).
Climate and Resiliency (EX) Task Force

December 14, 2021

1. Adopted its Summer National Meeting minutes
2. Received a report from the Technology Workstream recommending that the Center for Insurance Policy and Research (CIPR) create a Catastrophe Model Center of Excellence (COE) as a shared resource for state insurance regulators regarding catastrophe models.
3. Received a report from the Climate Risk Disclosure Workstream on its redesigned Climate Risk Disclosure Survey. The Workstream aligned its redesigned survey to the recommendations of the Financial Stability Board’s (FSB’s) Task Force on Climate-Related Financial Disclosure (TCFD).
4. Received a report from the Solvency Workstream, which plans to make its final recommendations regarding financial solvency tools to the Task Force in the first quarter of 2022.
5. Received a report from the Innovation Workstream, which has met twice since the Summer National Meeting to: 1) hear a presentation from Sola Insurance about a parametric product offered as an endorsement to a homeowners policy; and 2) hear a presentation from Guy Carpenter about community-based insurance for disaster resilience.
6. Received a report from the Pre-Disaster Mitigation Workstream, which has been focused on its charge to collect and share resources with consumers and other stakeholders and seeking out best practices to encourage consumer risk awareness.
7. Heard an update on federal activities, including President Joe Biden’s executive order on climate-related financial risk; the Financial Stability Oversight Council’s (FSOC’s) Report on Climate-Related Financial Risk; the U.S. Securities and Exchange Commission’s (SEC’s) development of a mandatory climate risk disclosure period for the Committee’s consideration; the Build Back Better Act; and the Disaster Mitigation and Tax Parity Act.
8. Heard an update on international activities, including the International Association of Insurance Supervisors’ (IAIS’) creation of a Climate Risk Steering Group; the NAIC’s participation in the COP26 Sustainable Insurance Series hosted by the UN Environment Programme’s (UNEP’s) Principles for Sustainable Insurance Initiative (PSI); and recent meetings of the Sustainable Insurance Forum (SIF) and the European Union (EU)-U.S. Insurance Dialogue Project.

Government Relations (EX) Leadership Council

The Government Relations (EX) Leadership Council did not meet at the Fall National Meeting.

Innovation and Technology (EX) Task Force

December 13, 2021

1. Adopted its Summer National Meeting minutes.
2. Adopted the report of the Big Data and Artificial Intelligence (EX) Working Group, including its Dec. 13 minutes. During this meeting, the Working Group took the following action:
   A. Reviewed its 2022 proposed charges.
   B. Heard a presentation from an insurance regulatory advisor on how to leverage the lessons learned in developing the regulatory framework for cybersecurity to the development of a regulatory framework for artificial intelligence (AI).
   C. Heard a presentation from Monitaur on a possible AI regulatory path.
   D. Heard a presentation from SigmaRed on monitoring and mitigating AI bias and enabling transparency.
   E. Heard a presentation on the preliminary, aggregate analysis of industry responses to the private personal auto (PPA) AI/machine learning (ML) survey on insurers’ use and governance of big data, as used in an AI/ML model.
   F. Discussed the next line of insurance to survey.
   G. Discussed development of its 2022 work plan.
3. Adopted the report of the Speed to Market (EX) Working Group, including its Nov. 16 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its June 30 and June 29 minutes, which included the following action:
      i. Adopted its March 10 minutes.
      ii. Heard an update from the Information Technology Group (ITG).
      iii. Discussed and considered the suggestions received for updates to the product coding matrices (PCMs) and uniform transmittal documents (UTDs).
C. Reviewed its charge to provide information to states on contacts and resources for updates that may need to be made to the Product Requirements Locator (PRL) tool. A help document was posted on the Working Group’s web page.

4. Adopted the report of the E-Commerce (EX) Working Group, including its Oct. 7 minutes. During this meeting, the Working Group took the following action:
   A. Heard a presentation from the American Council of Life Insurers (ACLI) and the American Property Casualty Insurance Association (APCIA) on the e-commerce legal landscape, COVID-19 regulatory accommodations, and state adoption of e-commerce rules/guidance.
   B. Heard a suggestion from the ACLI that the NAIC develop a handbook that would capture the regulatory framework that exists with respect to e-commerce, including variations among jurisdictions.
   C. Heard a presentation from the Insured Retirement Institute (IRI), the Missouri Insurance Department, and the Center for Economic Justice (CEJ). All of these presentations informed three surveys that were circulated to state insurance regulators and interested parties on Dec. 10.

5. Heard an update on Colorado’s Restrict Insurers’ Use of External Consumer Data legislation (S.B. 21-169), which is related to big data and AI oversight.

6. Heard presentations from the American InsurTech Council (AITC) and the InsurTech Coalition.

7. Received an update from the ad hoc drafting group on proposed draft charges for a new NAIC “H” Committee.

8. Received updates from other NAIC committees and working groups on related activities, including the Special (EX) Committee on Race and Insurance, the Privacy Protections (D) Working Group, and the Accelerated Underwriting (A) Working Group.

9. Heard a presentation from the MIB Group on its algorithmic bias testing for life insurers.

10. Received an update on the System for Electronic Rates & Forms Filing (SERFF) modernization project.

Long-Term Care Insurance (EX) Task Force
December 12, 2021

1. Adopted its Oct. 29 and Summer National Meeting minutes, which included the following action:
   A. Adopted its 2022 proposed charges.

2. Heard an update on industry trends that could have an impact on the solvency of long-term care insurance (LTCI) companies and factors affecting reserves.

3. Received the report of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, which met Dec. 12. During this meeting, the Subgroup took the following action:
   A. Adopted its Nov. 15 and Sept. 28 minutes, which included the following action:
      i. Received and discussed interested state insurance regulator and interested party comments on the LTCI multistate actuarial (MSA) rate review framework (MSA Framework) draft.
      ii. Exposed the revised MSA Framework for a 21-day public comment period ending Dec. 6.
   B. Received and discussed interested party comments on the MSA Framework and made a few revisions in response to the comments.
   C. Adopted the MSA Framework.

4. Adopted the MSA Framework.

5. Received the report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup, which met Dec. 7, Nov. 19, Oct. 19, Oct. 4, Sept. 27, and Aug. 23. During these meetings, the Subgroup took the following action:
   A. Adopted the “Issues Related to LTC Wellness Benefits” document.
   B. Adopted the “Checklist for Premium Increase Communications” document.
   C. Received and discussed comments from interested state insurance regulators and interested parties on the “Issues Related to LTC Wellness Benefits” document. Edits were made to the document to address comments.
   D. Received and discussed comments from interested state insurance regulators and interested parties on the “Checklist for Premium Increase Communications” document. Edits were made to the document to address comments.


7. Adopted the “Checklist for Premium Increase Communications” document.

Special (EX) Committee on Race and Insurance
December 14, 2021

1. Adopted its Summer National Meeting minutes.
2. Received a status report for the following workstreams:
   A. Workstream One: Research/analyze the level of diversity and inclusion within the insurance industry.
   B. Workstream Two: Research/analyze the level of diversity and inclusion within the NAIC and state insurance regulator community.
   C. Workstream Three: Examine and determine which practices or barriers exist in the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups in the property/casualty (P/C) line of business.
   D. Workstream Four: Examine and determine which practices or barriers exist in the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups in the life insurance and annuities line of business.
   E. Workstream Five: Examine and determine which practices or barriers exist in the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups in the health insurance line of business.

3. Heard an update on Colorado’s Restrict Insurers’ Use of External Consumer Data legislation (S.B. 21-169). The act prohibits an insurer from unfairly discriminating based on an individual’s race, color, national or ethnic origin, religion, sex, sexual orientation, disability, gender identity, or gender expression in any insurance practice.

4. Heard a presentation from the American Property Casualty Insurance Association (APCIA) on its initiatives underway to promote and advance a more diverse and inclusive industry and on its diversity, equity, and inclusion (DE&I) catalog created in partnership with PlusUltre.

5. Heard a presentation from Blue Cross and Blue Shield of Illinois on its efforts related to DE&I for the organization’s 24,000 employees and nearly 17 million members.

6. Heard a presentation from Zurich North America on its DE&I structure and its analytics metrics insights.

INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE
See the Executive (EX) Committee listing for details.

Information Systems (EX1) Task Force
November 18, 2021
1. Adopted its Summer National Meeting minutes.
2. Received an operational report on the NAIC’s information technology (IT) activities, including: product highlights; innovation and technology; service and support; data collection metrics; team; project portfolio summary; and technology adoption and system usage. The report provides updates for upcoming improvements, impacts to new state technology offerings from the NAIC, and general updates on the activities of the NAIC technology team.

3. Received a project portfolio update, including project status reports for 21 active technical projects and a summary of two recently completed projects.

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE
December 15, 2021
1. Adopted its Summer National Meeting minutes.
2. Adopted the report of the Accelerated Underwriting (A) Working Group, including its Dec. 6 minutes. During this meeting, the Working Group took the following action:
   A. Discussed comments received on the latest draft of the accelerated underwriting educational report.

3. Adopted the report of the Life Actuarial (A) Task Force. See the Task Force listing for details.
4. Received a memorandum from the Life Actuarial (A) Task Force and the Valuation Analysis (E) Working Group on the Financial Sector Assessment Program (FSAP) recommendation.

5. Adopted revisions to Actuarial Guide XXV—Calculation of Minimum Reserves and Minimum Nonforfeiture Values for Policies with Guaranteed Increasing Death Benefits Based on an Index (AG 25).

6. Adopted the 2022 Generally Recognized Expense Table (GRET)
7. Adopted the 2022 proposed charges of the Life Actuarial (A) Task Force.
Life Actuarial (A) Task Force
December 8, 2021 (in lieu of the Fall National Meeting)

1. Adopted its Dec. 1, Nov. 18, Nov. 4, Oct. 21, Sept. 30, and Sept. 16 minutes, which included the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Adopted its 2022 proposed charges.
   C. Adopted the Society of Actuaries’ (SOA’s) 2022 Generally Recognized Expense Table (GRET).
   D. Adopted the SOA historical mortality improvement (HMI) recommendation and the HMI scale factors.
   E. Adopted amendment proposal 2021-13, which corrects language that allows the addition of prescribed mortality margins for some life/long-term care (LTC) combination products to decrease, rather than increase, modeled reserves.
   F. Adopted amendment proposal 2021-12, which corrects a reference error in VM-21, Requirements for Principle-Based Reserves for Variable Annuities, and clarifies the requirements for variable annuity contracts with no minimum guaranteed benefits under three prescribed assumptions in VM-21 Section 6C.
   G. Exposed amendment proposal 2021-11, which addresses items related to VM-21 information necessary for regulatory review that companies did not include in their VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation, reports for a public comment period ending Dec. 1.
   H. Adopted revisions to Actuarial Guideline XXV—Calculation of Minimum Reserves and Minimum Nonforfeiture Values for Policies with Guaranteed Increasing Death Benefits Based on an Index (AG 25), which remove the fixed 4% nonforfeiture rate floor to align the guideline with the VM-02, Minimum Nonforfeiture Mortality and Interest, changes implemented for the 2021 Valuation Manual.

2. Adopted the report of the Longevity Risk (E/A) Subgroup, which has not met since the Summer National Meeting.
3. Adopted the report of the Guaranteed Issue (GI) Life Valuation (A) Subgroup, which has not met since the Summer National Meeting.
4. Adopted the report of the Experience Reporting (A) Subgroup, which has not met since the Summer National Meeting.
5. Adopted the report of the Valuation Manual (VM)-22 (A) Subgroup, which met Dec. 1 and Nov. 18 in joint session with the Task Force. The Subgroup approved a request to the SOA and the American Academy of Actuaries (Academy) for the development of mortality factors for structured settlements.
6. Adopted the report of the Index-Linked Variable Annuity (A) Subgroup, including its Nov. 23 and Sept. 23 minutes. During these meetings, the Subgroup took the following action:
   A. Exposed the draft actuarial guideline for index-linked variable annuities (ILVAs) for a 60-day public comment period ending Jan. 27, 2022.
   B. Discussed establishing interim values for ILVAs.
7. Adopted the report of the Indexed Universal Life (IUL) Illustration (A) Subgroup. The Subgroup provided background on the IUL illustration issues that led to the development of Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49) and Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold on or After December 14, 2020 (AG 49-A). Regulator reviews have revealed that while illustrated credited rates may have lowered, they have not lowered as much as was contemplated when AG 49-A was adopted.
9. Received an update on the development of the economic scenario generator (ESG).
10. Discussed comments received on the exposure of the asset adequacy testing (AAT) actuarial guideline.
11. Heard an update on experience reporting data collection.
12. Heard an update from the joint committee of the Academy and the SOA on future mortality improvement factors.
13. Heard an update from the SOA on research and education.
14. Heard an update on the activities of the Academy Life Practice Council, including recent webinars, a boot camp, its annual meeting, and a life policy update webinar scheduled for January 2022.

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE
December 15, 2021

1. Adopted its Summer National Meeting minutes.
2. Adopted the report of the Consumer Information (B) Subgroup, including its Dec. 2, Oct. 20, Oct. 14, and Aug. 24 minutes. During these meetings, the Subgroup took the following action:
   A. Adopted claims process-related guides; i.e., appeals process, medical necessity, explanation of benefits (EOBs), claims filing, and billing codes and claims.

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B. Adopted updates to the *Frequently Asked Questions About Health Care Reform* document.
C. Adopted a “New Protections From Surprise Medical Bills” consumer-facing brief on balance billing.

3. Adopted the report of the Health Innovations (B) Working Group, including its Dec. 11 and Nov. 2 minutes. During these meetings, the Working Group took the following action:
   A. Heard presentations from Blue Cross and Blue Shield of North Carolina and from Anthem on health plan efforts to address health disparities.
   B. Received an update on findings of research conducted with the Center for Insurance Policy and Research (CIPR) on the health disparities impacts of the rise in telehealth services and the move to alternative payment models.
   C. Heard a presentation from Georgia State University on using state rate review authority to limit premium growth.
   D. Heard a presentation from State Health and Value Strategies on state policy considerations with enhanced premium tax credits.
   E. Discussed its work on race and insurance.

4. Adopted the report of the Health Actuarial (B) Task Force. See the Task Force listing for details.
5. Adopted the report of the Regulatory Framework (B) Task Force. See the Task Force listing for details.
6. Adopted the report of the Senior Issues (B) Task Force. See the Task Force listing for details.
7. Adopted its 2022 proposed charges.
8. Adopted the 2022 proposed charges of its task forces.
9. Heard an update from the Center for Consumer Information and Insurance Oversight (CCIIO) on Biden administration federal legislative and administrative initiatives and priorities. The update included a discussion of the administration’s plans on working with the states with respect to the implementation and enforcement of the provider provisions of the federal No Surprises Act (NSA).
10. Discussed its work on developing guidance documents for state insurance departments to use as part of their outreach efforts to providers and consumers on the NSA.
11. Heard a presentation on the Kaiser Family Foundation’s (KFF’s) summary findings from its 2021 Employer Health Benefits Survey (EHBS).
12. Received an update on the work of Workstream Five of the Special (EX) Committee on Race and Insurance since its last update to the Committee during its meeting at the Summer National Meeting. The Workstream met Dec. 3, Nov. 18, Oct. 14, Sept. 9, and Aug. 26. During these meetings, the Workstream discussed and considered revisions to its “Principles for Data Collection” document. The Workstream also discussed and exposed a draft outline for its proposed white paper on provider networks, provider directories, and cultural competency for a public comment period ending Nov. 8. The Workstream plans to meet Dec. 20 to consider final revisions to the “Principles for Data Collection” document and, if finalized, forward the document to the Special Committee for consideration.

**Health Actuarial (B) Task Force**

**November 29, 2021 (in lieu of the Fall National Meeting)**

1. Adopted its Sept. 14 minutes, which included the following action:
   A. Adopted its April 23 and April 6 minutes, and the May 17 and March 29 minutes of the Long-Term Care Actuarial (B) Working Group, which included the following action:
      i. Exposed a proposal to revise the instructions for the health Statement of Actuarial Opinion (SAO) for a public comment period ending May 7.
      ii. Discussed a long-term care insurance (LTIC) data call.
      iii. Heard a presentation from the Society of Actuaries (SOA) on COVID-19 impacts on LTIC.
   B. Adopted a motion to disband the Health Care Reform Actuarial (B) Working Group and the State Rate Review (B) Subgroup.
   C. Adopted its 2022 proposed charges.
2. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on a system connection between the System for Electronic Rates & Forms Filing (SERFF) and the Health Insurance Oversight System Unified Rate Review (HIOS URR) module
3. Heard an update on SOA health care trend research.
5. Heard an update from the Academy and the SOA Research Institute on an LTIC mortality and lapse study.
6. Discussed a proposal to revise instructions for the health SAO.
7. Discussed the impact of legislation adding dental, hearing, and vision benefits to Medicare Part B on Medicare supplement plans.
Regulatory Framework (B) Task Force

November 30, 2021 (in lieu of the Fall National Meeting)

1. Adopted its Nov. 9 and Summer National Meeting minutes, which included the following action:
   A. Adopted its 2022 proposed charges.

2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Nov. 1, Oct. 4, Sept. 20, Aug. 23, Aug. 9, and July 26 minutes. During these meetings, the Subgroup took the following action:
   A. Continued discussion of revisions to Sections 1–7 of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) based on the comments received by the July 2 public comment deadline.
   B. Heard presentations on the products covered under Model #171. The presentations specifically discussed: 1) the different types of products covered under Model #171; 2) how they pay benefits; 3) what they are designed to do; 4) how they are marketed; and 5) how they are sold. The Subgroup also heard a consumer perspective on these products.

3. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group, including its Oct. 8 and July 30 minutes. During these meetings, the Working Group took the following action:
   A. Discussed potential updates to the Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation (ERISA Handbook) related to the U.S. Supreme Court’s decision in Rutledge vs. Pharmaceutical Care Management Association (PCMA) with respect to any ERISA preemption. The Working Group also discussed the Rutledge decision in relation to the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup’s new 2021 charge to develop a white paper discussing state laws regulating pharmacy benefit manager (PBM) business practices. Following these discussions, the Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings.
   B. Reviewed and discussed an initial draft summary of the Rutledge decision. The Working Group agreed that the initial draft summary needed to be revised. The Working Group plans to review and discuss a revised draft summary in early 2022.

4. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, which plans to meet at the Fall National Meeting. See the Working Group listing for details. The Working Group also met Aug. 5. During this meeting, the Working Group took the following action:
   A. Heard presentations discussing the provider perspective on mental health parity.

5. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, which has not held an open meeting since October 2020 because it completed its initial work to develop a new NAIC model regulating PBMs. The proposed new NAIC model did not receive sufficient votes for adoption during the Executive (EX) Committee and Plenary meeting at the Summer National Meeting. The Subgroup met Nov. 8 and Sept. 5 in regulator-to-regulator session, pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals), and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to continue work on its goals. The Subgroup also plans to meet at the Fall National Meeting. See the Subgroup listing for details.

6. Heard a presentation on the federal No Surprises Act’s (NSA’s) interim final rules and implications for the states. The presentation provided an overview of the NSA and detailed the provisions included in the interim final rules and proposed rules issued to date implementing the NSA.

7. Discussed the expanded scope of external review under the NSA, the implications of this expanded scope on the Uniform Health Carrier External Review Model Act (#76), and possible steps the Task Force can take to address the issue. The Task Force decided to set up an ad hoc group to work with NAIC staff to discuss the possible steps to address the issue and make recommendations to the Task Force sometime in late January or early February 2022.

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group

December 13, 2021

1. The Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group met in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to assess state needs and plan work for 2022.
Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
December 11, 2021

1. Heard an update of the recent ruling in the Pharmaceutical Care Management Association (PCMA) v. Wehbi case.
2. Heard presentations from Connecticut, Oklahoma, Virginia, and Wisconsin on their pharmacy benefit manager (PBM) laws.
3. Discussed moving forward with its next meeting to begin work to develop a white paper on issues related to the state regulation of certain PBM business practices. The white paper also will examine the role PBMs, pharmacy services administrative organizations (PSAOs), and other prescription drug supply chain entities play in the provision of prescription drug benefits. The Subgroup also plans to hear from a few states on the implementation of their PBM laws and regulations.

Senior Issues (B) Task Force
November 30, 2021 (in lieu of the Fall National Meeting)

1. Adopted its Oct. 6 minutes, which included the following action:
   A. Adopted its 2022 proposed charges.
   B. Heard a presentation on the WA Cares Fund.
2. Adopted the report of the Long-Term Care Insurance Model Update (B) Subgroup, including its Nov. 3 and Oct. 13 minutes. During these meetings, the Subgroup took the following action:
   A. Reviewed Sections 1–12 of the Long-Term Care Insurance Model Regulation (#641) to determine their flexibility to remain compatible with the evolving delivery of long-term care (LTC) services and the evolving long-term care insurance (LTCI) marketplace.
3. Discussed Medigap and durable medical equipment (DME), with a focus on excessive charges.
4. Heard a federal legislative update regarding funding for the State Health Insurance Assistance Program (SHIP) and the hearing benefit to be added to Medicare Part B.

PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

December 15, 2021

1. Adopted its Nov. 10 minutes, which included the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Adopted the Pet Insurance Model Act.
2. Adopted the report of the Casualty Actuarial and Statistical (C) Task Force. See the Task Force listing for details.
3. Adopted the report of the Surplus Lines (C) Task Force. See the Task Force listing for details.
4. Adopted the report of the Title Insurance (C) Task Force. See the Task Force listing for details.
5. Adopted the report of the Workers’ Compensation (C) Task Force, which has not met since the Summer National Meeting.
6. Adopted the report of the Cannabis Insurance (C) Working Group, including its Dec. 1 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its Oct. 21 minutes. During this meeting, the Working Group took the following action:
      i. Adopted its Summer National Meeting minutes.
      ii. Discussed the outline for the appendix to the Understanding the Market for Cannabis Insurance white paper.
      iii. Discussed its 2022 proposed charges.
   B. Received an update on the drafting of the Understanding the Market for Cannabis Insurance white paper appendix.
   C. Discussed the potential to collaborate with the Producer Licensing (D) Task Force to study, in states where cannabis is legalized for medical and/or recreational use, whether cannabis-related convictions are preventing individuals from being licensed as an agent or broker.
   D. Heard a presentation from the University of Colorado on emerging scientific issues in the cannabis space.
   E. Heard a presentation from the Cannabis Regulators Association (CANNRA) on cannabis policy and regulation trends.
7. Adopted the report of the Catastrophe Insurance (C) Working Group, including its Dec. 12 minutes. During this meeting, the Working Group met in joint session with the NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group and took the following action:
   A. Adopted the Catastrophe Insurance (C) Working Group’s Summer National Meeting minutes.
   B. Adopted the NAIC/FEMA (C) Advisory Group’s Nov. 15 minutes. During this meeting the Advisory Group took the following action:
      i. Heard an update from FEMA on Risk Rating 2.0. Risk Rating 2.0 is meant to better align individual property rates with risk. Phase I began on Oct. 1 and included the selling of new flood insurance policies under the new rating
system, as well as allowing current National Flood Insurance Program (NFIP) policyholders to take advantage of premium decreases.

ii. Heard about Risk Rating 2.0 training opportunities that are available from FEMA.

iii. Heard from FEMA about joint messaging opportunities.

C. Heard a report from FEMA on Risk Rating 2.0 and implementation of the new rating system for the NFIP.

D. Heard a report from FEMA on the FEMA structure and FEMA regional flood insurance specialists. FEMA discussed the ways in which it can assist the various DOIs, including: 1) outreach, education, and training; 2) technical assistance; 3) NFIP claims, underwriting and coverage; 5) pre- and post-disaster support; and 6) public awareness events and activities.

E. Received an update on the NAIC Catastrophe Resource Center. NAIC staff updated the Working Group and Advisory Group of the items added to the resource center, including FEMA regional information and FEMA contact information.

F. Heard a report from Louisiana regarding Hurricane Ida. Topics covered included: 1) the scope of the hurricane; 2) the path of the storm; 3) the parishes affected; 4) storm damage; and 5) the Louisiana Department of Insurance (DOI) response to the hurricane.

G. Received an update on the Catastrophe Modeling Handbook (Handbook). NAIC staff discussed a survey that was sent out to the state DOIs. There was a discussion held regarding the evaluation of models for various perils, as well as information regarding the usefulness of each section in the current Handbook. The drafting group will meet in January 2022 to further discuss the survey and the drafting process.

H. Discussed future engagements with FEMA, including: 1) an NAIC/FEMA meeting for FEMA Region 6; 2) an earthquake event to be hosted by the Missouri DOI in spring 2022; and 3) the Cascadia Rising 2022 National Level Exercise (NLE).

8. Adopted the report of the Pet Insurance (C) Working Group, including its Dec. 1 minutes. During this meeting, the Working Group took the following action:

   A. Adopted its Oct. 21 minutes, which included the following action:
      i. Adopted its Oct. 7 minutes, which included the following action:
         a. Adopted its Sept. 8 minutes, which included the following action:
            1) Discussed the definition of “wellness plans” in the draft Pet Insurance Model Act.
         b. Discussed comments on the revised draft Pet Insurance Model Act.
      ii. Discussed comments on the revised draft Pet Insurance Model Act.
   B. Discussed the collection of pet insurance data.

9. Adopted the report of the Terrorism Insurance Implementation (C) Working Group, which has not met since the Summer National Meeting.

10. Adopted the report of the Transparency and Readability of Consumer Information (C) Working Group, including its Nov. 17 minutes. During this meeting, the Working Group took the following action:

A. Adopted its Summer National Meeting minutes.

B. Adopted the report of the Consumer Education Drafting Group. The Drafting Group has split into two subgroups to complete the drafting of consumer education materials about rating factors and discounts on automobile insurance policies. Once the information regarding automobile insurance is complete, the drafting group will draft documents about homeowners insurance.

C. Heard a presentation on disparities in insurance access. This presentation was based on a grassroots survey done through the lens of community organizations.

11. Adopted its 2022 proposed charges with the following revisions:

   A. Added a charge for the Title Insurance (C) Task Force to “[r]eview current rate regulation practices.”

   B. Added a charge for the Statistical Data (C) Working Group to “[i]mplement the expedited reporting and publication of average auto and average homeowners premium portions of the annual Auto Insurance Database Report (Auto Report) and Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report (Homeowners Report).

12. Heard presentations related to auto insurance premium refunds resulting from reduced driving during the pandemic.

13. Heard a federal update related to flood insurance, federal spending bills, auto insurance, and cannabis legislation.

Casualty Actuarial and Statistical (C) Task Force
December 7, 2021 (in lieu of the Fall National Meeting)

1. Adopted its Nov. 17, Nov. 9, Oct. 19, Oct. 12, Aug. 20, and Summer National Meeting minutes, which included the following action:
B. Adopted a decision to discontinue requiring continuing education (CE) categorization by appointed actuaries in 2023.
C. Adopted its 2022 proposed charges.
E. Adopted a response to the Blanks (E) Working Group regarding proposal 2021-11BWG.
F. Heard a report on the NAIC rate model technical reviews.

2. Reported that it met Oct. 19, Sept. 21, and Aug. 17 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss rate filing issues.

3. Reported that it met Oct. 26 to hear a “Book Club” presentation about algorithmic accountability.

4. Adopted the report of the Actuarial Opinion (C) Working Group, including its Sept. 23, Sept. 8, and Sept. 2 minutes. During these meetings, the Working Group took the following action:
   A. Discussed and adopted the 2021 Regulatory Guidance.

5. Adopted the report of the Statistical Data (C) Working Group, which met Nov. 30 and Oct. 20 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings. The Working Group also met Oct. 7 and Sept. 23. During these meetings, the Working Group took the following action:
   A. Adopted the Auto Insurance Database Report (Auto Report), the Competition Database Report (Competition Report), and the Profitability Report.
   B. Researched the ability to collect and publish auto and home premium and exposures under an accelerated timeline.
   C. Reported that it is continuing to work on the Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report (Homeowners Report).

7. Exposed NAIC staff’s proposed random forest information items and glossary for a 60-day public comment period ending Jan. 20, 2022.
8. Heard a presentation from the Academy on the activities of its Casualty Practice Council and the Committee on Property and Liability Financial Reporting (COPFLR).
9. Heard a presentation from the CAS on its research activity.

Surplus Lines (C) Task Force
November 29, 2021 (in lieu of the Fall National Meeting)

1. Adopted its Summer National Meeting minutes.
2. Adopted the report of the Surplus Lines (C) Working Group, including its Sept. 22 minutes. During this meeting, the Working Group took the following action:
   A. Discussed proposed modifications to the NAIC Standard Form Trust Agreement.
   B. Adopted revisions to the Quarterly Listing of Alien Insurers.
3. Received an update from the drafting group for the Nonadmitted Insurance Model Act (#870).
4. Heard an update on surplus lines industry results.

Title Insurance (C) Task Force
November 16, 2021 (in lieu of the Fall National Meeting)

1. Adopted its Oct. 19 minutes, which included the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Discussed its 2022 proposed charges.
   C. Heard a presentation from Demotech on its Regional Title Underwriter Escrow Theft & Defalcation Prevention Measures report.
   D. Heard a presentation on the American Land Title Association’s (ALTA’s) new forms of Commitment, Owner’s Policy, and Loan Policy, effective July 1.
2. Adopted its 2022 proposed charges. Revisions from its 2021 charges include removing outdated or completed charges and minor editorial changes for clarification of intent.
3. Heard a presentation from AM Best on how the robust housing market has driven historic title industry performance.
4. Heard a presentation from ALTA on key changes to the homeowners policy of title insurance and ALTA endorsements.
Workers’ Compensation (C) Task Force
The Workers’ Compensation (C) Task Force did not meet at the Fall National Meeting.

MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE
December 15, 2021

1. Adopted its Summer National meeting minutes.
2. Adopted its 2022 proposed charges, which did not include any substantial changes from its 2021 charges. Its charges noted that further direction from the Executive (EX) Committee may result in the Privacy Protections (D) Working Group being moved to the new Innovation, Cybersecurity, and Technology (H) Committee.
3. Adopted new title in-force and title claims standardized data requests (SDRs) to be included in the reference documents of the Market Regulation Handbook (Handbook). A state may use these two SDRs to determine if a company follows appropriate procedures with respect to the issuance and underwriting of title policies and the handling of claims.
4. Adopted revisions to Chapter 24—Conducting the Health Examination of the Handbook to provide additional guidance that market conduct examiners should review complaints regarding quality of care.
5. Adopted revisions to Chapter 25—Conducting the Medicare Supplement Examination of the Handbook to provide more specific cross-references to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651).
6. Received the Privacy Protections (D) Working Group’s “Exposure Draft on Consumer Data Privacy Protections,” dated Dec. 7, which includes the following:
   A. A summary of consumer privacy protections provided by the Health Information Privacy Model Act (#55), the Insurance Information and Privacy Protection Model Act (#670), and the Privacy of Consumer Financial and Health Information Regulation (#672).
   B. A summary of the General Data Protection Regulation (GDPR) and recently adopted state consumer privacy protection laws.
   C. A summary of the Working Group’s discussion on data transparency, consumer control of data, consumer access to data, data accuracy, and data ownership and portability.
   D. A recommendation that Model #670 and Model #672 be revised to modernize their applicability to the current technology-based insurance market.
7. Received an update regarding the Market Conduct Examination Guidelines (D) Working Group’s coordination with the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group to update the mental health parity-related chapter of the Handbook to ensure it reflects the current mental health parity compliance requirements set forth in federal guidance enacted in December 2020.
8. Adopted the report of the Antifraud (D) Task Force. See the Task Force listing for details.
10. Adopted the report of the Producer Licensing (D) Task Force. See the Task Force listing for details.
11. Adopted the report of the Market Conduct Annual Statement Blanks (D) Working Group, including its Nov. 22 minutes.
    During this meeting, the Working Group took the following action:
    A. Adopted its Summer National Meeting minutes.
    B. Received an update on the life Market Conduct Annual Statement (MCAS) draft edits for accelerated underwriting (AU).
    C. Received an update on the Other Health Drafting Group, which has not met recently.
    D. Received a proposal from the subject matter expert (SME) group on lawsuit definitions and placement of lawsuit data elements for the homeowners and private passenger auto (PPA) MCAS.
    E. Received a proposal from the SME group on reporting of the digital claims interrogatory question.
12. Adopted the report of the Market Conduct Examination Guidelines (D) Working Group, including its Nov. 4 minutes.
    During this meeting, the Working Group took the following action:
    A. Adopted its Oct. 7 minutes, which included the following action:
       i. Adopted its Sept. 2 minutes, which included the following action:
          b. Received updates from state insurance regulator volunteers reviewing models potentially affecting the Handbook.
          iii. Discussed a new draft Chapter 25—Conducting the Medicare Supplement Examination for inclusion in the Handbook.
          iv. Discussed a new draft Chapter 24—Conducting the Health Examination for inclusion in the Handbook.
v. Received updates from state insurance regulator volunteers reviewing models potentially affecting the Handbook.

B. Adopted revisions to Chapter 25—Conducting the Medicare Supplement Examination relating to Model #651.

C. Adopted revisions to Chapter 24—Conducting the Health Examination relating to the Health Maintenance Organization Model Act (#430).

D. Discussed proposed revisions to Chapter 21—Conducting the Property and Casualty Examination relating to the Real Property Lender-Placed Insurance Model Act (#631).

E. Discussed proposed revisions to Chapter 20—General Examination Standards relating to the Insurance Holding Company System Regulatory Act (#440).

F. Received updates from state insurance regulator volunteers who reviewed recently adopted models with the potential to affect the Handbook.

G. Received an update on the background of the Working Group’s group supervision charge.

13. Adopted the report of the Market Analysis Procedures (D) Working Group, including its Nov. 18 minutes. During this meeting, the Working Group took the following action:

A. Adopted its July 1 minutes, which included the following action:
   i. Adopted its March 19 minutes.
   ii. Discussed market analysis training.
   iii. Discussed the next line of business for the MCAS.
   iv. Discussed the initial aggregate analysis of MCAS data for 2020.
   v. Discussed residence/issuance reporting in the MCAS.

B. Discussed market analysis training.

C. Discussed standard MCAS ratios for travel insurance MCAS and short-term limited-duration (STLD) insurance MCAS.

D. Discussed market analysis tools.

E. Discussed the need for clarification on the MCAS reporting of multiyear guaranteed annuities (MYGA).

14. Adopted the report of the Privacy Protections (D) Working Group, including its Dec. 11 minutes. During this meeting, the Working Group took the following action:

A. Adopted its Nov. 22, Oct. 25, and Oct. 11 minutes, which included the following action:
   i. Heard an update on state privacy legislation.
   ii. Received comments on the right to data portability and the right to restrict the use of data in the privacy policy statement exposure draft.
   iii. Walked through the final exposure draft of the privacy report to the Market Regulation and Consumer Affairs (D) Committee on the privacy policy statement and the right to consumer ownership of data.
   iv. Received comments on the right to restrict the use of data, the right of portability, and the right of consumer data ownership.
   v. Reviewed an update to the Abbreviated Data Privacy Legislation Chart and to the State Privacy Law Comparison Chart.
   vi. Received comments on the right to delete information and the right to correct information.
   vii. Heard an update on state privacy legislation.
   viii. Adopted its Sept. 25, Sept. 13, and Aug. 30 minutes, which included the following action:
      a. Received comments on Segment One (the right to opt-out) and Segment Two (the right to opt-in) of the privacy policy statement exposure draft.
      b. Announced a format change to the policy statement exposure draft.
      c. Adopted its July 12 minutes as amended with a revision to change the phrase “credit card” to “debit card.”
      d. Received an update on the Summer National Meeting.
      e. Received an update from NAIC Legal Division staff on state privacy legislation.
      g. Exposed the first Working Group exposure draft of the privacy policy statement with comments incorporated.
      h. Received additional comments from a consumer perspective on data privacy.

B. Received comments on the final exposure draft of its report on consumer data privacy protections.

C. Adopted the final exposure draft of its report on consumer data privacy protections.
Market Actions (D) Working Group
December 11, 2021
The Market Actions (D) Working Group met in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

Antifraud (D) Task Force
November 12, 2021 (in lieu of the Fall National Meeting)
1. Adopted its Oct. 27 and Summer National Meeting minutes, which included the following action:
   A. Adopted its 2022 proposed charges.
2. Received an update from the Antifraud Education Enhancement (D) Working Group. The Working Group has been working with NAIC staff in preparation for the upcoming investigator safety training webinar that will take place in December. The Working Group advised its members to send any suggested training/webinar topics they would like to have provided.
3. Received an update from the Antifraud Technology (D) Working Group. The Working Group formed a subject matter expert (SME) group to create a template for industry to use when creating their Antifraud Plan. The SME group has been meeting since September to finalize this project. The final draft will be exposed to the Working Group for comment. Once adopted by the Working Group, it will be presented to the Task Force for consideration.
4. Received an update from the Improper Marketing of Health Insurance (D) Working Group. The Working Group has continued to meet monthly in regulator-to-regulator session. It is holding its first open meeting at the Fall National Meeting. See the Working Group listing for more details.
5. Heard an update from the Coalition Against Insurance Fraud on its work to fight insurance fraud.

Improper Marketing of Health Insurance (D) Working Group
December 12, 2021
2. Heard a presentation from Out2Enroll on the efforts being made to fight against improper marketing of health insurance.
3. Heard a presentation from the Alliance of Health Care Sharing Ministries (AHCSM). The presentation focused on the regulation of health care ministries and issues faced with improper marketing of health insurance. The AHCSM will be completing an accreditation process in 2022.
4. Heard a presentation from America’s Health Insurance Plans (AHIP). The presentation discussed the issues being faced concerning the improper marketing of health insurance plans. AHIP notified the Working Group of its interest in assisting with the development of a model or guideline to help regulate the marketing of health insurance.

Market Information Systems (D) Task Force
November 23, 2021 (in lieu of the Fall National Meeting)
1. Adopted its Oct. 29 and Summer National Meeting minutes, which included the following action:
   A. Adopted its 2022 proposed charges.
2. Adopted the report of the Market Information Systems Research and Development (D) Working Group, including its Nov. 5 and Oct. 14 minutes. During these meetings, the Task Force took the following action:
   A. Adopted the artificial intelligence (AI) subject matter expert (SME) group’s recommendation, which included:
      i. Evaluate currently available market analysis data and assess its quality.
      ii. Adopt a more rigorously statistical approach to identify the predictive power of market scoring systems and integrate data into a single overall analysis.
      iii. Incorporate promising AI modes of analyses, as well as traditional statistical modeling.
      iv. Assess ways AI can improve the efficiency of qualitative analysis and facilitate pattern recognition across larger volumes of textual evidence.
      v. Explore potential data sources suitable for AI techniques.
   B. Reviewed and prioritized the outstanding Uniform System Enhancement Request (USER) forms.
   C. Reviewed the 2020 Market Information Systems (MIS) data analysis metric results. The Working Group will continue its analysis of the results and determine recommendations to improve data quality.
3. Discussed the Market Information Systems Research and Development (D) Working Group recommendations regarding the incorporation of AI in the NAIC MIS.
Producer Licensing (D) Task Force

November 29, 2021 (in lieu of the Fall National Meeting)

1. Adopted its Oct. 29 and Summer National Meeting minutes, which included the following action:
   A. Adopted its 2022 proposed charges.
2. Received the report of the Producer Licensing Uniformity (D) Working Group, including its Nov. 3 minutes. During this meeting, the Working Group took the following action:
   A. Reviewed the results of its survey addressing the appropriate producer licensing standard for the sell, solicitation, and negotiation of pet insurance. Seven states responded to the survey that the current uniform licensing standard for pet insurance is the correct policy direction; seven responded that the major lines of authority of property/casualty (P/C) should be required; one state responded that pet insurance should become a core limited line; and one state responded that a license for any major line of authority should be required.
3. Received the report of the Uniform Education (D) Working Group, including its Oct. 7 minutes. During this meeting, the Working Group took the following action:
   A. Discussed the distribution of a survey regarding state requirements for the approval of continuing education (CE) course instructors.
4. Discussed the draft procedures for amending the NAIC uniform producer licensing applications, which are being developed to ensure that the consideration of changes to the uniform applications support the NAIC members’ goal of providing stable, uniform applications and encourage the use of electronic technology for licensing.
5. Received comments from the American Council of Life Insurers (ACLI) on diversity, inclusion, and unnecessary barriers to individuals seeking an insurance producer license. The ACLI referenced the 1033 waiver process and the presence of unnecessary pre-licensing education mandates.
6. Discussed the elimination of cultural bias in producer licensing examinations, which included a review of preliminary feedback from two examination vendors on their internal training and industry standards for examination fairness.
7. Received a report from the National Insurance Producer Registry (NIPR) Board of Directors. October marked the NIPR’s 25th anniversary, and it is on track to have its highest transaction volume and review year in 2021. NIPR continues to implement the contact change request application for business entities. NIPR has implemented the application in 28 states and has processed more than 7,300 transactions. NIPR recently implemented a chat feature for customers, and from January to October, the customer service department handled more than 162,000 calls, more than 70,000 emails, and 20,000 chats. NIPR is also on track to complete its transition to the cloud before the end of the year.
8. Discussed how states could address errors or misstatements on producer licensing applications that were completed by third-party authorized submitters.

FINANCIAL CONDITION (E) COMMITTEE

December 13, 2021

1. Adopted its Nov. 19 and Summer National Meeting minutes, which included the following action:
   A. Adopted a response to a referral received from the Financial Regulation and Accreditation Standards (F) Committee regarding captive insurers.
   B. Received a response from the Valuation Analysis (E) Working Group chair related to principle-based reserving (PBR) and a recommendation from the International Monetary Fund (IMF) related to its Financial Sector Assessment Program (FSAP).
   C. Received a request from the Capital Adequacy (E) Task Force chair about a proposed new working group related to investment risks.
   D. Adopted its 2022 proposed charges.
3. Adopted the report of the Capital Adequacy (E) Task Force. See the Task Force listing for details.
4. Adopted the report of the Examination Oversight (E) Task Force. See the Task Force listing for details.
5. Adopted the report of the Financial Stability (E) Task Force. See the Task Force listing for details.
6. Adopted the report of the Receivership and Insolvency (E) Task Force. See the Task Force listing for details.
7. Adopted the report of the Reinsurance (E) Task Force. See the Task Force listing for details.
9. Adopted the report of the Valuation of Securities (E) Task Force. See the Task Force listing for details.
10. Adopted the report of the Group Capital Calculation (E) Working Group, including its Nov. 22 minutes. During this meeting, the Working Group took the following action:
    A. Adopted its Nov. 8, Sept. 8, and Summer National Meeting minutes, which included the following action:
i. Exposed a staff memorandum that includes possible group capital calculation (GCC) modifications for a public comment period ending Dec. 23.

ii. Exposed some clarifying changes to the GCC instructions that were previously provided to the Working Group and the public as part of the GCC Trial Implementation for a public comment period ending Dec. 8.

iii. Discussed comments on maintenance documents and proposed revisions.

iv. Discussed comments on a draft referral to the Capital Adequacy (E) Task Force.


B. Discussed the results of the GCC Trial Implementation.

11. Adopted the report of the Group Solvency Issues (E) Working Group, including its Nov. 30 minutes. During this meeting, the Working Group took the following action:

A. Adopted its Summer National Meeting minutes.

B. Discussed comments received during the re-exposure of proposed revisions to the Financial Analysis Handbook to incorporate elements of the International Association of Insurance Supervisors’ (IAIS’) Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) deemed appropriate for the U.S. system of solvency regulation.

C. Received updates from its ComFrame Examination Drafting Group and its ComFrame Own Risk and Solvency Assessment (ORSA) Drafting Group on the status of their efforts to develop proposed revisions to incorporate ComFrame elements into the Financial Condition Examiners Handbook and the NAIC Own Risk and Solvency Assessment Guidance Manual (ORSA Guidance Manual).

D. Heard an update on the status of IAIS group-related activities, including its recent adoption of its revised Application Paper on Supervisory Colleges.

12. Adopted the report of the Mutual Recognition of Jurisdictions (E) Working Group, including its Nov. 18 minutes. During this meeting, the Working Group took the following action:

A. Adopted the yearly due diligence reviews of the qualified jurisdictions and reciprocal jurisdictions.

B. Adopted the Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation (GCC Process).

C. Provided an update on the Republic of Korea application to become a qualified jurisdiction.

13. Adopted the report of the NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group, including its Sept. 13 minutes. During this meeting, the Working Group took the following action:

A. Discussed the premium threshold in the Annual Financial Reporting Model Regulation (#205).

B. Heard an update from PricewaterhouseCoopers (PwC) on recent auditing pronouncements affecting statutory audit reports.

C. Received an update on the results from a joint project between the NAIC and the AICPA on reserve data training for state insurance regulators that was conducted in 2020.

14. Adopted the report of the National Treatment and Coordination (E) Working Group, including its Dec. 1 minutes. During this meeting, the Working Group took the following action:

A. Adopted its Sept. 29 minutes, which included the following action:

i. Discussed its 2022 proposed charges.

ii. Adopted proposal 2021-06 (Request for Disclaimer).

iii. Received a referral from the Financial Analysis (E) Working Group requesting an addition to the Form A database to inform state insurance regulators when private equity firms are acquiring ownership of an insurer and to assist in maintaining a record of private equity-owned insurers.

iv. Discussed drafting guidance or frequently asked questions (FAQ) document for Form A applications.

v. Discussed non-domiciliary state notification of dissolution or mergers.

B. Exposed proposal 2021-07 (Application Instructions Regarding Company Responses) for a 45-day public comment period ending Jan. 14, 2022.

C. Exposed proposal 2021-08 (Voluntary Dissolution Best Practices) for a 45-day public comment period ending Jan. 14, 2022.

D. Discussed shell acquisitions.

15. Adopted the report of the Restructuring Mechanisms (E) Working Group, including its Dec. 6 minutes. During this meeting, the Working Group took the following action:

A. Discussed comments received on a co-chair draft white paper. The white paper is structured around the existing good practices within the NAIC’s 1997 Liability-Based Restructuring White Paper, as well as other best practices presented to the Working Group in 2019 from various organizations.
16. Adopted the report of the Risk-Focused Surveillance (E) Working Group, including its Nov. 9 minutes. During this meeting, the Working Group took the following action:
   A. Discussed comments received on the exposure of proposed revisions to the Financial Analysis Handbook and the Financial Condition Examiners Handbook to enhance guidance related to the review of affiliated service agreements.
   B. Adopted updated salary ranges for analysts and examiners, as well as legacy per diem rates for examiners.
   C. Discussed a referral received from the Chief Financial Regulator Forum regarding the need to update the standardized job descriptions for analyst and examiner positions maintained by the Working Group.

17. Reported that the Financial Analysis (E) Working Group met Dec. 11, Nov. 3, and Oct. 13 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss letter responses and financial results.

18. Reported that the Valuation Analysis (E) Working Group met Nov. 30, Nov. 10, Sept. 27, and July 26 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss valuation items related to specific companies.


21. Received and discussed a request from the Center for Economic Justice (CEJ) with regard to taking on a project to examine and identify investment practices of insurers that may disproportionately affect communities of color.

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

Accounting Practices and Procedures (E) Task Force
December 11, 2021 (in lieu of the Fall National Meeting)

1. Adopted its Summer National Meeting minutes.

2. Adopted the report of the Statutory Accounting Principles (E) Working Group, including its Dec. 11 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its Nov. 10, Oct. 25, Sept. 10, Aug. 26, July 20, and July 12 minutes, which included the following action:
      i. During its Nov. 10 meeting, the Working Group took the following action:
         a. Adopted the following nonsubstantive revisions to statutory accounting guidance:
            1) Statement of Statutory Accounting Principles (SSAP) No. 43R—Loan-Backed and Structured Securities: Revisions direct that residual equity tranches shall be reported on Schedule BA: Other-Long Term Invested Assets for year-end 2022 reporting. However, for entities currently reporting on Schedule D-1, early application (and reclassification) is permitted. In addition, the Working Group directed that a joint memorandum with the Valuation of Securities (E) Task Force be provided to the Blanks (E) Working Group to clarify that a self-assigned NAIC 5GI is not permitted for residual tranches and that such items reported on Schedule D-1 for year-end 2021 are required to be reported with an NAIC 6 designation. (Ref #2021-15)
            2) Revisions clarify that salvage and subrogation estimates and recoveries should be reported as a reduction to both claims/losses and loss adjusting expenses, as appropriate. (Ref #2021-13)
         b. Adopted the following editorial revisions to statutory accounting; (Ref #2021-12EP):
            1) Preamble: Incorporates a paragraph number for the existing statutory hierarchy section.
            2) Updates designation codes for preferred stock as noted in Section 2 of Appendix A-001: Investments of Reporting Entities.
            3) Updates reference to the former Emerging Actuarial Issues (E) Working Group, in Appendix C, as well as add reference to the Valuation Analysis (E) Working Group’s use of included interpretations.
            4) Updates reference to the former Emerging Actuarial Issues (E) Working Group in Appendix C-2, as well as add reference to the Valuation Analysis (E) Working Group’s use of included interpretations.
            5) Updates improve the readability of SSAP No. 21R—Other Admitted Assets paragraph 9 regarding receivables for securities.
         c. Adopted Interpretation (INT) 21-02: Extension of the Ninety-Day Rule for the Impact of Hurricane Ida: This INT provides temporary options to the “90-day rule” in SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due from Agents and Brokers for policies affected by Hurricane Ida. The INT automatically nullifies Jan. 24, 2022. (Ref #2021-13)
      ii. During its Oct. 25 e-vote, the Working Group took the following action:

iii. During its Sept. 10 e-vote, the Working Group took the following action:

iv. During its Aug. 26 meeting, the Working Group:
   a. Adopted the following nonsubstantive revisions to statutory accounting guidance:
      1) Revisions clarify that the required adjustments directed in SSAP No. 97 —Investments in Subsidiary, Controlled and Affiliated Entities, paragraph 9, may result in a negative equity valuation. Revisions also clarify that foreign insurance subsidiary, controlled, and affiliated (SCA) entities, when applying paragraph 9 adjustments, may stop at zero if the entity does not provide services or hold assets on behalf of a U.S.-based reporting entity. (Ref #2021-04)
      2) Revisions clarify that the “effective call price” valuation ceiling in SSAP No. 32R —Preferred Stock shall only apply in cases where the issuer has announced that the instrument will be called, or the call is currently exercisable, by the issuer. (Ref #2021-10)
   b. Exposed the following nonsubstantive revisions for a public comment period ending Oct. 1:
      1) SSAP No. 43R: Revisions correspond with guidance adopted by the Valuation of Securities (E) Task Force to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), which directs that mortgage loans in scope of SSAP No. 37 —Mortgage Loans will continue historical practice. However, for loans that have completed a structural assessment, as determined by the Securities Valuation Office (SVO), the mortgage loan may be reclassified from Schedule B: Mortgage Loans to Schedule D-1: Long-Term Bonds. Additional revisions included the removal of various examples of securities that may be in scope of SSAP No. 43R. In addition, the agenda item sought comment on whether INT 20-10 should be explicitly nullified and if agenda item 2020-24 should be disposed of without statutory revisions. (Ref #2021-11)
      2) Revisions clarify that salvage and subrogation estimates and recoveries should be reported as a reduction to both claims/losses and loss adjusting expenses, as appropriate. (Ref #2021-13)
      3) NAIC Policy Statement on Statutory Accounting Principles Maintenance Agenda: Revisions, in response to a referral received from the Financial Condition (E) Committee, modify the terminology of “substantive” and “nonsubstantive” to describe statutory accounting revisions being considered by the Working Group. (Ref #2021-14)
   c. Exposed Issue Paper No. 165 —Levelized Commission for a public comment period ending Oct. 1 to document the discussion of recent nonsubstantive revisions to SSAP No. 71 —Policy Acquisition Costs and Commissions. (Ref #2019-24)
   d. Received an update on the following projects and referrals:
      1) Received a referral from the Valuation of Securities (E) Task Force on proposed revisions that would permit the use of unrated and nonguaranteed subsidiary obligors in the evaluation of working capital finance investment (WCFI) programs. The Working Group directed a response that additional changes to SSAP No. 105R —Working Capital Finance Investments may be considered in the future, dependent upon Task Force actions.
      2) Ref #2019-21: The Working Group discussed the exposed principles-based bond definition and comments received. The Working Group directed NAIC staff to proceed with drafting an issue paper and proposed SSAP revisions to reflect the concepts reflected in the exposed principles, and it directed that the “43R Study Group” be repurposed to a “Bond Proposal Small Group” made up of additional state insurance regulators to work with dedicated interested party representatives and continue discussion on the application of the principles, as well as specific investment structures.
   v. During its July 20 e-vote, the Working Group exposed agenda item 2021-10: SSAP No. 32R – Clarification of Effective Call Price for a public comment period ending Aug 6.
   vi. During its July 12 e-vote, the Working Group adopted its May 20, April 20, and Spring National Meeting minutes.

B. Adopted the following substantive revisions to statutory accounting guidance:
   i. Issue Paper No. 165 —Levelized Commissions to document the discussion that led to the adoption of nonsubstantive revisions to SSAP No. 71 from agenda item 2019-24: Levelized and Persistency Commission. (Ref #2019-24)
   C. Adopted the following nonsubstantive revisions to statutory accounting guidance:
i. SSAP No. 32R: Revisions remove lingering references to clarify that historical cost is not a permitted valuation method. Other revisions ensure consistency with previously adopted language. (Ref #2021-17)

ii. SSAP No. 43R: Revisions capture SVO-identified credit tenant loans (CTLs) in scope of SSAP No. 43R. Revisions also remove examples of various securities from a non-scope paragraph. (Ref #2021-11)

iii. Appendix F – NAIC Policy Statements: NAIC Policy Statement on Maintenance of Statutory Accounting Principles: Revisions, in response to a referral received from the Financial Condition (E) Committee, modify the historical use of the terms “substantive” and “nonsubstantive.” Effective Jan. 1, 2022, substantive modifications will be identified as a “new SAP concept,” while nonsubstantive modifications will be a “SAP clarification.” (Ref #2021-14)

iv. Blanks proposal: Adopted an agenda item supporting supplemental reporting of Federal Home Loan Bank (FHLB) borrowings classified as a deposit-type contract and reported on Exhibit 7 – Deposit-Type Contracts. This agenda item did not result in statutory revisions. However, it reflected support for blanks proposal 2021-15BWG. (Ref #2021-16)

v. Adopted the following editorial revisions (Ref #2021-19EP):
   a. SSAP No. 16R—Electronic Data Processing Equipment and Software: Revisions correct various paragraph references.
   b. SSAP No. 43R: Revisions remove outdated references to previously deleted guidance.

vi. Nullified INT 20-10: Reporting Nonconforming Credit Tenant Loans as no longer applicable for statutory accounting. While the INT expired on Oct. 1, for historical documentation purposes, the Working Group nullified the reporting exceptions within the INT. The revisions adopted to the P&P Manual make this guidance no longer relevant. (INT 20-10 and Ref# 2021-11)

D. Exposed the following nonsubstantive revisions to statutory accounting guidance:
   i. SSAP No. 22R—Leases: Revisions clarify that in any scenario in which a lease terminates early, all remaining leasehold improvements shall be immediately expensed. (Ref #2021-25)
   ii. SSAP No. 22R: Revisions reject Accounting Standards Update (ASU) 2021-05, Leases (Topic 842), Lessors—Certain Leases with Variable Lease Payments for statutory accounting. (Ref #2021-29)
   iii. SSAP No. 25—Affiliates and Other Related Parties and SSAP No. 43R: Revisions clarify the identification and reporting requirements for affiliated transactions and incorporate new disclosures to identify investments held that involve related parties. The new disclosures will require identification when investments are acquired through, or in, related parties, regardless of if they meet the definition of an affiliate. (Ref #2021-21)
   iv. SSAP No. 43R: Revisions reflect updated NAIC designation and designation category guidance adopted by the Valuation of Securities (E) Task Force to the P&P Manual, for residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS). (Ref #2021-23)
   v. SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance: Revisions reflect 2021 clarifications to life and health reinsurance disclosures and provide a proposed guidance document to address auditor inquiries based on disclosures initially reported at year-end 2020. (Ref #2021-31)
   vi. SSAP No. 68—Business Combinations and Goodwill: Revisions reject ASU 2021-03, Intangibles – Goodwill and Other (Topic 350) – Accounting Alternative for Evaluating Triggering Events for statutory accounting. (Ref #2021-28)
   vii. SSAP No. 72—Surplus and Quasi-Reorganizations: Revisions reject ASU 2021-04, Earnings Per Share (Topic 260), Debt—Modifications and Extinguishments (Subtopic 470-50), Compensation—Stock Compensation (Topic 718), and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40)—Issuer’s Accounting for Certain Modifications or Exchanges of Freestanding Equity-Classified Written Call Options for statutory accounting. Revisions incorporate guidance on how to account for changes in fair values for written call options. (Ref #2021-27)
   viii. SSAP No. 86—Derivatives: Agenda item seeks public comment regarding possible SSAP No. 86 revisions if considering an expanded effective hedge relationship permitted under U.S. generally accepted accounting principles (GAAP) within ASU 2017-12: Derivatives and Hedging: Targeted Improvements to Accounting for Hedging Activities. (Ref #2021-20)
   ix. SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees: Revisions remove reference to the “standard scenario” to ensure consistency with VM-21, Requirements for Principle-Based Reserves for Variable Annuities. (Ref #2021-18)
   x. Appendix D—Nonapplicable GAAP Pronouncements: Revisions reject ASU 2021-04, Presentation of Financial Statements (Topic 205), Financial Services— Depository and Lending (Topic 942), and Financial Services—Investment Companies (Topic 946), Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10786, Amendments to Financial Disclosures about Acquired and Disposed Businesses, and No. 33-10835,
Update of Statistical Disclosures for Bank and Savings and Loan Registrants as not applicable for statutory accounting. (Ref #2021-30)

xi. Bond Proposal Project: Exposed a discussion draft of potential reporting options to revise Schedule D, Part 1: Long-Term Bonds to capture more granularity and transparency of investments reported as bonds. Also exposed revisions to the proposed principle concepts in determining whether an asset-backed security (ABS) satisfies the credit enhancement criteria for reporting as a bond. (Ref #2019-21)

xii. Blanks referrals:
   a. Exposed and sponsored a proposal to the Blanks (E) Working Group to supplement reporting of SCA entities investments reported on Schedule D-6-1. (Ref #2021-22)
   b. Exposed and sponsored a referral to the Blanks (E) Working Group to add a new general interrogatory to require disclosure of when cryptocurrencies are directly held or permitted for the remittance of premiums. (Ref #2021-24)

xiii. Editorial revisions: Exposed revisions to terminology references of “substantive” and “nonsubstantive” to reflect “new SAP concept” and “SAP clarification.” (Ref #2021-26EP)

xiv. The public comment period for items exposed ends Feb. 18, 2022, except for agenda items 2021-18 and 2021-31, which have a Jan. 14, 2022, public comment deadline to allow for possible adoption prior to the filing of the 2021 financial statements and their audited reports.

E. Disposed agenda item 2020-24: Accounting and Reporting of Credit Tenant Loans without statutory revisions. (Ref #2020-24)

F. Received an update on the following items:
   ii. Working Group referral of agenda item 2019-49: Retroactive Reinsurance Exception regarding diversity in the reporting of companies applying the retroactive reinsurance exception, which allows certain contracts to be reported prospectively: The Casualty Actuarial and Statistical (C) Task Force discussed this item on Dec. 7 and exposed preliminary recommendations.
   iii. U.S. GAAP exposures: Pending items will be addressed during the normal maintenance process.

3. Adopted the report of the Blanks (E) Working Group, including its Nov. 16 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Adopted proposal: 2021-14BWG – Expand the number of lines of business reported on Schedule H to match the lines of business reported on the health statement. Modify the instructions so they will be uniform between life/fraternal and property.
   C. Adopted its editorial listing.
   D. Approved the State Filing Checklists content.
   E. Rejected proposal 2021-11BWG requesting to add a new annual statement supplement to the property/casualty (P/C) statement to capture exposure data for Annual Statement Lines 4, 19.1, 19.2, and 21.2 of the Exhibit of Premiums and Losses.
   F. Deferred for future discussion proposal 2021-13BWG for a public comment period ending March 4, 2022. Proposal 2021-13BWG adds a new supplement to capture premium and loss data for annual statement lines 17.1, 17.2, and 17.3 of the Exhibit of Premiums and Losses (State Page) – Other Liability by more granular lines of business.
   G. Exposed seven new proposals for a public comment period ending March 4, 2022.

Capital Adequacy (E) Task Force
November 17, 2021 (in lieu of the Fall National Meeting)

1. Adopted its Sept. 30, minutes, which included the following action:
   A. Adopted its 2022 proposed charges.

2. Adopted the report of the Health Risk-Based Capital (E) Working Group, including its Nov. 4 minutes. During this meeting, the Working Group took the following action:
   A. Exposed proposal 2021-18-H (Benchmarking Guidelines for Investment Income Adjustment in the Underwriting Risk Factors) for a 30-day public comment period ending Dec. 3.
   B. Adopted its 2021 revised working agenda to add an item to review the investment income adjustment annually, and revised bond factors to a priority 3 with a completion date of year-end 2023 or later.
C. Received an update from the American Academy of Actuaries (Academy) regarding the H2 – Underwriting Risk Component Review.
D. Received an update on the Excessive Growth Charge Ad Hoc Group and the Health Test Ad Hoc Group.
E. Discussed incorporating pandemic risk into the health risk-based capital (RBC) formula.

3. Adopted the report of the Life Risk-Based Capital (E) Working Group, including its Nov. 9 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Exposed its guidance document on bond factor changes for a 30-day comment period ending Dec. 9.
   C. Exposed the Academy’s C2 Mortality Risk Work Group recommendation on mortality factor updates for a 60-day public comment period ending Jan. 10, 2022.

4. Adopted the report of the Catastrophe Risk (E) Subgroup, including its Oct. 27 minutes. During this meeting, the Subgroup took the following action:
   A. Adopted its Sept. 28 minutes, which included the following action:
      i. Discussed its 2021 working agenda.
      ii. Received an update from its Catastrophe Model Technical Review Ad Hoc Group.
      iii. Heard a presentation from Karen Clark & Company (KCC) on current wildfire trends and its KCC U.S. wildfire model.
      iv. Discussed the possibility of allowing additional third-party models or adjustments to the vendor models.
   B. Discussed allowing third-party models to calculate the catastrophe model losses.
   D. Received an update from its Catastrophe Model Technical Review Ad Hoc Group, which met Oct. 18 to discuss additional questions with Risk Management Solutions (RMS) on its wildfire model.

5. Adopted the report of the Property and Casualty Risk-Based Capital (E) Working Group, including its Oct. 25 minutes. During this meeting, the Working Group took the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Adopted the report of the Catastrophe Risk (E) Subgroup, including its Sept. 28 minutes. During this meeting, the Subgroup took the following action:
      i. Discussed its 2021 working agenda.
      iii. Heard a presentation from KCC regarding the KCC U.S. wildfire model.
      iv. Discussed the possibility of allowing third-party models calculate the catastrophe model losses.
   C. Exposed a draft recommendation to the Restructuring Mechanism (E) Subgroup for a 30-day public comment period ending Nov. 24. The draft recommendation was developed by the Property and Casualty Risk-Based Capital (E) Working Group, which included the findings and recommendation of the runoff companies.
   D. Exposed proposal 2021-14-P (R3 Factor Adjustment) for a 30-day public comment period ending Nov. 24.
   E. Heard an update from the Academy on the status of the research on recommending adjustments to the formulas for premium and reserve risk to reflect the impact of interest rates.

7. Adopted its working agenda.
8. Discussed a memorandum to the Financial Condition (E) Committee requesting a new working group under the direction of the Capital Adequacy (E) Task Force.
9. Heard a presentation from RMS on its North America wildfire HD model.

**Examination Oversight (E) Task Force**

December 1, 2021 (in lieu of the Fall National Meeting)

1. Adopted its Sept. 30 and Summer National Meeting minutes, which included the following action:
   A. Adopted its 2022 proposed charges.
2. Adopted the report of the Electronic Workpaper (E) Working Group, which met Nov. 16 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.
3. Adopted the report of the Financial Analysis Solvency Tools (E) Working Group, including its Nov. 15 and Oct. 12 minutes. During these meetings, the Working Group took the following action:
   A. Adopted the following revisions to the Financial Analysis Handbook:
      i. Included additional guidance and another procedure to the existing liquidity stress test (LST) framework and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) requesting
that the lead state review and determine if any concerns exist and, if necessary, seek further explanation from
the insurer.
ii. Included guidance to incorporate the group capital calculation (GCC) into the analysis process, specifically to be
used as an analysis tool, rather than a set of ratios.
4. Adopted the report of the Financial Examiners Coordination (E) Working Group, which met Nov. 29 in regulator-to-
regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on
Open Meetings, to continue work on its goals.
5. Adopted the report of the Financial Examiners Handbook (E) Technical Group, including its Nov. 17 and Oct. 5 minutes.
During these meetings, the Technical Group took the following action:
A. Adopted the following revisions to the Financial Condition Examiners Handbook:
   i. Coordination framework revisions to simplify the guidance and clarify the roles/responsibilities of each state
      that has a company in a holding company group.
   ii. Completeness and accuracy repository revisions, which include the addition of analytical procedures to mirror
      the testing approaches of external auditors and enhanced collaboration with the actuary to determine
      significant lines of business and data elements to focus on for testing purposes.
B. Exposed the above revisions to the Financial Condition Examiners Handbook for a 30-day public comment period
   ending Nov. 5.
6. Adopted the report of the Information Technology (IT) Examination (E) Working Group, including its Nov. 18 and Oct. 13
minutes. During these meetings, the Working Group took the following action:
A. Adopted the following guidance updates for inclusion in the Financial Condition Examiners Handbook:
   i. New guidance in Section 1-3 describing the importance of insurance companies maintaining data in a manner
      that would allow for timely and efficient transfer of policyholder data, as well as guidance referencing tools that
      may be used in conducting this assessment.
   ii. Updates to the Exhibit C – IT Planning Questionnaire and Instructional Notes to include inquiries regarding
      comingled data and the accessibility and transferability of significant company datasets, as well as references
      to procedures within the IT work program that could be used in addressing related risks.
   iii. Updates to Exhibit C – Work Program to include common controls, preliminary information requests, and
      possible test procedures regarding the accessibility and transferability of data.
   iv. New guidance in Section 1-3 describing ransomware and considerations for assessing an insurer’s overall cyber
      hygiene.
   v. Updates to Exhibit C – Work Program to include common controls, preliminary information requests, and
      possible test procedures regarding the nature of company backup systems and whether those backups are air-
      gapped and immutable.
B. Approved a new sound practices document that was developed in response to a referral from the Chief Financial
Regulator Forum requesting additional guidance for assessing cyber vulnerabilities.
C. Exposed two referrals sent to the Working Group for a 30-day public comment period ending Nov. 12. The first
referral was received from the Receivership Financial Analysis (E) Working Group asking the IT Examination (E)
Working Group to consider guidance for evaluating an insurer’s systems and data (as part of the IT review during an
examination). The second referral was received from the facilitator of the Chief Financial Regulator Forum asking
the Working Group to consider additional guidance for addressing cyber vulnerabilities, particularly in response to
emerging vulnerabilities arising outside of the full-scope examination.
D. Exposed ransomware revisions for inclusion in the Financial Condition Examiners Handbook for a 30-day public
comment period ending Nov. 12.

Financial Stability (E) Task Force
December 7, 2021 (in lieu of the Fall National Meeting)
1. Adopted its Sept. 30 and Summer National Meeting minutes, which included the following action:
   A. Adopted its 2022 proposed charges.
   B. Heard an update on private equity (PE).
   C. Heard a macroprudential risk assessment update.
2. Heard an update on Financial Stability Oversight Council (FSOC) developments.
3. Received the report of the Macroprudential (E) Working Group, which met Nov. 30 and Nov. 12 in regulator-to-regulator
session, pursuant to paragraph 3 (specific companies, entities or individuals), and Oct. 18 in regulator-to regulator
session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC staff) and
paragraph 8 (consideration of strategic planning issues), of the NAIC Policy Statement on Open Meetings. During these meetings, the Working Group took the following action:

A. Discussed PE/related party risks.
B. Received an initial high-level summary of 2020 liquidity stress test (LST) filing results.
C. Heard an update on macroprudential risk, including a macroprudential process overview, a public report concept, and a risk analysis concept.

4. Received the report of the Valuation Analysis (E) Working Group. The Working Group’s report included an update to the Task Force on its request to the Working Group to assess a potential concern related to economic scenario generators (ESGs) developed by the American Academy of Actuaries (Academy).

5. Heard an international update, which includes an update on the International Association of Insurance Supervisors’ (IAIS’) global monitoring exercise and the consultation on LST.

**Receivership and Insolvency (E) Task Force**

**Nov. 30, 2021 (in lieu of the Fall National Meeting)**

1. Adopted its Oct. 21 minutes, which included the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Exposed a referral to the Financial Regulation Standards and Accreditation (F) Committee regarding receivership amendments to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) for a 30-day public comment period ending Nov. 22.
   C. Exposed a draft memorandum to state insurance departments on receivership and guaranty fund laws for a 30-day public comment period ending Nov. 22.
   D. Heard an update on international resolution activities.

2. Adopted a referral to the Financial Regulation Standards and Accreditation (F) Committee recommending the receivership revisions to Model #440 and Model #450 be “Acceptable, but Not Required” to be adopted by states under Part A Standards, rather than identifying “substantially similar” provisions that would be required.

3. Adopted a memorandum to state insurance departments encouraging them to consider review of their laws and adopt updates, including the Model #440 and Model #450 receivership amendments, recently adopted guidelines, and the 2017 amendments to the Life and Health Insurance Guaranty Association Model Act (#520).

4. Adopted the report of the Receivership Financial Analysis (E) Working Group, which met Nov. 15 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss companies in receivership.

5. Adopted the report of the Receiver’s Handbook (E) Subgroup, including its Nov. 18 minutes. During this meeting, the Subgroup took the following action:
   A. Exposed revisions to Chapter 1 and Chapter 2 of the Receiver’s Handbook for Insurance Company Insolvencies (Receiver’s Handbook) for a 30-day public comment period ending Dec. 20. The Subgroup is currently working on revisions to the other chapters of the Receiver’s Handbook.
   B. Heard an update on federal activities. The NAIC’s proposed State Insurance Receivership Priority (SIRP) Act establishes a claims filing deadline in the Federal Priority Act (FPA) for the U.S. Department of Justice (DOJ) to file claims of the U.S. to insolvent insurance company estates and to ensure state insurance regulators are not held personally liable if claims of the government are not paid first. The SIRP Act is expected to be introduced to the U.S. House of Representatives in early 2022.

**Reinsurance (E) Task Force**

**December 13, 2021**

1. Adopted its Summer National Meeting minutes.
2. Adopted the report of the Reinsurance Financial Analysis (E) Working Group, which met Nov. 23, Oct. 13, and Aug. 25 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings. During these meetings, the Working Group took the following action:
   A. Completed the annual certified reinsurer reviews.
   B. Approved the first four reciprocal jurisdiction reinsurers for passporting.
   C. Discussed the comments received by the Task Force on the ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers.

3. Adopted the ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers.
4. Received an update on the reinsurance activities of the Mutual Recognition of Jurisdictions (E) Working Group.
5. Received an update on the states’ implementation of the 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786). As of Dec. 9, 46 U.S. jurisdictions have adopted the 2019 revisions to Model #785, and four jurisdictions have action under consideration. Additionally, 25 states have adopted the revisions to Model #786, and 11 states jurisdictions currently have action under consideration.
6. Received an update on the states’ implementation of the Term and Universal Life Insurance Reserve Financing Model Regulation (#787). As of Nov. 30, eight jurisdictions have adopted Model #787, with another 10 jurisdictions with action under consideration.

Risk Retention Group (E) Task Force
December 1, 2021 (in lieu of the Fall National Meeting)
1. Adopted its Summer National Meeting minutes.
2. Discussed a proposed preliminary memorandum template that can be prepared by a domiciliary risk retention group (RRG) state when a new RRG is chartered and an Insurer Profile Summary (IPS) is not available. The Preliminary Memorandum can then be shared with non-domiciliary regulators where the RRG is registering. An exposure of the Preliminary Memorandum is expected in spring 2022.
3. Discussed the impact of the proposed revisions to the Insurance Holding Company System Regulatory Act (#440) accreditation standard related to the group capital calculation (GCC) on RRGs. Discussion included the element of the proposed standard that does not require at least a one-time filing of the GCC before exemptions can be requested from the commissioner. The Task Force will consider this further in 2022 and provide a comment letter to the Financial Regulation Standards and Accreditation (F) Committee during the exposure period.
4. Discussed the Surplus Lines (C) Task Force’s work to update the Nonadmitted Insurance Model Act (#870) and its impact on the risk purchasing groups (RPGs), such as complications regarding how premium tax will be collected from RPGs.

Valuation of Securities (E) Task Force
December 12, 2021 (in lieu of the Fall National Meeting)
1. Adopted its Nov. 17, Sept. 30, and Summer National Meeting minutes, which included the following action:
   B. Adopted an amendment to the P&P Manual to include bank loans to the definition of “obligation.”
   C. Received a referral from the Statutory Accounting Principles (E) Working Group and exposed a related amendment to the P&P Manual to clarify the proper reporting and NAIC designation for residual tranches and interests for a 15-day public comment period ending Dec. 2.
   D. Exposed a proposed non-substantive technical correction amendment to the P&P Manual to clarify the mapping of NAIC 5GI to a designation category for a 15-day public comment period ending Dec. 2.
   E. Received a report from the Structured Securities Group (SSG) on the year-end process.
   F. Adopted its 2022 proposed charges.
   G. Exposed a proposed amendment to the P&P Manual to add the U.S. International DFC to the “U.S. Government Full Faith and Credit – Filing Exempt” list for a 30-day public comment period ending Oct. 30.
   H. Adopted an amendment to the P&P Manual to add Spanish generally accepted accounting principles (GAAP) to the list of Countries and Associated National Financial Presentation Standards after a technical procedural assessment and recommendation to adopt was submitted to the Task Force by the Securities Valuation Office (SVO).
   I. Exposed a proposed amendment to the P&P Manual to add bank loans to the definition of “obligation” for a 30-day public comment period ending Oct. 30.
   J. Exposed a proposed amendment to the P&P Manual to add zero-loss criteria for legacy-modeled residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS) for a 15-day public comment period ending Oct. 15.
   K. Discussed the status of private rating letters.
2. Adopted an amendment to the P&P Manual to remove residual tranches from receiving an NAIC designation.
3. Adopted an amendment to the P&P Manual clarifying 5GI mapping to a designation category in the recently amended Private Letter Rating section.
4. Exposed a proposed amendment to the P&P Manual to update the definition of “other non-payment risk” assigned a subscript “S” for a 60-day public comment period ending Feb. 11, 2022.
5. Exposed a proposed amendment to the P&P Manual to update the definition of “principal protected securities” (PPS) for a 60-day public comment period ending Feb. 11, 2022.
6. Exposed a proposed amendment to the P&P Manual to assign NAIC designations to investments with a fixed income component for reporting on Schedule BA for a 60-day public comment period ending Feb. 11, 2022.
7. Exposed a proposed amendment to the P&P Manual to permit the SVO to assign NAIC designations to unrated subsidiaries in working capital finance investment (WCFI) transactions for a 60-day public comment period ending Feb. 11, 2022.
8. Received a staff report on the use of NAIC designations by other jurisdictions in the regulation of insurers and exposed it for a 60-day public comment period ending Feb. 11, 2022.
9. Received a staff report on rating issues and proposed changes to the filing exemption (FE) process.
10. Received a staff report on projects of the Statutory Accounting Principles (E) Working Group.

FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE
December 12, 2021
The Financial Regulation Standards and Accreditation (F) Committee met in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards by the Financial Standards and Accreditation (F) Committee or any subgroup appointed thereunder) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE
December 15, 2021
1. Adopted its Summer National Meeting minutes.
2. Adopted its 2022 proposed charges.
3. Discussed international efforts on insurer culture.
4. Heard an update on recent activities and priorities of the International Association of Insurance Supervisors (IAIS), including: 1) implementation assessment activities related to the holistic framework for systemic risk; 2) the comparability assessment process for the aggregation method (AM); 3) publication of the Global Monitoring Exercise (GME); and 4) publication of three supporting material documents: a) an Issues Paper on Insurer Culture; b) a revised Application Paper on Supervisory Colleges; and c) a revised Application Paper on Combating Money Laundering and Terrorist Financing.
5. Heard an update on international activities, including: 1) recent virtual meetings and events with international regulators; 2) plans for the 2022 NAIC International Fellows Programs; 3) recent meetings of the Organisation for Economic Co-operation and Development (OECD) Insurance and Private Pensions Committee; 4) recent meetings of the Sustainable Insurance Forum (SIF); and 5) a recently held virtual webinar of the European Union (EU)-U.S. Dialogue Project.

NAIC/CONSUMER LIAISON COMMITTEE
December 13, 2021
1. Announced that the Liaison Committee reaffirmed its mission statement for 2022 via e-vote that concluded Oct. 19.
2. Adopted its Summer National Meeting minutes.
3. Received a report from the NAIC/Consumer Board of Trustees on its activities. The Board met Dec. 13 to appoint consumer representatives to serve in 2022. Notifications of status to all applicants will be announced in February 2022.
5. Heard a presentation from the American Kidney Fund on federal health policy updates, developments, and recommendations. This is important for state insurance regulators, industry, and consumers to follow the change to the federal No Surprises Act (NSA) and upcoming vote on the Build Back Better Act.
6. Heard a presentation from a health care consumer advocate titled “Insurance Privacy Protection: Do the Right Thing – A Consumer Perspective.” This is important to help consumers understand how their data is being collected, used, and shared or sold by the insurance industry.
7. Heard a presentation from the Center for Economic Justice (CEJ) on regulatory failures in credit-related insurance. This is important because lower loss ratios experienced in this line of business lead to higher profit margins for insurers.
8. Heard a presentation from United Policyholders on when private options for insuring property shrink.
9. Heard a presentation from the California Western School of Law on the impact of demand surge post-disaster on the labor and material costs of reconstruction.

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

December 11, 2021

1. Announced that the Liaison Committee reaffirmed its 2022 mission statement via e-vote that concluded Oct. 15.

2. Heard a presentation from MIGIZI about the frustrations encountered by Native Americans in the organization regarding the trials of underinsurance and the claims process following fires during the riots in Minneapolis, MN. This presentation brought to light the necessity of fine art riders and the concerns with putting a value on priceless family and tribal heritage heirlooms, such as lost native languages.
EXECUTIVE (EX) COMMITTEE AND PLENARY

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The Executive (EX) Committee and Plenary met in San Diego, CA, Dec. 16, 2021. The following members participated: David Altmaier, Chair (FL); Dean L. Cameron, Vice Chair (ID); Chlora Lindley-Myers, Vice President (MO); Andrew N. Mais, Secretary-Treasurer (CT); Raymond G. Farmer, Most Recent Past President (SC); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Reyn Norman (AL); Alan McClain (AR); Peni Itula Sapini Teo (AS); Evan G. Daniels (AZ); Ricardo Lara (CA); Michael Conway (CO); Karima M. Woods (DC); Trinidad Navarro represented by Dave Lonchar (DE); John F. King (GA); Michelle B. Santos (GU); Colin M. Hayashida (HI); Doug Ommen (IA); Dana Popish Severinghaus (IL); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon represented by Tom Travis (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox (MI); Grace Arnold (MN); Edward M. Deleon Guerrero (MP); Mike Chaney (MS); Troy Downing (MT); Mike Causey represented by Michelle Osborne (NC); Jon Godfread (ND); Eric Dunning (NE); Chris Nicolopoulos (NH); Marlene Caride (NJ); Russell Toal represented by Jennifer Catechis (NM); Barbara D. Richardson (NV); Adrienne A. Harris represented by My Chi To (NY); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Carter Lawrence (TN); Cassie Brown represented by Doug Slape (TX); Jonathan T. Pike (UT); Scott A. White (VA); Tregenza Roach (VI); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler represented by Mark Dietzler (WA); Mark Afable (WI); Allan L. McVey represented by Tonya Gillespie (WV); and Jeff Rude (WY).

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

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

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

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

The Committee adopted its 2022 proposed charges.

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

The Committee received a status report on model law development efforts for amendments to: 1) the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171); 2) the Life Insurance Disclosure Model Regulation (#580); 3) the Mortgage Guaranty Insurance Model Act (#630); 4) the Nonadmitted Insurance Model Act (#870); and 5) the new Pet Insurance Model Act.

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

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

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

Commissioner Godfread reported that, in proposing the formation of a new committee, NAIC members recognized the importance of raising visibility and prioritizing and organizing the work of the NAIC and its Members, relating to innovation, technology and cybersecurity. The intention is to provide more consistency and collaboration and ensure the coordination of
related workstreams. Further, it will help to provide clarity and understanding regarding related activities taking place in other committees and workstreams.

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

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

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

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

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

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

4. **Adopted the Proposed NAIC 2022 Budget**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Commissioner Godfread reported that the Health Insurance and Managed Care (B) Committee met Dec. 15. During this meeting, the Committee adopted its Summer National Meeting minutes.

The Committee adopted the report of the Consumer Information (B) Subgroup, which met Dec. 2, Oct. 20, Oct. 14, and Aug. 24. During these meetings, the Subgroup took the following action: 1) adopted claims process-related guides; i.e., appeals process, medical necessity, explanation of benefits (EOBs), claims filing, and billing codes and claims; 2) adopted updates to the “Frequently Asked Questions about Health Care Reform” document; and 3) adopted a consumer-facing brief, “New Protections Against Surprise Medical Bills,” on balance billing.
The Committee adopted the report of the Health Innovations (B) Working Group, which met Dec. 11 and Nov. 7. During these meetings, the Working Group took the following action: 1) heard presentations related to its charges from the Special (EX) Committee on Race and Insurance on issues related to telehealth, alternative payment models, and their impacts on health disparities; 2) heard a presentation on using state rate review authority to limit premium growth; 3) heard a presentation on state policy considerations with enhanced premium tax credits; and 4) heard a presentation from Consumers’ Checkbook on ways to make health care price information relevant and understandable for consumers.

The Committee adopted the report of its task forces: 1) the Health Actuarial (B) Task Force; 2) the Regulatory Framework (B) Task Force; and 3) the Senior Issues (B) Task Force.

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

The Committee heard an update from Jeff Wu (Center for Consumer Information & Insurance Oversight—CCIO) on the Biden administration’s federal legislative and administrative initiatives and priorities. The update included a discussion of the administration’s plans on working with the states with respect to the implementation and enforcement of the provider provisions of the federal No Surprises Act (NSA).

The Committee discussed its work on developing guidance documents for state insurance departments to use as part of their outreach efforts to providers and consumers on the NSA.

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

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

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

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

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

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

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

Commissioner Altmaier noted that due to the need for additional discussion, the Plenary would not be considering the Pet Insurance Model Act for adoption at this meeting.
11. Received the Report of the Market Regulation and Consumer Affairs (D) Committee

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

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

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

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

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

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

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

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

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

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

Commissioner Richardson made a motion, seconded by Commissioner McClain, to adopt the Travel Insurance MCAS blank (Attachment Six). The motion passed with New York abstaining.
13. **Adopted the Short-Term, Limited-Duration (STLD) MCAS Blank**

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

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

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

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

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

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

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

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

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

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

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

The Committee adopted the reports of the following task forces and working groups: the Accounting Practices and Procedures (E) Task Force; the Capital Adequacy (E) Task Force; the Examination Oversight (E) Task Force; the Financial Stability (E) Task Force; the Receivership and Insolvency (E) Task Force; the Reinsurance (E) Task Force; the Risk Retention Group (E) Task Force; the Valuation of Securities (E) Task Force; the Group Capital Calculation (E) Working Group; the Group Solvency Issues (E) Working Group; the Mutual Recognition of Jurisdictions (E) Working Group; the NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group; the National Treatment and Coordination (E) Working Group; the Restructuring Mechanisms (E) Working Group; and the Risk-Focused Surveillance (E) Working Group.
The Committee also: 1) adopted the Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation; and 2) adopted the ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers.

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

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

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

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

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

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

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

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

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

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

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

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

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

Superintendent Dwyer reported that the Financial Regulation Standards and Accreditation (F) Committee met Dec. 12 in regulator-to-regulator session, pursuant to paragraph 7 (consideration of individual state insurance department’s compliance with NAIC financial regulation standards) of the NAIC Policy Statement on Open Meetings, to: 1) discuss state-specific accreditation issues; and 2) vote to award continued accreditation to the insurance departments of Hawaii, Kansas, and South Carolina.

The Financial Regulation Standards and Accreditation (F) Committee did not meet in open session at the Fall National meeting.
19. **Exposes the 2020 Revisions to Model #440 and Model #450 as an Update to the Accreditation Standards**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Having no further business, the Executive (EX) Committee and Plenary adjourned.
Innovation, Cybersecurity and Technology (H) Committee Draft Charges
Post-Public Comments Meeting
December 1, 2021

2022 Proposed Charges

INNOVATION, CYBERSECURITY, AND TECHNOLOGY (H) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

G. Track the implementation of and issues related to all model laws pertaining to innovation, technology, data privacy, and cybersecurity including the Insurance Data Security Model Law (#668), the NAIC Insurance Information and Privacy and Privacy Protection Model Act (#670), the Privacy of Consumer Financial and Health Information Regulation (#672), and the Unfair Trade Practices Act (#880) rebating language and providing assistance to state insurance regulators as needed.

H. Coordinate with other NAIC committees and task forces, as appropriate, and evaluate and recommend certifications, continuing education, and training for regulatory staff related to technology, innovation, cybersecurity, and data privacy.

I. Follow the work of federal, state, and international governmental bodies to avoid conflicting standards and practices.

2. The Big Data and Artificial Intelligence (H) Working Group will:
   A. Research the use of big data and artificial intelligence (AI) including machine learning (ML) in the business of insurance and evaluate existing regulatory frameworks for overseeing and monitoring their use. Present findings and recommendations to the Innovation, Cybersecurity, and Technology (H) Committee including potential recommendations for development of model governance for the use of big data and AI including ML for the insurance industry.
   B. Review current audit and certification programs and/or frameworks that could be used to oversee insurers’ use of consumer and non-insurance data, and models using intelligent algorithms, including AI. If appropriate, issue recommendations and coordinate with the appropriate subject matter expert (SME) committees on the development of or modifications to model laws, regulations, handbooks, and regulatory guidance, regarding data analysis, marketing, rating, underwriting and claims, regulation of data vendors and brokers, regulatory reporting requirements, and consumer disclosure requirements.
   C. Assess data and regulatory tools needed for state insurance regulators to appropriately monitor the marketplace, and evaluate the use of big data, algorithms, and machine learning, including AI/ML in underwriting, rating, claims and marketing practices. This assessment shall include a review of currently available data and tools, as well as recommendations for development of additional data and tools, as appropriate. Based on this assessment, propose a means to include these tools in existing and/or new regulatory oversight and monitoring processes to promote consistent oversight and monitoring efforts across state insurance departments.

3. The Speed to Market (H) Working Group will:
   A. Consider proposed System for Electronic Rates and Forms Filing (SERFF) features or functionality presented to the Working Group by the SERFF Advisory Board (SAB), likely originating from the SERFF Product Steering Committee (PSC). Upon approval and acquisition of any needed funding, direct the SAB to implement the project. Receive periodic reports from the SAB, as needed.
   B. Provide feedback and recommendations concerning the SERFF modernization when requested by the Executive (EX) Committee and any group assigned oversight of the SERFF modernization by the Executive (EX) Committee.
   C. Discuss and oversee the implementation and ongoing maintenance/enhancement of speed to market operational efficiencies related to product filing needs, efficiencies, and effective consumer protection. This includes the following activities:
1. Provide a forum to gather information from the states and the industry regarding tools, policies, and resolutions to assist with common filing issues. Provide oversight in evaluating product filing efficiency issues for state insurance regulators and the industry, particularly regarding uniformity.

2. Use SERFF data to develop, refine, implement, collect, and distribute common filing metrics that provide a tool to measure the success of the speed to market modernization efforts, as measured by nationwide and individual state speed to market compliance, with an emphasis on monitoring state regulatory and insurer responsibilities for speed to market for insurance products.

3. Facilitate proposed changes to the product coding matrices (PCMs) and the uniform transmittal document (UTD) on an annual basis, including the review, approval, and notification of changes. Monitor, assist with and report on state implementation of any PCM changes.

4. Facilitate the review and revision of the *Product Filing Review Handbook*, which contains an overview of all the operational efficiency tools and describes best practices for industry filers and state reviewers regarding the rate and form filing and review process. Develop and implement a communication plan to inform the states about the *Product Filing Review Handbook*.

D. Provide direction to NAIC staff regarding SERFF functionality, implementation, development, and enhancements. Direct NAIC staff to provide individual state speed to market reports to each commissioner at each national meeting. Receive periodic reports from NAIC staff, as needed.

E. Conduct the following activities, as desired, by the Interstate Insurance Product Regulation Commission (Compact):
   1. Provide support to the Compact as the speed to market vehicle for asset-based insurance products, encouraging the states’ participation in, and the industry’s usage of, the Compact.
   2. Receive periodic reports from the Compact, as needed.

4. **The E-Commerce (H) Working Group** will:
   A. Examine e-commerce laws and regulations; survey states regarding federal Uniform Electronic Transactions Act (UETA) exceptions; and work toward meaningful, unified recommendations. The Working Group will also examine whether a model bulletin would be appropriate for addressing some of the identified issues and draft a proposed bulletin if determined appropriate.

5. **The Cybersecurity (H) Working Group** will:
   A. Monitor cybersecurity trends such as vulnerabilities, risk management, governance practices and breaches with the potential to affect the insurance industry.
   B. Interact with and support state insurance departments responding to insurance industry cybersecurity events.
   C. Promote communication across state insurance departments regarding cybersecurity risks and events.
   D. Oversee the development of a regulatory cybersecurity response guidance document to assist state insurance regulators in the investigation of insurance cyber events.
   E. Coordinate NAIC committee cybersecurity work including cybersecurity guidance developed by the Market Conduct Examination Guidelines (D) Working Group and the Information Technology Examination (E) Working Group.
   F. Advise on the development of cybersecurity training for state insurance regulators.
G. Work with the Center for Insurance Policy and Research (CIPR) to analyze publicly available cybersecurity related information.

H. Support the states with implementation efforts related to the adoption of Insurance Data Security Model Law (#668).

I. Engage with federal and international supervisors and agencies on efforts to manage and evaluate cybersecurity risk.
Adopted by the Executive (EX) Committee and Plenary, Dec. 16, 2021

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

Article VI, Section 2 (h):

(h) Innovation, Cybersecurity and Technology (H) Committee. This Standing Committee shall consider issues related to cybersecurity, innovation, data security and privacy, and emerging technology issues.
Executive Summary
NAIC 2022 Budget

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

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

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

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

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

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

A Focus on Consumers

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

Valuable Products and Services

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

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

Building the Budget

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

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**By the Numbers**

NAIC products and services make life easier.

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

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

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

**Expected Results for 2021**

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

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

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

**2022 Budget**

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

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

**State Ahead 2.0 is on the horizon**

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

- Financial Solvency, including macroprudential surveillance and principle-based reserving
- Long-term care insurance
- Consumer data privacy protections
- Climate/natural catastrophes risk and resiliency
- Big data and artificial intelligence
- Race and Insurance
A fiscal impact statement (fiscal) is prepared for new or existing NAIC initiatives with revenue, expense, or capital impacts of $100,000 or more either in the current budget or within the following few years’ budgets or requires more than 1,150 hours of internal technical resources to accomplish. Each fiscal includes a detailed description of the initiative; impact on key stakeholders; financial and operational impact of the initiative; and an assessment of the risks. The total financial impact of the three fiscals included in the 2022 budget is $2.8 million in expenses with $312,627 in revenues. Additional information about each initiative is included in the various fiscal sections of the budget.

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

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

Preparing for the Unknown

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

Ensuring Financial Stability

The NAIC’s operating reserve is designed to ensure the financial stability of the NAIC in the event of emerging business risks and uncertainties and to absorb new priority initiatives pursued by NAIC membership. The association’s reserve status is of paramount consideration in the budgeting process, as is strong and prudent financial management of the NAIC’s assets.
In July 2015, the Executive (EX) Committee and Internal Administration (EX1) Subcommittee approved a report from an independent financial advisory firm which established the NAIC’s liquid operating reserve target range of 83.4% to 108.2%. This range was the result of a comprehensive review of current and future identified risks and an evaluation of comparable organizations. This report recognized the increased level of uncertainty facing the NAIC and anticipated future investments which would be required to enhance the association’s information technology and technical infrastructure, represented by many elements of the 2022 budget. A review of the NAIC’s risk profile is currently in progress and is expected to be finalized in early 2022.

**Contact Information**

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

Please feel free to contact Jim Woody, Chief Financial Officer, at jwoody@naic.org, or Carol Thompson, Senior Controller, at cthompson@naic.org, should you have any questions or need additional information.
## 2021 Budget with Fiscal Impact Statements

### Revenue and Expense by Line

<table>
<thead>
<tr>
<th>Description</th>
<th>Reference</th>
<th>2020 Actual</th>
<th>6/30/2021 Actual</th>
<th>12/31/2021 Actual</th>
<th>2021 Projected</th>
<th>2022 Budget</th>
<th>Increase (Decrease) from 2021</th>
<th>Increase (Decrease) from 2021</th>
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<tr>
<td>Member Assessments</td>
<td>R1</td>
<td>$2,110,951</td>
<td>$1,056,497</td>
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<td>Publications and Insurance Data Products</td>
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<td>Valuation Services</td>
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<td>Transaction Filing Fees</td>
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<td>National and Major Meetings</td>
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<td>(1,073,455)</td>
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<td>150,785</td>
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<td>$410,940</td>
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<td>Administrative Services and License Fees</td>
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<td>20,724,524</td>
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<td>(2,553,219)</td>
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<td>Other</td>
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<td>(97,900)</td>
<td>$58,360</td>
<td>(39,540)</td>
<td>-40.4%</td>
</tr>
<tr>
<td><strong>Total Operating Revenues</strong></td>
<td></td>
<td>117,134,378</td>
<td>75,457,183</td>
<td>122,219,229</td>
<td>117,248,932</td>
<td>126,402,966</td>
<td>9,154,034</td>
<td>7.8%</td>
</tr>
<tr>
<td>Salaries</td>
<td>E1</td>
<td>56,718,567</td>
<td>28,754,962</td>
<td>58,404,049</td>
<td>38,329,280</td>
<td>61,605,459</td>
<td>3,276,179</td>
<td>5.6%</td>
</tr>
<tr>
<td>Temporary Personnel</td>
<td>E2</td>
<td>684,900</td>
<td>340,570</td>
<td>697,027</td>
<td>919,738</td>
<td>707,433</td>
<td>307,704</td>
<td>44.1%</td>
</tr>
<tr>
<td>Payroll Taxes</td>
<td>E3</td>
<td>3,873,262</td>
<td>2,330,640</td>
<td>4,120,328</td>
<td>4,064,077</td>
<td>12,576,793</td>
<td>3,201,410</td>
<td>5.5%</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td>E4</td>
<td>11,306,966</td>
<td>6,694,240</td>
<td>12,680,835</td>
<td>(129,020)</td>
<td>10,404,132</td>
<td>320,944</td>
<td>3.1%</td>
</tr>
<tr>
<td>Employee Development</td>
<td>E5</td>
<td>580,404</td>
<td>229,560</td>
<td>501,846</td>
<td>121,594</td>
<td>7,570,416</td>
<td>251,116</td>
<td>13.7%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>E6</td>
<td>11,306,966</td>
<td>6,694,240</td>
<td>12,680,835</td>
<td>(129,020)</td>
<td>10,404,132</td>
<td>320,944</td>
<td>3.1%</td>
</tr>
<tr>
<td>Computer Services</td>
<td>E7</td>
<td>4,844,689</td>
<td>2,691,867</td>
<td>5,792,816</td>
<td>459,824</td>
<td>6,233,024</td>
<td>84,722</td>
<td>9.2%</td>
</tr>
<tr>
<td>Travel</td>
<td>E8</td>
<td>614,614</td>
<td>57,088</td>
<td>2,306,453</td>
<td>(1,648,208)</td>
<td>4,881,551</td>
<td>125,116</td>
<td>13.7%</td>
</tr>
<tr>
<td>Occupancy and Rental</td>
<td>E9</td>
<td>4,461,064</td>
<td>2,109,554</td>
<td>4,625,182</td>
<td>4,077,375</td>
<td>4,722,460</td>
<td>125,116</td>
<td>13.7%</td>
</tr>
<tr>
<td>Computer Hardware and Software Maintenance</td>
<td>E10</td>
<td>5,167,370</td>
<td>3,362,452</td>
<td>6,926,950</td>
<td>5,609,952</td>
<td>7,303,735</td>
<td>125,116</td>
<td>13.7%</td>
</tr>
<tr>
<td>Depreciation and Amortization</td>
<td>E11</td>
<td>4,012,527</td>
<td>2,000,037</td>
<td>4,098,263</td>
<td>4,245,378</td>
<td>4,042,863</td>
<td>125,116</td>
<td>13.7%</td>
</tr>
<tr>
<td>Operational</td>
<td>E12</td>
<td>1,382,028</td>
<td>300,140</td>
<td>1,294,736</td>
<td>1,638,762</td>
<td>1,796,506</td>
<td>125,116</td>
<td>13.7%</td>
</tr>
<tr>
<td>Library Reference Materials</td>
<td>E13</td>
<td>306,260</td>
<td>175,855</td>
<td>301,843</td>
<td>330,213</td>
<td>370,242</td>
<td>125,116</td>
<td>13.7%</td>
</tr>
<tr>
<td>National and Major Meetings</td>
<td>E14</td>
<td>728,761</td>
<td>263,714</td>
<td>2,953,126</td>
<td>3,840,723</td>
<td>4,898,774</td>
<td>1,945,648</td>
<td>65.9%</td>
</tr>
<tr>
<td>Education and Training</td>
<td>E15</td>
<td>20,889</td>
<td>23,647</td>
<td>33,663</td>
<td>272,638</td>
<td>265,063</td>
<td>7,570,416</td>
<td>11.6%</td>
</tr>
<tr>
<td>Grant and Zone</td>
<td>E16</td>
<td>167,799</td>
<td>97,028</td>
<td>1,742,037</td>
<td>2,400,072</td>
<td>2,405,956</td>
<td>7,570,416</td>
<td>11.6%</td>
</tr>
<tr>
<td>Other</td>
<td>E17</td>
<td>1,107,722</td>
<td>856,316</td>
<td>987,125</td>
<td>1,152,660</td>
<td>1,265,311</td>
<td>112,871</td>
<td>9.8%</td>
</tr>
<tr>
<td><strong>Total Operating Expenses</strong></td>
<td></td>
<td>112,803,298</td>
<td>55,090,629</td>
<td>124,700,971</td>
<td>130,480,969</td>
<td>136,269,708</td>
<td>5,788,739</td>
<td>4.4%</td>
</tr>
<tr>
<td>Revenues Over/(Under) Expenses before Investment Income</td>
<td></td>
<td>4,331,080</td>
<td>20,366,554</td>
<td>(2,481,742)</td>
<td>(13,232,037)</td>
<td>10,750,295</td>
<td>(9,866,742)</td>
<td>3,365,295</td>
</tr>
<tr>
<td>Investment Income</td>
<td>I1</td>
<td>12,611,828</td>
<td>8,682,075</td>
<td>11,866,474</td>
<td>10,106,656</td>
<td>2,400,115</td>
<td>640,297</td>
<td>9.466,359</td>
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<tr>
<td>Revenues Over/(Under) Expenses</td>
<td></td>
<td>16,942,908</td>
<td>29,048,629</td>
<td>9,384,732</td>
<td>(11,472,219)</td>
<td>20,856,951</td>
<td>(7,466,627)</td>
<td>(36,851,359)</td>
</tr>
</tbody>
</table>

A detailed analysis of each line item is included in the Revenue Detail, Expense Detail, and Investment Income Detail sections.
## 2022 Budget

### Fiscal Impact Statements

<table>
<thead>
<tr>
<th>Fiscal Impact Number</th>
<th>Description</th>
<th>Capital Expenditures</th>
<th>Revenues</th>
<th>Expenses</th>
<th>Net Impact 2022 Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Revenues Over/(Under) Expenses Before Fiscals and Investment Income</td>
<td>$469,961</td>
<td>$126,090,339</td>
<td>$133,474,340</td>
<td>($7,384,001)</td>
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<tr>
<td>1</td>
<td>Financial Data Repository (FDR) Modernization Pre-Work</td>
<td></td>
<td>384,000</td>
<td></td>
<td>(384,000)</td>
</tr>
<tr>
<td>2</td>
<td>SBS State Implementations 2022</td>
<td></td>
<td>312,627</td>
<td>1,696,750</td>
<td>(1,384,123)</td>
</tr>
<tr>
<td>3</td>
<td>2022 NAIC Staffing Request</td>
<td></td>
<td></td>
<td>714,618</td>
<td>(714,618)</td>
</tr>
<tr>
<td></td>
<td>Total Fiscal Revenues Over/(Under) Expenses</td>
<td></td>
<td>312,627</td>
<td>2,795,368</td>
<td>(2,482,741)</td>
</tr>
<tr>
<td></td>
<td>Investment Income</td>
<td></td>
<td></td>
<td>2,400,115</td>
<td>2,400,115</td>
</tr>
<tr>
<td></td>
<td>Total Revenues Over/(Under) Expenses</td>
<td></td>
<td>$469,961</td>
<td>$128,803,081</td>
<td>$136,269,708</td>
</tr>
</tbody>
</table>
Date: December 2, 2021

To: All NAIC Members and Interested Parties

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

Re: Summary of Comments on the Proposed 2022 NAIC Budget

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

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

**NAIC’s Commitment to Innovation, Cybersecurity, and Technology**

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

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

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

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

Embrace Collaborative Work to Promote Transparency and Create Efficiencies

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

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

The NAIC takes a holistic approach to the development of its annual budget, which involves input from NAIC staff, NAIC officers, the Executive Committee, and all of the NAIC’s members. To provide transparency to the public, the NAIC publishes a copy of its proposed budget on its website before the budget is approved and welcomes input and comments from interested parties, which are addressed in writing and in an open Public Hearing. This process ensures that State insurance regulators, supported by the NAIC, are committed to protecting policyholders as well as ensuring the financial solvency of the insurance industry in a cost-effective and financially prudent manner, while minimizing the impact to industry where possible. The NAIC continuously seeks opportunities to reduce operating costs while providing world-class support to its members, regulators, interested parties, and insurance customers.
November 19, 2021

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

Re: NAMIC Comments – Proposed 2022 NAIC Budget

Dear Mr. Woody:

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

Innovation, Cybersecurity, and Technology

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

1 The National Association of Mutual Insurance Companies is the largest property/casualty insurance trade group with a diverse membership of more than 1,500 local, regional, and national member companies, including seven of the top 10 property/casualty insurers in the United States. NAMIC members lead the personal lines sector representing 66 percent of the homeowner’s insurance market and 53 percent of the auto market. Through our advocacy programs NAMIC promotes public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.
In addition to the investments in State Ahead 2.0 and the addition of two new IT professionals, two technology-based fiscals are being proposed in the 2022 budget. This includes the modernization of the data collection tool that stores annual and quarterly financial statements and is leveraged by state financial analysts to conduct solvency reviews. This also includes significant investments in the State-Based System (SBS) to expand and transition to a new platform to improve the regulatory processes resulting in cost-savings for the states. NAMIC appreciates the support the NAIC provides to the states and continuous efforts to keep its systems and technology modernized for the future.

**Consider Initiatives That Streamline Existing Regulatory Tools**

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

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

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

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

Embrace Collaborative Work to Promote Transparency and Create Efficiencies

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

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

Again, as we move toward a post-pandemic world, it presents a unique opportunity for organizations to take stock of where they are going. Given the speed the NAIC has grown in recent years, analysis exercises should be more frequent and aimed at looking to create efficiencies. The NAIC has committed itself in years past to restructuring and/or reducing the number of subgroups, working groups, and task forces. On the other hand, with each new evolving risk seems to come more specialized and technical groups producing an environment that creates silos, potentially resulting in inefficient methods to solving common problems. These barriers can be overcome through a more collaborative effort, one that brings together various groups to solve common problems. By combining certain groups or conducting business in joint sessions, for example, this can result in better transparency, development of deeper expertise, and more efficient use of regulators, industry, and NAIC staff time. Further, new issues eventually mature and short-term ad hoc efforts accomplish their discrete purposes. While as new issues emerge, there may be a need for a limited deep dive on an aspect of an issue, after some initial understanding is gained, it may be worth asking whether less splintering of attention and more focused effectiveness may be achieved by consolidating and or sunsetting such narrow efforts.
Conclusion
As always NAMIC appreciates the opportunity to provide comments on the NAIC’s proposed budget. Being a strong supporter of the state-based system of insurance regulation, our intent is not to be critical but rather to offer constructive ideas, because NAMIC values the mission of the NAIC. NAMIC believes the NAIC is positioned very well and has an opportunity to make progress in a number of areas. NAMIC supports the commitments made to innovation, cybersecurity, and technology, and encourages NAIC leadership to consider streamlining existing regulatory tools and to embrace a more collaborative and transparent work environment.

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

Jonathan Rodgers
Director of Financial and Tax Policy
National Association of Mutual Insurance Companies
Executive (EX) Committee

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Andrew J. Beal/Kay Noonan
CLIMATE AND RESILIENCY (EX) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Jennifer Gardner
**GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL**

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

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

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

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

NAIC Support Staff: Ethan Sonnichsen/Brian R. Webb/Brooke Stringer
LONG-TERM CARE INSURANCE (EX) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Long-Term Care Insurance (EX) Task Force will:
   A. Once adopted by the NAIC Executive (EX) Committee and Plenary, monitor, and evaluate the progress of the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document. Monitor state insurance department rate review actions subsequent to implementation of the MSA Framework and MSA rate review recommendations.
   B. Complete an evaluation and recommend options to provide consumers with choices regarding modifications to LTCI contract benefits where policies are no longer affordable due to rate increases.
   C. Monitor the work performed by other NAIC solvency working groups and assist in the timely multi-state coordination and communication of the review of the financial condition of LTC insurers.

2. The Long-Term Care Insurance Multistate Rate Review (EX) Subgroup will:
   A. Finalize the development of the MSA rate review process as outlined in the MSA Framework document which outlines a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. Implement the MSA rate review process once adopted by the NAIC Executive (EX) Committee and Plenary.
   B. Evaluate the progress of the MSA rate review process and provide ongoing maintenance and enhancements, as deemed necessary.
   C. The Subgroup should complete its charges by the 2022 Fall National Meeting.

3. The Long-Term Care Reduced Benefit Options (EX) Subgroup will:
   A. Complete an evaluation and/or recommendation of options to help consumers manage the impact of rate increases. This includes:
      1. Finalizing development of a process to evaluate innovative options that allow for insurers to offer benefits that lessen the likelihood of an insured needing long-term care services, including evaluation of the suitability of and regulatory barriers to proposed options.
      2. The potential development of mechanisms to help regulators and consumers objectively compare reduced benefit options (RBOs), including comparison of accepting a rate increase and retaining current benefits to electing an offered RBOs.
      3. Finalizing the Consumer Notices Checklist for RBOs.
   B. Support and provide expertise to the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup regarding evaluation of RBOs.
   C. The Subgroup should complete its charges by the 2022 Fall National Meeting.

NAIC Support Staff: Jeff Johnston/Jane Koenigsman
SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE

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

Ongoing Support of NAIC Programs, Products or Services

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

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

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

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

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

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

I. Direct NAIC and Center for Insurance Policy & Research (CIPR) staff to conduct necessary research and analysis, including:

1. (Workstream Three) The status of studies concerning the affordability of auto and homeowners insurance, including a gap analysis of what has not been studied.

2. (Workstream Three) The availability of producer licensing exams in foreign languages, steps exam vendors have taken to mitigate cultural bias, and the number and locations of producers by company compared to demographics in the same area.

3. (Workstream Five) Aggregation of existing research on health care disparities and the collection of insurance responses to the COVID-19 pandemic and its impact across demographic populations.

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE – NEW CHARGES

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

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

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

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

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

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

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

NAIC Support Staff: Andrew J. Beal/Michael F. Consedine
 INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Andrew J. Beal/Jim Woody
INFORMATION SYSTEMS (EX1) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Sherry Stevens/Keith Bollig
LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Life Insurance and Annuities (A) Committee will:
   A. Monitor the activities of the Life Actuarial (A) Task Force.

2. The Accelerated Underwriting (A) Working Group will:
   A. Consider the use of external data and data analytics in accelerated life underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue; and, if appropriate, draft guidance for the states.

3. The Annuity Suitability (A) Working Group will:
   A. Consider how to promote greater uniformity in the adoption of the Suitability in Annuity Transactions Model Regulation (#275) across NAIC member jurisdictions.

4. The Life Insurance Online Guide (A) Working Group will:
   A. Develop an online resource on life insurance, including the evaluation of existing content on the NAIC website, to be published digitally for the benefit of the public.

NAIC Support Staff: Jennifer R. Cook/Jolie H. Matthews
LIFE ACTUARIAL (A) TASK FORCE

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

Ongoing Support of NAIC Programs, Products and Services

1. The Life Actuarial (A) Task Force will:
   A. Work to keep reserve, reporting and other actuarial-related requirements current. This includes principle-based reserving (PBR) and other requirements in the Valuation Manual, actuarial guidelines, and recommendations for appropriate actuarial reporting in blanks. Respond to changes from the Life Insurance and Annuities (A) Committee and referrals from other groups or committees, as appropriate.
   B. Report progress on all work to the Life Insurance and Annuities (A) Committee and provide updates to the Financial Condition (E) Committee on matters related to life insurance company solvency. This work includes the following:
      1. Work with the American Academy of Actuaries (Academy) and the Society of Actuaries (SOA) to develop new mortality tables for valuation and minimum nonforfeiture requirements, as appropriate, for life insurance and annuities.
      2. Provide recommendations for guidance and requirements for accelerated underwriting, as needed.
      3. Evaluate and provide recommendations regarding the VM-21/AG 43 Standard Projection Amount, which may include continuing as a required floor or providing as disclosure. This evaluation is to be completed prior to year-end 2023.
      4. Work with the SOA on the annual development of the Generally Recognized Expense Table (GRET) factors.
      5. Provide recommendations and changes, as appropriate, to other reserve and nonforfeiture requirements to address issues, and provide actuarial assistance and commentary to other NAIC committees relative to their work on actuarial matters.
      6. Work with the selected vendor to develop and implement the new economic scenario generator (ESG) for use in regulatory reserve and capital calculations.
      7. Monitor international developments regarding life and health insurance reserving, capital and related topics. Compare and benchmark with PBR requirements.

2. The Variable Annuities Capital and Reserve (E/A) Subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor the impact of the changes to the variable annuities reserve framework and RBC calculation and determine if additional revisions need to be made.
   B. Develop and recommend appropriate changes, including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.

3. The Experience Reporting (A) Subgroup will:
   A. Continue development of the experience reporting requirements within the Valuation Manual. Provide input, as appropriate, for the process regarding the experience reporting agent, data collection, and subsequent analysis and use of experience submitted.

4. The Indexed Universal Life (IUL) Illustration (A) Subgroup will:
   A. Monitor the results and practices of IUL illustrations following implementation of Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold On or After December 14, 2020 (AG 49-A). Provide recommendations for consideration of changes to Life Insurance Illustrations Model Regulation (#582) to the Life Actuarial (A) Task Force, as needed.

5. The Longevity Risk (E/A) Subgroup of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group will:
   A. Provide recommendations for recognizing longevity risk in statutory reserves and/or risk-based capital (RBC), as appropriate. Complete by the 2022 Summer National Meeting.

6. The Valuation Manual (VM)-22 (A) Subgroup will:
   A. Recommend requirements, as appropriate, for non-variable (fixed) annuities in the accumulation and payout phases for consideration by the Life Actuarial (A) Task Force. Continue working with the Academy on a PBR methodology for non-variable annuities.
LIFE ACTUARIAL (A) TASK FORCE (Continued)

7. The Guaranteed Issue (GI) Life Valuation (A) Subgroup will:
   A. Provide recommendations regarding valuation requirements for GI life business, including any appropriate mortality table(s) for valuation as well as nonforfeiture. Initial recommendations are to be provided to the Life Actuarial (A) Task Force by the 2022 Summer National Meeting.

8. The Index-Linked Variable Annuity (A) Subgroup will:
   A. Provide recommendations and changes, as appropriate, to nonforfeiture, or interim value requirements related to index-linked variable annuities.

NAIC Support Staff: Reggie Mazyck/Jennifer Frasier
HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Health Insurance and Managed Care (B) Committee** will:
   A. Respond to inquiries from the U.S. Congress (Congress), the White House, and federal agencies; analyze policy implications and their effect on the states of proposed and enacted federal legislation and regulations; and communicate the NAIC’s position through letters and testimony, when requested.
   B. Monitor the activities of the Health Actuarial (B) Task Force.
   C. Monitor the activities of the Regulatory Framework (B) Task Force.
   D. Monitor the activities of the Senior Issues (B) Task Force.
   E. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC).
   F. Examine factors that contribute to rising health care costs and insurance premiums. Review state initiatives to address cost drivers.
   G. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
   H. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the federal Affordable Care Act (ACA), including short-term, limited-duration (STLD) insurance, association health plans (AHPs), and packaged indemnity health products.

2. The **Consumer Information (B) Subgroup** will:
   A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
   B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.

3. The **Health Innovations (B) Working Group** will:
   A. Gather and share information, best practices, experience, and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.
   B. Discuss state innovations related to health care—i.e., access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision-making, and health care delivery and financing models—to achieve better patient outcomes and lower spending trends.
   C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.
   D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to utilize the information gathered by the Working Group.
   E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

NAIC Support Staff: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook
HEALTH ACTUARIAL (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

2. The **Long-Term Care Actuarial (B) Working Group** will:
   A. Assist the Health Actuarial (B) Task Force in completing the following charges:
      1. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices, and rate changes.
      2. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a PBR framework.
      3. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.

3. The **Long-Term Care Pricing (B) Subgroup** will:
   A. Assist the Long-Term Care Actuarial (B) Working Group in completing the following charge:
      1. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices, and rate changes.

4. The **Long-Term Care Valuation (B) Subgroup** will:
   A. Assist the Long-Term Care Actuarial (B) Working Group in completing the following charges:
      1. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a PBR framework.
      2. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.

NAIC Support Staff: Eric King
REGULATORY FRAMEWORK (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products and Services

1. The Regulatory Framework (B) Task Force will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority, and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2022.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze, and report developments related to association health plans (AHPs).
   F. Monitor, analyze, and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.

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

3. The ERISA (B) Working Group will:
   A. Monitor, report, and analyze developments related to the federal ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate with the states and the U.S. Department of Labor (DOL) efforts related to sham health plans.
   C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.

4. The Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group will:
   A. Monitor, report, and analyze developments related to the federal Paul Wellstone and Pete Domenici MHPAEA of 2008, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate best practices with the states, the DOL, and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
   C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to the MHPAEA.
   D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook.
   E. Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.

5. The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup will:
   A. Develop a white paper to: 1) analyze and assess the role PBMs, pharmacy services administrative organizations (PSAOs), and other supply chain entities play in the provision of prescription drug benefits; 2) identify, examine, and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements, rebating, and spread pricing, including the implications of the Rutledge v. Pharmaceutical Care Management Association (PCMA) decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.
REGULATORY FRAMEWORK (B) TASK FORCE (Continued)

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

NAIC Support Staff: Jolie H. Matthews/Jennifer R. Cook
SENIOR ISSUES (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

2. The Long-Term Care Insurance (LTCI) Model Update (B) Subgroup will:
   A. Review and update Model #640 and Model #641 to determine their flexibility to remain compatible with the evolving delivery of LTC services and the evolving LTCI marketplace.
   B. Update Model #642 and Model #643 to correlate with Model #640 and Model #641.
   C. Consider recommendations referred from the Long-Term Care Insurance (EX) Task Force and/or its subgroups.

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

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

1. **The Property and Casualty Insurance (C) Committee** will:
   - Discuss issues arising and make recommendations with respect to advisory organization and insurer filings for personal and commercial lines, as needed. Report yearly.
   - Monitor the activities of the Casualty Actuarial and Statistical (C) Task Force.
   - Monitor the activities of the Surplus Lines (C) Task Force.
   - Monitor the activities of the Title Insurance (C) Task Force.
   - Monitor the activities of the Workers’ Compensation (C) Task Force.
   - Provide an impartial forum for considering appeals of adverse decisions involving alien insurers delisted or rejected for listing to the Quarterly Listing of Alien Insurers. Appeal procedures are described in the International Insurers Department (IID) Plan of Operation.
   - Monitor and review developments in case law and rehabilitation proceedings related to risk retention groups (RRGs). If warranted, make appropriate changes to the Risk Retention and Purchasing Group Handbook.
   - Monitor the activities of the Federal Crop Insurance Corporation (FCIC) that affect state insurance regulators:
     1. Serve as a forum for discussing issues related to the interaction of federal crop insurance programs with state insurance regulation.
   - Monitor the regulatory information exchanges between the FCIC and state insurance regulators, as well as the FCIC and the NAIC, and make recommendations for improvements or revisions, as needed.
   - Report on the cyber insurance market, including data reported within the Cybersecurity Insurance and Identity Theft Coverage Supplement.
   - Monitor regulatory issues that arise with the development of autonomous vehicles. Study and, if necessary, develop recommendations for changes needed to the state-based insurance regulatory framework.
   - Provide a forum for discussing issues related to parametric insurance and consider the development of a white paper or regulatory guidance.

2. **The Cannabis Insurance (C) Working Group** will:
   - Assess and periodically report on the status of federal legislation that would protect financial institutions from liability associated with providing services to cannabis businesses operating legally under state law.
   - Encourage admitted insurers to ensure coverage adequacy in states where cannabis, including hemp, is legal.
   - Provide insurance resources to stakeholders and keep up with new products and innovative ideas that may shape insurance in this space.
   - Develop an appendix to the Understanding the Market for Cannabis Insurance white paper, providing updated information on cannabis-related insurance issues for adoption by the 2022 Summer National Meeting.
   - Collaborate with the Producer Licensing (D) Task Force to study whether cannabis-related convictions in states where cannabis is legalized for medical and/or recreational use are preventing individuals from being licensed as an agent or broker.

3. **The Catastrophe Insurance (C) Working Group** will:
   - Monitor and recommend measures to improve the availability and affordability of insurance and reinsurance related to catastrophe perils for personal and commercial lines.
   - Evaluate potential state, regional, and national programs to increase capacity for insurance and reinsurance related to catastrophe perils.
   - Monitor and assess proposals that address disaster insurance issues at the federal and state levels. Assess concentration-of-risk issues and whether a regulatory solution is needed.
   - Provide a forum for discussing issues and recommending solutions related to insuring for catastrophic risk, including terrorism, war, and natural disasters.
   - Consider revisions to the Catastrophe Computer Modeling Handbook.
PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE (Continued)

F. Investigate and recommend ways the NAIC can assist states in responding to disasters by continuing to build the NAIC’s Catastrophe Resource Center for state insurance regulators to better prepare for disasters.

G. Continue to monitor the growth of the private flood insurance market and assess the actions taken by individual states to facilitate growth. Update the Considerations for Private Flood Insurance appendix to include new ways states are growing the private flood insurance market.

H. Study, in coordination with other NAIC task forces and working groups, earthquake matters of concern to state insurance regulators. Consider various innovative earthquake insurance coverage options aimed at improving take-up rates.

4. The NAIC/Federal Emergency Management Agency (FEMA) (C) Working Group will:
   A. Assist state insurance regulators in engaging and collaborating with FEMA on an ongoing basis by establishing a process for the oversight, prioritization, and reporting of disaster-related regional workshops and other exercises to improve disaster preparation and resilience.

5. The Terrorism Insurance Implementation (C) Working Group will:
   A. Coordinate the NAIC’s efforts to address insurance coverage for acts of terrorism. Work with the U.S. Department of the Treasury’s (Treasury Department’s) Terrorism Risk Insurance Program (TRIP) Office on matters of mutual concern. Discuss long-term solutions to address the risk of loss from acts of terrorism.
   B. Review and report on data collection related to insurance coverage for acts of terrorism.

6. The Transparency and Readability of Consumer Information (C) Working Group will:
   A. Facilitate consumers’ capacity to understand the content of insurance policies and assess differences in insurers’ policy forms.
   B. Assist other groups with drafting language included within consumer-facing documents.
   C. Complete the drafting of regulatory best practices that serve to inform consumers of the reasons for significant premium increases related to P/C insurance products.
   D. Update and develop web page and mobile content for A Shopping Tool for Homeowners Insurance and A Shopping Tool for Automobile Insurance.
   E. Study and evaluate ways to engage department of insurance (DOI) communication to more diverse populations, such as rural communities.

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

Ongoing Support of NAIC Programs, Products or Services

1. The Casualty Actuarial and Statistical (C) Task Force will:
   A. Provide reserving, pricing, ratemaking, statistical, and other actuarial support to NAIC committees, task forces, and/or working groups. Propose changes to the appropriate work products (with the most common work products noted below) and present comments on proposals submitted by others relating to casualty actuarial and statistical matters. Monitor the activities, including the development of financial services regulations and statistical (including disaster) reporting, regarding casualty actuarial issues.
      1. Property and Casualty Insurance (C) Committee – ratemaking, reserving, or data issues.
      2. Blanks (E) Working Group – P/C annual financial statement, including Schedule P; P/C quarterly financial statement; P/C quarterly and annual financial statement instructions, including Statement of Actuarial Opinion (SAO) and Actuarial Opinion Summary Supplement.
   B. Monitor national casualty actuarial developments and consider regulatory implications.
      1. Casualty Actuarial Society (CAS) – Statements of Principles and Syllabus of Basic Education.
      3. Society of Actuaries (SOA) – general insurance track’s basic education.
   C. Facilitate discussion among state insurance regulators regarding rate filing issues of common interest across the states through the scheduling of regulator-only conference calls.
   D. Conduct the following predictive analytics work:
      1. Facilitate training and the sharing of expertise through predictive analytics webinars (Book Club).
      2. Review the completed work on artificial intelligence (AI) from other committee groups. Coordinate with the Innovation, Cybersecurity, and Technology (H) Committee on the tracking of new uses of AI, auditing algorithms, product development, and other emerging regulatory issues in as far as these issues contain a Task Force component.
      3. With NAIC staff assistance, discuss guidance for the regulatory review of tree-based models and generalized additive models (GAM) used in rate filings.

2. The Actuarial Opinion (C) Working Group will:
   A. Propose revisions to the following, as needed, especially to improve actuarial opinions, actuarial opinion summaries, and actuarial reports, as well as the regulatory analysis of these actuarial documents and loss and premium reserves:
      3. Annual Statement Instructions—Property/Casualty.
      4. Regulatory guidance to appointed actuaries and companies.
      5. Other financial blanks and instructions, as needed.

3. The Statistical Data (C) Working Group will:
   A. Consider updates and changes to the Statistical Handbook of Data Available to Insurance Regulators.
   B. Consider updates and developments, provide technical assistance, and oversee the production of the following reports and databases. Periodically evaluate the demand and utility versus the costs of production of each product.
      1. Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance.
      2. Auto Insurance Database.
C. Implement the expedited reporting and publication of average auto and average homeowners premium portions of the annual Auto Insurance Database and Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance.

NAIC Support Staff: Kris DeFrain/Jennifer Gardner/Libby Crews
SURPLUS LINES (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

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

NAIC Support Staff: Andy Daleo
TITLE INSURANCE (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Anne Obersteadt
WORKERS’ COMPENSATION (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

2. The NAIC/IAIABC Joint (C) Working Group will:
   A. Study issues of mutual concern to state insurance regulators and the IAIABC. Review relevant IAIABC model laws and white papers and consider possible charges in light of the Working Group’s recommendations.

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

Ongoing Support of NAIC Programs, Products or Services

1. The Market Regulation and Consumer Affairs (D) Committee will:
   A. Monitor the centralized collection and storage of market conduct data, national analysis, and reporting at the NAIC, including issues regarding the public availability of data.
   B. Monitor and assess the current process for multi-jurisdictional market conduct activities and provide appropriate recommendations for enhancement, as necessary.
   C. Evaluate all data currently collected in the NAIC Market Information Systems (MIS) and considered confidential to determine what, if any, can be made more widely available.
   D. Oversee the activities of the Antifraud (D) Task Force.
   E. Oversee the activities of the Market Information Systems (D) Task Force.
   F. Oversee the activities of the Producer Licensing (D) Task Force.
   G. Monitor the underwriting and market practices of insurers and producers, as well as the conditions of insurance marketplaces, including urban markets, to identify specific market conduct issues of importance and concern. Hold public hearings on these issues at the NAIC national meetings, as appropriate.
   H. In collaboration with other technical working groups, discuss and share best practices through public forums to address broad consumer concerns regarding personal insurance products.
   I. Coordinate with the International Insurance Relations (G) Committee to develop input and submit comments to the International Association of Insurance Supervisors (IAIS) and/or other related groups on issues regarding market regulation concepts.
   J. Coordinate with the Health Insurance and Managed Care (B) Committee to provide policy recommendations regarding uniform state enforcement of the federal Affordable Care Act (ACA).
   K. Review the “Best Practices and Guidelines for Consumer Information Disclosures” (adopted October 2012) and update, as needed.

2. The Advisory Organization Examination Oversight (D) Working Group will:
   A. Revise the protocols, as necessary, for the examination of national or multistate advisory organizations (including rating organizations and statistical agents) to be more comprehensive, efficient, and possibly less frequent than the current system of single-state exams. Solicit input and collaboration from other interested and affected committees and task forces.
   B. Monitor the data reporting and data collection processes of advisory organizations (including rating organizations and statistical agents) to determine if they are implementing appropriate measures to ensure data quality. Report the results of this ongoing charge, as needed.
   C. Actively assist with and coordinate multistate examinations of advisory organizations (including rating organizations and statistical agents).

3. The Market Actions (D) Working Group will:
   A. Facilitate interstate communication and coordinate collaborative state regulatory actions.

4. The Market Analysis Procedures (D) Working Group will:
   A. Recommend changes to the market analysis framework based on results over the past five years, including the current set of Level 1 and Level 2 questions.
   B. Discuss other market data collection issues and make recommendations, as necessary.
   C. Consider recommendations for new lines of business for the Market Conduct Annual Statement (MCAS).

5. The Market Conduct Annual Statement Blanks (D) Working Group will:
   A. Review the MCAS data elements and the “Data Call and Definitions” for those lines of business that have been in effect for longer than three years and update them, as necessary.
   B. Develop an MCAS blank to be used for the collection of data for additional lines of business, where appropriate.
MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE (Continued)

6. The Market Conduct Examination Guidelines (D) Working Group will:
   A. Develop market conduct examination standards, as necessary, for inclusion in the Market Regulation Handbook.
   B. Monitor the adoption and revision of NAIC models and develop market conduct examination standards to correspond with adopted NAIC models.
   C. Develop updated standardized data requests, as necessary, for inclusion in the Market Regulation Handbook.
   D. Develop uniform market conduct procedural guidance (e.g., a library, depository or warehouse with market conduct examination templates, such as an exam call letter, exam exit agenda, etc.) for inclusion in, or for use in conjunction with, the Market Regulation Handbook.
   E. Coordinate with the Innovation, Cybersecurity and Technology (H) Committee to develop market conduct examiner guidance for the oversight of regulated entities’ use of insurance and non-insurance consumer data and models using algorithms and artificial intelligence (AI).
   F. Discuss the effectiveness of group supervision of market conduct risks and develop examination procedural guidance, as necessary.
   G. Discuss the role of market conduct examiners in reviewing insurers’ corporate governance as outlined in the NAIC’s Corporate Governance Annual Disclosure Model Act (#305) and Corporate Governance Annual Disclosure Model Regulation (#306).

7. The Market Regulation Certification (D) Working Group will:
   A. Develop a formal market regulation certification proposal for consideration by the NAIC membership that provides recommendations for the following: 1) certification standards; 2) a process for the state implementation of the standards; 3) a process to measure the states’ compliance with the standards; 4) a process for future revisions to the standards; and 5) assistance for jurisdictions to achieve certification.

8. The Privacy Protections (D) Working Group will:
   A. Review state insurance privacy protections regarding the collection, use and disclosure of information gathered in connection with insurance transactions and make recommended changes, as needed, to certain NAIC models, such as the NAIC Insurance Information and Privacy Protection Model Act (#670) and the Privacy of Consumer Financial and Health Information Regulation (#672). (Further direction from NAIC Executive (EX) Committee may result in this charge being moved to the new Innovation, Cybersecurity, and Technology (H) Committee.)

NAIC Support Staff: Tim Mullen/Randy Helder
ANTIFRAUD (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

2. The Antifraud Education Enhancement (D) Working Group will:
   A. Develop seminars, trainings, and webinars regarding insurance fraud. Provide three webinars by the 2022 Fall National Meeting.

3. The Antifraud Technology (D) Working Group will:
   A. Work with the NAIC to develop an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions. Complete by 2022 Fall National Meeting.
   B. Evaluate sources of antifraud data and propose methods for enhancing the utilization and exchange of information among state insurance regulators, fraud investigative divisions, law enforcement officials, insurers, and antifraud organizations. Complete by the 2022 Fall National Meeting.

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

NAIC Support Staff: Greg Welker/Lois E. Alexander
MARKET INFORMATION SYSTEMS (D) Task Force

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

Ongoing Support of NAIC Programs, Products or Services

1. The Market Information Systems (D) Task Force will:
   A. Ensure that the MIS support the strategic direction set forth by the Market Regulation and Consumer Affairs (D) Committee.
   B. Develop recommendations for the incorporation of artificial intelligence (AI) abilities in NAIC Market Information Systems for use in market analysis. Complete by the 2022 Summer National Meeting.
   C. Analyze the data in the MIS. If needed, recommend methods to ensure better data quality. Complete by the 2022 Fall National Meeting.
   D. Provide guidance on the appropriate use of the MIS and the data entered in them.
      2. Electronic Forums.
      4. Market Analysis Profile.
      5. Market Analysis Prioritization Tool (MAPT).
      9. 1033 State Decision Repository (SDR1033) (in conjunction with the Antifraud (D) Task Force).

2. The Market Information Systems Research and Development (D) Working Group will:
   A. Serve as the business partner to review and prioritize submitted Uniform System Enhancement Request (USER) forms to ensure an efficient use of available NAIC staffing and resources.
   B. Assist the Task Force with tasks as assigned, such as:
      1. Analyze MIS data.
      2. Provide state users with query access to MIS data.
      3. Provide guidance on the appropriate use of the MIS.

NAIC Support Staff: Randy Helder
PRODUCER LICENSING (D) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Producer Licensing (D) Task Force will:
   A. Work closely with NIPR to encourage the full utilization of NIPR products and services by all the states and producers, and encourage accurate and timely reporting of state administrative actions to the NAIC’s Regulatory Information Retrieval System (RIRS) to ensure that this data is properly reflected in the State Producer Licensing Database (SPLD) and the Producer Database (PDB).
   B. Facilitate roundtable discussions, as needed, with the state producer licensing directors for the exchange of views, opinions, and ideas on producer licensing activities in the states and at the NAIC.
   C. Discuss, as necessary, state perspectives regarding the regulation and benefit of the activities of the federal Affordable Care Act (ACA), established enrollment assisters (including navigators and non-navigator assisters and certified application counselors), and the activities of producers in assisting individuals and businesses purchasing in the health insurance marketplaces. Coordinate with the Health Insurance and Managed Care (B) Committee and the Antifraud (D) Task Force, as necessary.
   D. Monitor the activities of the National Association of Registered Agents and Brokers (NARAB) in the development and enforcement of the NARAB membership rules, including the criteria for successfully passing a background check.
   E. Coordinate through NAIC staff to provide guidance to NIPR on producer licensing-related electronic initiatives. Hear a report from NIPR at each national meeting.
   F. Coordinate with the Market Information Systems (D) Task Force and the Antifraud (D) Task Force to evaluate and make recommendations regarding the entry, retention, and use of data in the NAIC’s Market Information Systems (MIS).
   G. Monitor the state implementation of adjuster licensing reciprocity and uniformity; update, as necessary, NAIC adjuster licensing standards.
   H. Coordinate with the Special (EX) Committee on Race and Insurance on referrals affecting insurance producers.
   I. Discuss how criminal convictions may affect producer licensing applicants and review the NAIC’s Guidelines for State Insurance Regulators to the Violent Crime Control and Law Enforcement Act of 1994 to create a more simplified and consistent approach in how states review 1033 waiver requests.

2. The Producer Licensing Uniformity (D) Working Group will:
   A. Work closely with state producer licensing directors and exam vendors to ensure that: 1) the states achieve full compliance with the standards in order to achieve greater uniformity; and 2) the exams test the qualifications for an entry-level position as a producer.
   B. Provide oversight and ongoing updates, as needed, to the State Licensing Handbook.
   C. Monitor and assess the state implementation of the Uniform Licensing Standards (ULS) and update the standards, as needed.
   D. Review and update, as needed, the NAIC’s uniform producer licensing applications and uniform appointment form. Provide any recommended updates to the Producer Licensing (D) Task Force by the NAIC Summer National Meeting.

3. The Uniform Education (D) Working Group will:
   A. Update, as needed, the reciprocity guidelines, the uniform application forms for continuing education (CE) providers, and the process for state review and approval of instructors and courses. Provide any recommended updates to the Producer Licensing (D) Task Force by the 2022 Fall National Meeting.
   B. Coordinate with NAIC parent committees, task forces, and/or working groups to review and provide recommendations, as necessary, on prelicensing education and CE requirements that are included in NAIC model acts, regulations, and/or standards.

NAIC Support Staff: Tim Mullen/Greg Welker
FINANCIAL CONDITION (E) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Financial Condition (E) Committee will:
   B. Appoint and oversee the activities of the following: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; and Valuation of Securities (E) Task Force.
   C. Oversee a process to address financial issues that may compromise the consistency and uniformity of the U.S. solvency framework, referring valuation and other issues to the appropriate committees as needed.
   D. Use the Risk-Focused Surveillance (E) Working Group to address specific industry concerns regarding regulatory redundancy, and review any issues industry subsequently escalates to the Committee.

2. The Financial Analysis (E) Working Group will:
   A. Analyze nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled; determine if appropriate action is being taken.
   B. Interact with domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods, and action(s).
   C. Support, encourage, promote, and coordinate multistate efforts in addressing solvency problems, including identifying adverse industry trends.
   D. Increase information-sharing and coordination between state insurance regulators and federal authorities, including through representation of state insurance regulators in national bodies with responsibilities for system-wide oversight.

3. The Group Capital Calculation (E) Working Group will:
   A. Continually review and monitor the effectiveness of the group capital calculation (GCC), and consider revisions, as necessary, to maintain the effectiveness of its objective under the U.S. solvency system.
   B. Liaise, as necessary, with the International Insurance Relations (G) Committee on international group capital developments, and consider input from participation of U.S. state insurance regulators in the International Association of Insurance Supervisors (IAIS) monitoring process.

4. The Group Solvency Issues (E) Working Group will:
   A. Continue to develop potential enhancements to the current regulatory solvency system as it relates to group solvency-related issues.
   B. Critically review and provide input and drafting to the IAIS Insurance Groups Working Group on other IAIS material dealing with group supervision issues.
   C. Continually review and monitor the effectiveness of the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450), and consider revisions, as necessary, to maintain effective oversight of insurance groups.
   D. Assess the IAIS Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame), and make recommendations on its implementation in a manner appropriate for the U.S.

5. The Own Risk and Solvency Assessment (ORSA) Implementation (E) Subgroup of the Group Solvency Issues (E) Working Group will:
   A. Continue to provide and enhance an enterprise risk management (ERM) education program for state insurance regulators in support of the ORSA implementation.
   B. Continually review and monitor the effectiveness of the Risk Management and Own Risk and Solvency Assessment Model Act (#505) and its corresponding NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual; consider revisions as necessary.
6. The **Mortgage Guaranty Insurance (E) Working Group** will:
   A. Develop changes to the **Mortgage Guaranty Insurance Model Act (#630)** and other areas of the solvency regulation of mortgage guaranty insurers, including, but not limited to, revisions to **Statement of Statutory Accounting Principles (SSAP) No. 58—Mortgage Guaranty Insurance**, and develop an extensive mortgage guaranty supplemental filing. Finalize Model #630 by the 2022 Spring National Meeting.

7. The **Mutual Recognition of Jurisdictions (E) Working Group** will:
   A. Oversee the process for evaluating jurisdictions and maintain a listing of jurisdictions that meets the NAIC requirements for recognizing and accepting the NAIC GCC.
   B. Maintain the **NAIC List of Qualified Jurisdictions** and the **NAIC List of Reciprocal Jurisdictions** in accordance with the **Process for Evaluating Qualified and Reciprocal Jurisdictions**.

8. The **NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group** will:
   A. Continually review the **Annual Financial Reporting Model Regulation (#205)** and its corresponding implementation guide; revise as appropriate.
   B. Address financial solvency issues by working with the AICPA and responding to AICPA exposure drafts.
   C. Monitor the federal Sarbanes-Oxley (SOX) Act of 2002, as well as rules and regulations promulgated by the U.S. Securities and Exchange Commission (SEC), the Public Company Accounting Oversight Board (PCAOB), and other financial services regulatory entities.
   D. Review annually the premium threshold amount included in Section 16 of Model #205, with the general intent that those insurers subject to the Section 16 requirements would capture at least approximately 90% of industry premium and/or in response to any future regulatory or market developments.

9. The **National Treatment and Coordination (E) Working Group** will:
   A. Increase utilization and implementation of the **Company Licensing Best Practices Handbook**.
   B. Encourage synergies between corporate changes/amendments and rate and form filing review and approval to improve efficiency.
   C. Continue to monitor the usage and make necessary enhancements to the **Form A Database**.
   D. Maintain educational courses in the existing NAIC Insurance Regulator Professional Designation Program for company licensing regulators.
   E. Make necessary enhancements to promote electronic submission of all company licensing applications.

10. The **Restructuring Mechanisms (E) Working Group** will:
    A. Evaluate and prepare a white paper that:
        1. Addresses the perceived need for restructuring statutes and the issues those statutes are designed to remedy. Also, consider alternatives that insurers are currently employing to achieve similar results.
        2. Summarizes the existing state restructuring statutes.
        3. Addresses the legal issues posed by an order of a court (or approval by an insurance department) in one state affecting the policyholders of other states.
        4. Considers the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring.
        5. Identifies and addresses the legal issues associated with restructuring using a protected cell.
    B. Consider requesting approval from the Executive (EX) Committee on developing changes to specific NAIC models as a result of findings from the development of the white paper.

11. The **Long-Term Care Insurance Restructuring (E) Subgroup** of the Restructuring Mechanisms (E) Working Group will:
    A. Identify and assess potential legal and regulatory issues arising from a corporate transaction that would seek to legally separate certain long-term care (LTC) policies from the general account of the issuing insurer. Report on the Subgroup’s consideration of the issue, including a recommendation as to merits of an existing regulatory framework (e.g., Insurance Business Transfers state statutes) or a new regulatory framework, as contemplated by Workstream #2 of the Long-Term Care Insurance (EX) Task Force.
12. The Restructuring Mechanisms (E) Subgroup of the Restructuring Mechanisms (E) Working Group will:

A. Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer, along with the adequacy of long-term liquidity needs. Also, develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for its consideration.

B. Consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff.

C. Review the various restructuring mechanisms and develop, if deemed needed, accounting and reporting requirements for referring to the Statutory Accounting Principles (E) Working Group.

13. The Risk-Focused Surveillance (E) Working Group will:

A. Continually review the effectiveness of risk-focused surveillance, and develop enhancements to processes as necessary.

B. Continually review regulatory redundancy issues identified by interested parties, and provide recommendations to other NAIC committee groups to address as needed.

C. Oversee and monitor the Peer Review Program to encourage consistent and effective risk-focused surveillance processes.

D. Continually maintain and update standardized job descriptions/requirements and salary range recommendations for common solvency monitoring positions to assist insurance departments in attracting and maintaining suitable staff.

14. The Valuation Analysis (E) Working Group will:

A. Respond to states in a confidential forum regarding questions and issues arising during the course of annual principle-based reserving (PBR) reviews or PBR examination, which also may include consideration of asset adequacy analysis questions and issues.

B. Work with NAIC resources to assist in prioritizing and responding to issues and questions regarding PBR and asset adequacy analysis, including actuarial guidelines or other requirements making use of or relating to PBR, such as Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation (AG 38), Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued Under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48), and the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).

C. Develop and implement a plan with NAIC resources to identify outliers/concerns regarding PBR/asset adequacy analysis.

D. Refer questions/issues, as appropriate, to the Life Actuarial (A) Task Force that may require consideration of changes/interpretations to be provided in the Valuation Manual.

E. Assist NAIC resources in the development of a standard asset/liability model portfolio used to calibrate company PBR models.

F. Make referrals, as appropriate, to the Financial Analysis (E) Working Group.

G. Perform other work to carry out the Valuation Analysis (E) Working Group procedures.

NAIC Support Staff: Dan Daveline/Julie Gann/Bruce Jenson
ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Accounting Practices and Procedures (E) Task Force will:

2. The Blanks (E) Working Group will:
   A. Consider improvements and revisions to the various annual/quarterly statement blanks to:
   1. Conform these blanks to changes made in other areas of the NAIC to promote uniformity in reporting of financial information by insurers.
   2. Develop reporting formats for other entities subject to the jurisdiction of state insurance departments.
   3. Conform the various NAIC blanks and instructions to adopted NAIC policy.
   4. Oversee the development of additional reporting formats within the existing annual financial statements as needs are identified.
   B. Continue to monitor state filing checklists to maintain current filing requirements.
   C. Continue to monitor and improve the quality of financial data filed by insurance companies by recommending improved or additional language for the Annual Statement Instructions.
   D. Continue to monitor and review all proposals necessary for the implementation of statutory accounting guidance to ensure proper implementation of any action taken by the Accounting Practices and Procedures (E) Task Force affecting annual financial statements and/or instructions.
   E. Continue to coordinate with other task forces of the NAIC to ensure proper implementation of reporting and instructions changes as proposed by these taskforces.
   F. Coordinate with the Life Actuarial (A) Task Force to use any special reports developed and avoid duplication of reporting.
   G. Review requests for investment schedule blanks and instructions changes in connection with the work being performed by the Capital Adequacy (E) Task Force and its working groups.
   H. Review changes requested by the Valuation of Securities (E) Task Force relating to its work on other invested assets reporting for technical consistency within the investment reporting schedules and instructions.

3. The Statutory Accounting Principles (E) Working Group will:
   A. Maintain codified statutory accounting principles by providing periodic updates to the guidance that address new statutory issues and new generally accepted accounting principles (GAAP) pronouncements. Provide authoritative responses to questions of application and clarifications for existing statutory accounting principles. Report all actions and provide updates to the Accounting Practices and Procedures (E) Task Force.
   B. At the discretion of the Working Group chair, develop comments on exposed GAAP and International Financial Reporting Standards (IFRS) pronouncements affecting financial accounting and reporting. Any comments are subject to review and approval by the chairs of the Accounting Practices and Procedures (E) Task Force and the Financial Condition (E) Committee.
   C. Coordinate with the Life Actuarial (A) Task Force on changes to the AP&P Manual related to the Valuation Manual VM-A, Requirements, and VM-C, Actuarial Guidelines, as well as other Valuation Manual requirements. This process will include the receipt of periodic reports on changes to the Valuation Manual on items that require coordination.
   D. Obtain, analyze and review information on permitted practices, prescribed practices or other accounting treatments suggesting that issues or trends occurring within the industry may compromise the consistency and uniformity of statutory accounting, including, but not limited to, activities conducted by insurers for which there is currently no statutory accounting guidance or where the states have prescribed statutory accounting that differs from the guidance issued by the NAIC. Use this information to consider possible changes to statutory accounting.

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

Ongoing Support of NAIC Programs, Products or Services

1. The Capital Adequacy (E) Task Force will:
   A. Evaluate emerging “risk” issues for referral to the risk-based capital (RBC) working groups/subgroups for certain issues involving more than one RBC formula. Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
   B. Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).
   C. Evaluate relevant historical data and apply defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to the current asset risk structure and factors in each of the RBC formulas.

2. The Health Risk-Based Capital (E) Working Group, Life Risk-Based Capital (E) Working Group, and Property and Casualty Risk-Based Capital (E) Working Group will:
   A. Evaluate refinements to the existing NAIC RBC formulas implemented in the prior year. Forward the final version of the structure of the current year life and fraternal, property/casualty (P/C), and health RBC formulas to the Financial Condition (E) Committee by June.
   B. Consider improvements and revisions to the various RBC blanks to: 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity; and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified. Any proposal that affects the RBC structure must be adopted no later than April 30 in the year of the change, and adopted changes will be forwarded to the Financial Condition (E) Committee by the next scheduled meeting or conference call. Any adoptions made to the annual financial statement blanks or statutory accounting principles that affect an RBC change adopted by April 30 and results in an amended change may be considered by July 30 for those exceptions where the Capital Adequacy (E) Task Force votes to pursue by super-majority (two-thirds) consent of members present no later than June 30 for the current reporting year.
   C. Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the revised Accounting Practices and Procedures Manual (AP&P Manual) to ensure that model laws, publications, formulas, analysis tools, etc., supported by the Task Force continue to meet regulatory objectives.
   D. Review the effectiveness of the NAIC’s RBC policies and procedures as they affect the accuracy, audit ability, timeliness of reporting access to RBC results and comparability between the RBC formulas. Report on data quality problems in the prior year RBC filings at the summer and fall national meetings.

3. The Longevity Risk (E/A) Subgroup, a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force, will:
   A. Provide recommendations for the appropriate treatment of longevity risk transfers by the new longevity factors.

4. The Variable Annuities Capital and Reserve (E/A) Subgroup, a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force, will:
   A. Monitor the impact of the changes to the variable annuities reserve framework and RBC calculation, and determine if additional revisions need to be made.
   B. Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.

5. The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group will:
   A. Recalculate the premium risk factors on an ex-catastrophe basis, if needed.
   B. Continue to update the U.S. and non-U.S. catastrophe event list.
   C. Continue to evaluate the need for exemption criteria for insurers with minimal risk.
   D. Evaluate the RBC results inclusive of a catastrophe risk charge.
   E. Refine instructions for the catastrophe risk charge.
   F. Continue to evaluate any necessary refinements to the catastrophe risk formula.
   G. Evaluate other catastrophe risks for possible inclusion in the charge.
6. The Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group will:
   A. Perform a comprehensive review of the RBC investment framework for all business types, which could include:
      1. Identifying and acknowledging uses that extend beyond the purpose of the Risk-Based Capital (RBC) for Insurers Model Act (#312).
      2. Assessing the impact and effectiveness of potential changes in contributing to the identification of weakly capitalized companies; i.e., those companies at action level.
      3. Documenting the modifications made over time to the formulas, including, but not limited to, an analysis of the costs in study and development, implementation (internal and external), assimilation, verification, analysis, and review of the desired change to the RBC formulas and facilitating the appropriate allocation of resources.

NAIC Support Staff: Jane Barr
EXAMINATION OVERSIGHT (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Examination Oversight (E) Task Force will:
   A. Accomplish its mission using the following groups:
      5. Information Technology (IT) Examination (E) Working Group.

2. The Electronic Workpaper (E) Working Group will:
   A. Monitor and support the state insurance departments in using electronic workpaper software tools to conduct and document solvency monitoring activities.
   B. Provide ongoing oversight to the transition of electronic workpaper work to the TeamMate+ application.
   C. Monitor state insurance regulator use of TeamMate+ to proactively identify best practices and improvements to the application, as necessary.

3. The Financial Analysis Solvency Tools (E) Working Group will:
   A. Provide ongoing maintenance and enhancements to the Financial Analysis Handbook and related applications for changes to the NAIC annual/quarterly financial statement blanks, as well as enhancements developed to assist in the risk-focused analysis and monitoring of the financial condition of insurance companies and groups. Monitor the coordination of analysis activities of holding company groups, and coordinate and analyze input received from other state regulators.
   B. Provide ongoing development maintenance and enhancements to the automated financial solvency tools developed to assist in conducting risk-focused analysis and monitoring the financial condition of insurance companies and groups. Prioritize and perform analysis to ensure that the tools remain reliable and accurate.
   C. Coordinate with the Financial Examiners Handbook (E) Technical Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.
   D. Adjust the Financial Analysis Handbook and current financial analysis solvency tools for life insurance companies based on any recommendations as requested from the Life Actuarial (A) Task Force to incorporate principle-based reserving (PBR) changes.

4. The Financial Examiners Coordination (E) Working Group will:
   A. Develop enhancements that encourage the coordination of examination activities regarding holding company groups.
   B. Promote coordination by assisting and advising domiciliary regulators and exam coordinating states as to what might be the most appropriate regulatory strategies, methods and actions regarding financial examinations of holding company groups.
   C. Facilitate communication among regulators regarding common practices and issues arising from coordinating examination efforts.
   D. Provide ongoing maintenance and enhancements to the Financial Examination Electronic Tracking System (FEETS).
EXAMINATION OVERSIGHT (E) TASK FORCE (Continued)

5. The Financial Examiners Handbook (E) Technical Group will:
   A. Continually review the Financial Condition Examiners Handbook and revise, as appropriate.
   B. Coordinate with the Risk-Focused Surveillance (E) Working Group to monitor the implementation of the risk-assessment process by developing additional guidance and exhibits within the Financial Condition Examiners Handbook, including consideration of potential redundancies affected by the examination process, corporate governance and other guidance as needed to assist examiners in completing financial condition examinations.
   C. Coordinate with the Financial Analysis Solvency Tools (E) Working Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.
   D. Coordinate with the IT Examination (E) Working Group and the Financial Examiners Coordination (E) Working Group to maintain specialized areas of guidance within the Financial Condition Examiners Handbook related to the charges of these specific working groups.
   E. Adjust the Financial Condition Examiners Handbook based upon any recommendations as requested from the Life Actuarial (A) Task Force to incorporate PBR changes.

6. The Information Technology (IT) Examination (E) Working Group will:
   A. Continually review and revise, as needed, the “General Information Technology Review” and “Exhibit C—Evaluation of Controls in Information Systems” sections of the Financial Condition Examiners Handbook.
   B. Monitor cybersecurity trends, including emerging and/or ongoing vulnerabilities, and develop guidance within the Financial Condition Examiners Handbook or other tools, if deemed necessary, to support IT examiners.

NAIC Support Staff: Bailey Henning
FINANCIAL STABILITY (E) TASK FORCE

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

Ongoing Support of NAIC Program, Products or Services

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

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

NAIC Support Staff: Todd Sells/Tim Nauheimer
RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Receivership and Insolvency (E) Task Force will:
   A. Monitor and promote efficient operations of insurance receiverships and guaranty associations.
   B. Monitor and promote state adoption of insurance receivership and guaranty association model acts and regulations, and monitor other legislation related to insurance receiverships and guaranty associations.
   C. Provide input and comments to the International Association of Insurance Supervisors (IAIS), the Financial Stability Board (FSB) or other related groups on issues regarding international resolution authority.
   D. Monitor, review and provide input on federal rulemaking and studies related to insurance receiverships.
   F. Monitor the work of other NAIC committees, task forces and working groups to identify and address any issues that affect receivership law and/or regulatory guidance.
   G. Perform additional work as directed by the Financial Condition (E) Committee and/or received through referral by other groups.

2. The Receiver’s Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force will:
   A. Review the Receiver’s Handbook to identify areas where information is outdated, updates are required, or additional guidance is needed. Based on this review, draft and propose recommended edits to the Receiver’s Handbook. Complete by the 2022 Fall National Meeting.

3. The Receivership Financial Analysis (E) Working Group will:
   A. Monitor receiverships involving nationally significant insurers/groups to support, encourage, promote and coordinate multistate efforts in addressing problems.
   B. Interact with the Financial Analysis (E) Working Group, domiciliary regulators, and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and/or action(s) regarding potential or pending receiverships.

4. The Receivership Law (E) Working Group will:
   A. Review and provide recommendations on any issues identified that may affect states’ receivership and guaranty association laws (e.g., any issues that arise as a result of market conditions; insurer insolvencies; federal rulemaking and studies; international resolution initiatives; or as a result of the work performed by or referred from other NAIC committees, task forces and/or working groups).
   B. Discuss significant cases that may impact the administration of receiverships.

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

Ongoing Support of NAIC Programs, Products or Services

1. The Reinsurance (E) Task Force will:
   A. Provide a forum for the consideration of reinsurance-related issues of public policy.
   C. Monitor the implementation of the 2011, 2016 and 2019 revisions to the Credit for Reinsurance Model Law (#785); and the 2011 and 2019 revisions to the Credit for Reinsurance Model Regulation (#786) and the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).
   D. Communicate and coordinate with the Federal Insurance Office (FIO), other federal authorities, and international regulators and authorities on matters pertaining to reinsurance.
   E. Consider any other issues related to the revised Model #785, Model #786 and Model #787.
   F. Monitor the development of international principles, standards and guidance with respect to reinsurance. This includes, but is not limited to, monitoring the activities of various groups within the International Association of Insurance Supervisors (IAIS), including the Reinsurance and Other Forms of Risk Transfer Subcommittee, the Reinsurance Mutual Recognition Subgroup and the Reinsurance Transparency Group.
   G. Consider the impact of reinsurance-related federal legislation, including, but not limited to, the federal Nonadmitted and Reinsurance Reform Act (NRRA) and the Federal Insurance Office Act, and coordinate any appropriate NAIC action.
   H. Continue to monitor the impact of reinsurance-related international agreements, including the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement).

2. The Reinsurance Financial Analysis (E) Working Group will:
   A. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings and operate in open session when discussing certified reinsurance topics and policy issues, such as amendments to the Uniform Application for Certified Reinsurers.
   B. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.
   C. Provide a forum for discussion among NAIC jurisdictions of reinsurance issues related to specific companies, entities, or individuals.
   D. Support, encourage, promote, and coordinate multistate efforts in addressing issues related to certified reinsurers, including, but not limited to, multistate recognition of certified reinsurers.
   E. Provide analytical expertise and support to the states with respect to certified reinsurers and applicants for certification.
   F. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.
   G. Ensure the public passporting website remains current.
   H. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective approaches for the financial solvency surveillance to assist the states in their work to protect the interests of policyholders.

NAIC Support Staff: Jake Stultz/Dan Schelp
RISK RETENTION GROUP (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Becky Meyer/Sara Franson
VALUATION OF SECURITIES (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Charles Therriault
FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE

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

Ongoing Support of NAIC Programs, Products and Services

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

NAIC Support Staff: Becky Meyer/Sara Franson
INTERNATIONAL INSURANCE RELATIONS (G) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Ryan Workman/Nikhail Nigam
NAIC/CONSUMER LIAISON COMMITTEE

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

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

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

NAIC Support Staff: Jim Woody
TABLE 1
PROPOSED 2022 GRET FACTORS, BASED ON AVERAGE OF 2018/2019 DATA

<table>
<thead>
<tr>
<th>Description</th>
<th>Acquisition per Policy</th>
<th>Acquisition per Unit</th>
<th>Acquisition per Premium</th>
<th>Maintenance per Policy</th>
<th>Companies Included</th>
<th>Average Premium Per Policy Issued During Year</th>
<th>Average Face Amt (000) Per Policy Issued During Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>$1.83</td>
<td>$1.00</td>
<td>46%</td>
<td>$55</td>
<td>142</td>
<td>3,252</td>
<td>194</td>
</tr>
<tr>
<td>Career</td>
<td>2.12</td>
<td>1.20</td>
<td>53%</td>
<td>64</td>
<td>77</td>
<td>2,327</td>
<td>197</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>2.00</td>
<td>1.10</td>
<td>50%</td>
<td>60</td>
<td>23</td>
<td>875</td>
<td>72</td>
</tr>
<tr>
<td>Niche Marketing</td>
<td>1.51</td>
<td>0.90</td>
<td>37%</td>
<td>45</td>
<td>24</td>
<td>517</td>
<td>13</td>
</tr>
<tr>
<td>Other*</td>
<td>1.39</td>
<td>0.80</td>
<td>35%</td>
<td>42</td>
<td>109</td>
<td>786</td>
<td>70</td>
</tr>
</tbody>
</table>
* Includes companies that did not respond to this or prior year surveys

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Acquisition per Policy</th>
<th>Acquisition per Unit</th>
<th>Acquisition per Premium</th>
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<th>Companies Included</th>
<th>Average Premium Per Policy Issued During Year</th>
<th>Average Face Amt (000) Per Policy Issued During Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>$1.66</td>
<td>$0.90</td>
<td>43%</td>
<td>$50</td>
<td>121</td>
<td>2,916</td>
<td>194</td>
</tr>
<tr>
<td>Career</td>
<td>2.14</td>
<td>1.20</td>
<td>54%</td>
<td>64</td>
<td>63</td>
<td>2,517</td>
<td>195</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>1.95</td>
<td>1.10</td>
<td>49%</td>
<td>59</td>
<td>15</td>
<td>2,933</td>
<td>119</td>
</tr>
<tr>
<td>Niche Marketing</td>
<td>1.37</td>
<td>0.80</td>
<td>34%</td>
<td>41</td>
<td>26</td>
<td>590</td>
<td>11</td>
</tr>
<tr>
<td>Other*</td>
<td>1.26</td>
<td>0.70</td>
<td>32%</td>
<td>38</td>
<td>67</td>
<td>836</td>
<td>29</td>
</tr>
</tbody>
</table>
* Includes companies that did not respond to this or prior year surveys

APPENDIX A -- DISTRIBUTION CHANNELS

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

1. **Independent** – Business written by a company that markets its insurance policies through an independent insurance agent or insurance broker not primarily affiliated with any one insurance company. These agencies or agents are not employed by the company and operate without an exclusive distribution contract with the company. These include most PPGA arrangements.

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4. **Niche Marketers** – Business written by home service, pre-need, or final expense insurance companies as well as niche-market companies selling small face amount life products through a variety of distribution channels.

5. **Other** – Companies surveyed were only provided with the four options described above. Nonetheless since there were many companies for which we did not receive a response (or whose response in past years’ surveys confirmed an “other” categorization (see below), values for the “other” category are given in the tables in this memo. It was also included to indicate how many life insurance companies with no response (to this survey and prior surveys) and to indicate whether their exclusion has introduced a bias into the resulting values.
APPENDIX B – UNIT EXPENSE SEEDS

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

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

### 2006-2010 (AVERAGE) CLICE STUDIES:

<table>
<thead>
<tr>
<th></th>
<th>Acquisition/Policy</th>
<th>Acquisition/Face Amount (000)</th>
<th>Acquisition/Premium</th>
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</tr>
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<tbody>
<tr>
<td><strong>Term</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weighted Average</td>
<td>$149</td>
<td>$0.62</td>
<td>38%</td>
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<td>Unweighted Average</td>
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<td>$158</td>
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<td>$67</td>
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### CURRENT UNIT EXPENSE SEEDS:

<table>
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<tr>
<th></th>
<th>Acquisition/Policy</th>
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<tbody>
<tr>
<td>All distribution channels</td>
<td>$200</td>
<td>$1.10</td>
<td>50%</td>
<td>$60</td>
</tr>
</tbody>
</table>
TO: Reggie Mazyck, NAIC

FROM: Pete Miller, Experience Study Actuary, Society of Actuaries (SOA)
       Tony Phipps, Chair, SOA Committee on Life Insurance Company Expenses

DATE: August 4, 2021

RE: 2022 Generally Recognized Expense Table (GRET) – SOA Analysis

Dear Mr. Mazyck:

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

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

APPROACH USED

The methodology for calculating the recommended GRET factors based on this data is similar to that followed the last several years. The methodology was last altered in 2015. The changes made at that time can be found in the recommendation letter sent to LATF on July 30, 2015.1

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

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

1 https://www.soa.org/Files/Research/Projects/research-2016-gret-recommendation.pdf
years to increase the response rate to the surveys of companies that submit Annual Statements in order to reduce the number of companies in the “Other” category would be most welcomed. The intention is to continue surveying the companies in future years to enable enhancement of this multiple distribution channel information.

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

**THE RECOMMENDATION**

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

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**TABLE 1**

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

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

USAGE OF THE GRET

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

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

Kindest personal regards,

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

Tony Phipps, FSA, MAAA Chair, SOA Committee on Life Insurance Company Expenses
APPENDIX A -- DISTRIBUTION CHANNELS

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</table>
CALCULATION OF MINIMUM RESERVES AND MINIMUM NONFORFEITURE VALUES FOR POLICIES WITH GUARANTEED INCREASING DEATH BENEFITS BASED ON AN INDEX

A. Valuation - Text

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

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

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

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

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

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

B. Nonforfeiture – Text

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

The index used to determine the threshold amount for years beginning after December 31, 2009, shall be the Consumer Price Index for All Urban Consumers (CPI-U) as of June 30 of that year. If this index is no longer available, another index which, in the actuary’s opinion, reflects the change in general consumer prices for the year should be substituted.
I. FOR POLICIES WHERE ANY DEATH BENEFIT FOR ANY POLICY YEAR WOULD EXCEED THE THRESHOLD AMOUNT EVEN IN ABSENCE OF ANY ANNUAL INCREASES BASED ON THE INDEX

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

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

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

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

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

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

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

(a) The nonforfeiture interest rate defined in Section 3 of VM-02, Minimum Nonforfeiture Mortality and Interest, less:
   1. 4.5%–0 bp If the annual increase based on the index is limited to a maximum of 0% through 5.0%.
   2. 4.25%–25 bp If the annual increase based on the index is limited to a maximum of 5.01% through 10.0%.
   3. 4.0%–50 bp For all other plans.

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

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

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

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

BACKGROUND

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

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

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

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

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

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

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

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

1 In 2010, the actuarial guideline was modified to substitute a threshold amount for 10,000, such threshold being increased by the change in the CPI-U, the CPI for All Urban Consumers.
Property & Casualty Market Conduct Annual Statement
Travel Insurance Data Call & Definitions

Line of Business: Travel
Reporting Period: January 1, 2022 through December 31, 2022
Filing Deadline: April 30, 2023

Contact Information

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

Additional state specific Claims comments (optional)

Additional state specific Lawsuit and Complaints comments (optional)

Additional state specific Underwriting comments (optional)

Coverages

<table>
<thead>
<tr>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trip Cancellation</td>
</tr>
<tr>
<td>Trip Interruption</td>
</tr>
<tr>
<td>Trip Delay</td>
</tr>
<tr>
<td>Baggage Loss/Delay</td>
</tr>
<tr>
<td>Emergency Medical/Dental</td>
</tr>
<tr>
<td>Emergency Transportation/Repatriation</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

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

Schedule 2—Travel Claims Activity, Counts Reported by Claimant, by Coverage
Report the number of reserves/lines/features opened for each coverage part per claim.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-17</td>
<td>Number of claims open at the beginning of the period</td>
</tr>
<tr>
<td>2-18</td>
<td>Number of claims opened during the period</td>
</tr>
<tr>
<td>2-19</td>
<td>Number of claims closed during the period, with payment</td>
</tr>
<tr>
<td>2-20</td>
<td>Number of claims closed during the period, without payment</td>
</tr>
<tr>
<td>2-21</td>
<td>Number of claims open at the end of the period</td>
</tr>
<tr>
<td>2-22</td>
<td>Median days to final payment</td>
</tr>
<tr>
<td>2-23</td>
<td>Number of claims closed with payment within 0-30 days</td>
</tr>
<tr>
<td>2-24</td>
<td>Number of claims closed with payment within 31-90 days</td>
</tr>
<tr>
<td>2-25</td>
<td>Number of claims closed with payment beyond 90 days</td>
</tr>
<tr>
<td>2-26</td>
<td>Number of claims closed without payment within 0-30 days</td>
</tr>
<tr>
<td>2-27</td>
<td>Number of claims closed without payment within 31-90 days</td>
</tr>
<tr>
<td>2-28</td>
<td>Number of claims closed without payment beyond 90 days</td>
</tr>
<tr>
<td>2-29</td>
<td>Dollar amount of claims closed with payment</td>
</tr>
</tbody>
</table>
### Schedule 3 – Lawsuits and Complaints

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

### Schedule 4 – Underwriting

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

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

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

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

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

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

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

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

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

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

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

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

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

Exclude:

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

Clarifications:

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

Calculation Clarification:

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

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

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

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

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

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

Include:

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

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

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

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

Calculation Clarification:

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

Example:

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

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

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

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

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

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

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

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

For purposes of reporting lawsuits in the Travel MCAS blank:

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

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

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

Calculation for losses with one final payment date during the reporting period:
- Date the loss was reported to the company to the date of final payment.

Calculation for losses with multiple final payment dates during the reporting period:
- Date the request for supplemental payment received to the date of final payment (for each different final payment date.)

Exclude:
- Subrogation payments.

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

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

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

<table>
<thead>
<tr>
<th>Days to Settle</th>
<th>Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
<th>Nbr 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Days to Settle</th>
<th>Nbr 1</th>
<th>Nbr 2</th>
<th>Nbr 3</th>
<th>Nbr 4</th>
<th>Nbr 5</th>
<th>Nbr 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

Median Days to Final Payment = (5 + 6)/2 = 5.5
The median should be consistent with the paid claim counts reported in the closing time intervals.

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

**Closing Time # of Claims**

<table>
<thead>
<tr>
<th>Closing Time</th>
<th># of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>22</td>
</tr>
<tr>
<td>31-60</td>
<td>13</td>
</tr>
<tr>
<td>61-90</td>
<td>18</td>
</tr>
<tr>
<td>91-180</td>
<td>11</td>
</tr>
<tr>
<td>181-365</td>
<td>12</td>
</tr>
<tr>
<td>&gt;365</td>
<td>15</td>
</tr>
</tbody>
</table>

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

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

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

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

Data Call & Definitions

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

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

**Filing Deadline:** June 30, 2023

### Contact Information

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAS Administrator</td>
<td>The person responsible for assigning who may view and input company data.</td>
</tr>
<tr>
<td>MCAS Contact</td>
<td>The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.</td>
</tr>
<tr>
<td>MCAS Attestor</td>
<td>The person who attests to the completeness and accuracy of the MCAS data.</td>
</tr>
</tbody>
</table>

### Schedule 1 - Interrogatories

<table>
<thead>
<tr>
<th>No</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-01</td>
<td>List the states where your STLDI products are marketed</td>
<td>Comment</td>
</tr>
<tr>
<td>1-02</td>
<td>Does the company offer STLDI policies/certificates with up to a 90-day duration?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-03</td>
<td>Does the company offer STLDI policies/certificates with 91- to 180-day duration?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-04</td>
<td>Does the company offer STLDI policies/certificates with 181- to 364-day duration?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-05</td>
<td>Number of STLDI forms offered to residents in this state</td>
<td>Comment</td>
</tr>
<tr>
<td>1-06</td>
<td>Number of STLDI forms offered in all states</td>
<td>Comment</td>
</tr>
<tr>
<td>1-07</td>
<td>Number of STLDI forms filed in this state</td>
<td>Comment</td>
</tr>
<tr>
<td>1-08</td>
<td>Number of STLDI forms filed in all states</td>
<td>Comment</td>
</tr>
<tr>
<td>1-09</td>
<td>List the states where your STLDI products are filed</td>
<td>Comment</td>
</tr>
<tr>
<td>1-10</td>
<td>How many policy forms have waiting periods that apply to the entire policy/certificate?</td>
<td>Number</td>
</tr>
<tr>
<td>1-11</td>
<td>How many policy forms have waiting periods that apply per specific benefits?</td>
<td>Number</td>
</tr>
<tr>
<td>1-12</td>
<td>Do any waiting periods exceed the policy/certificate term?</td>
<td>Y/N</td>
</tr>
<tr>
<td>1-13</td>
<td>If the answer to #12 is yes, please explain</td>
<td>Comment</td>
</tr>
<tr>
<td>1-14</td>
<td>Does the company issue STLDI products through associations? If yes, list the associations</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Q</td>
<td>Question</td>
<td>Option (Yes/No)</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>1-15</td>
<td>If #14 is yes, list the associations</td>
<td>Comment</td>
</tr>
<tr>
<td>1-16</td>
<td>If #14 is yes, do you have a contractual relationship with each Association?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-17</td>
<td>If #14 is yes, does the contract cover the marketing of your product?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-18</td>
<td>If #14 is yes, does the contract cover the collection of dues and fees?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-19</td>
<td>If #14 is yes, does the contract cover commissions?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-20</td>
<td>If #14 is yes, what other operational areas are covered in the contract?</td>
<td>Comment</td>
</tr>
<tr>
<td>1-21</td>
<td>Does the company issue STLDI products through trusts?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-22</td>
<td>If #21 is yes, how many?</td>
<td>Comment</td>
</tr>
<tr>
<td>1-23</td>
<td>Does the company issue STLDI products through administrators?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-24</td>
<td>If #23 is yes, how many?</td>
<td>Comment</td>
</tr>
<tr>
<td>1-25</td>
<td>Does the company contract with third-party administrators for administrative services related to STLDI products?</td>
<td>Comment</td>
</tr>
<tr>
<td>1-26</td>
<td>If yes, does your delegation structure include claims related to STLDI products?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-27</td>
<td>If yes, does your delegation structure include claims related to STLDI products?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-28</td>
<td>If yes, does your delegation structure include complaints related to STLDI products?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-29</td>
<td>If yes, does your delegation structure include medical underwriting related to STLDI products?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-30</td>
<td>If yes, does your delegation structure include pricing related to STLDI products?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-31</td>
<td>If yes, does your delegation structure include producer appointments related to STLDI products?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-32</td>
<td>If yes, does your delegation structure include marketing, advertisement, lead generation, or enrollment related to STLDI products?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-33</td>
<td>Does your company audit Third parties to whom you have delegated responsibilities?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-34</td>
<td>If #33 is yes, please provide frequency of audits</td>
<td>Comment</td>
</tr>
<tr>
<td>1-35</td>
<td>Does the company offer renewals/reissues?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-36</td>
<td>Are any renewals/reissues subject to optional or mandatory underwriting?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-37</td>
<td>If the response to 1-36 is Yes, identify the products or plans subject to underwriting upon renewal/reissue</td>
<td>Comment</td>
</tr>
<tr>
<td>1-38</td>
<td>Are there limitations on the number renewals per individual?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-39</td>
<td>Does your company offer renewal(s) without underwriting for an additional charge?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-40</td>
<td>If the response to 1-39 is Yes, identify the products or plans subject to underwriting for an additional charge</td>
<td>Comment</td>
</tr>
<tr>
<td>1-41</td>
<td>Are the limitations on renewals based on state, federal, or company rules?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-42</td>
<td>Does your company distribute its product through independent agents?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-43</td>
<td>Does your company distribute its products through captive agents?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-44</td>
<td>Does your company distribute its products through its employees?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>1-45</td>
<td>What triggers a pre-existing exclusion review (dollar, diagnosis, prescription, other)?</td>
<td>Comment</td>
</tr>
</tbody>
</table>
**Products**

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

**Schedule 2 – Policy/Certificate Administration**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2-1</td>
<td>Net Written Premium</td>
</tr>
<tr>
<td>2-2</td>
<td>Earned premiums for Reporting Year</td>
</tr>
<tr>
<td>2-3</td>
<td>Number of Policies/Certificates in Force at the Beginning of the Period</td>
</tr>
<tr>
<td>2-4</td>
<td>Number of Covered Lives on Policies/Certificates In Force at the Beginning of the Period</td>
</tr>
<tr>
<td>2-5</td>
<td>Number of new policy/certificate applications received during the period</td>
</tr>
<tr>
<td>2-6</td>
<td>Number of new policy/certificates issued during the period</td>
</tr>
<tr>
<td>2-7</td>
<td>Number of new policies/certificates denied during the period</td>
</tr>
<tr>
<td>2-8</td>
<td>Number of Covered Lives on New Policies/Certificates Issued During the Period</td>
</tr>
<tr>
<td>2-9</td>
<td>Member months for policies/certificates newly issued during the period</td>
</tr>
<tr>
<td>2-10</td>
<td>Number of policy/certificate renewal/reissue applications received during the period</td>
</tr>
<tr>
<td>2-11</td>
<td>Number of policies/certificates renewed/reissued during the period</td>
</tr>
<tr>
<td>2-12</td>
<td>Number of policies/certificates non-renewed or denied at the option of insurer during the period</td>
</tr>
<tr>
<td>2-13</td>
<td>Number of Covered Lives on Renewed/Reissued Policies/Certificates During the Period</td>
</tr>
<tr>
<td>2-14</td>
<td>Number of renewals/reissues allowed?</td>
</tr>
<tr>
<td>2-15</td>
<td>Member months for policies/certificates renewed/reissued during the period</td>
</tr>
<tr>
<td>2-16</td>
<td>Member months for policies/certificates renewed/reissued which had an option to renew/reissue without underwriting</td>
</tr>
<tr>
<td>2-17</td>
<td>Number of Member Months of on Other Than New Policies/Certificates or Renewal/Reissued Policies/Certificates During the Period</td>
</tr>
<tr>
<td>2-18</td>
<td>Number of policy/certificate terminations and cancellations initiated by the policyholder/certificateholder</td>
</tr>
<tr>
<td>2-19</td>
<td>Number of Covered Lives on Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Period</td>
</tr>
<tr>
<td>2-20</td>
<td>Number of policies/certificates cancelled during the free look period</td>
</tr>
<tr>
<td>2-21</td>
<td>Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Free Look Period During the Period</td>
</tr>
<tr>
<td>2-22</td>
<td>Number of Covered Lives on Policies/Certificates Cancelled at the Initiation of the policyholder/certificateholder During the Free Look Period During the Period</td>
</tr>
<tr>
<td>2-23</td>
<td>Number of policy/certificate terminations and cancellations due to non-payment of premium</td>
</tr>
<tr>
<td>2-24</td>
<td>Number of Lives on Policies/Certificates Cancelled Due to Non-Payment of Premium During the Period</td>
</tr>
<tr>
<td>2-25</td>
<td>Number of Policies/Certificates Cancelled by Insurer for Any Reason Other Than Non-Payment of Premium During the Period</td>
</tr>
<tr>
<td>2-26</td>
<td>Number of Policies/Certificates Cancelled by Insurer Following Filing of a Claim or Prior Authorization Request by the policyholder/certificateholder During the Period</td>
</tr>
<tr>
<td>2-27</td>
<td>Number of Lives on Policies/Certificates Cancelled by Insurer Following Filing of a Claim or Prior Authorization Request by the policyholder/certificateholder During the Period</td>
</tr>
<tr>
<td>2-28</td>
<td>Number of rescissions</td>
</tr>
<tr>
<td>2-29</td>
<td>Number of insured lives impacted on terminations and cancellations initiated by the policyholder/certificateholder</td>
</tr>
<tr>
<td>2-30</td>
<td>Number of insured lives impacted on terminations and cancellations due to nonpayment</td>
</tr>
<tr>
<td>2-31</td>
<td>Number of insured lives impacted by rescissions</td>
</tr>
<tr>
<td>2-32</td>
<td>Number of Policies/Certificates in Force at the End of the Period</td>
</tr>
<tr>
<td>2-33</td>
<td>Number of Covered Lives on Policies/Certificates in Force at the End of the Period</td>
</tr>
</tbody>
</table>
### Schedule 3 – Prior Authorizations

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3-1</td>
<td>Number of Prior Authorization Requests Pending at the Beginning of the Period</td>
</tr>
<tr>
<td>3-2</td>
<td>Number of prior authorizations requested during period</td>
</tr>
<tr>
<td>3-3</td>
<td>Number of prior authorizations approved during period</td>
</tr>
<tr>
<td>3-4</td>
<td>Number of prior authorizations denied during period</td>
</tr>
<tr>
<td>3-5</td>
<td>Number of claims where prior authorization penalties were assessed</td>
</tr>
<tr>
<td>3-6</td>
<td>Number of Prior Authorization Requests Pending at the End of the Period</td>
</tr>
<tr>
<td>3-7</td>
<td>Median Number of Days from Receipt of Prior Authorization Request to Decision</td>
</tr>
<tr>
<td>3-8</td>
<td>Average Number of Days from Receipt of Prior Authorization to Decision</td>
</tr>
</tbody>
</table>

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

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

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

### Schedule 6 – Marketing and Sales

<table>
<thead>
<tr>
<th>6-1</th>
<th>Number of Individual Applications Pending at the Beginning of the Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-2</td>
<td>Number of applications received</td>
</tr>
<tr>
<td>6-3</td>
<td>Number of Renewal/Reissue Individual Applications Received During the Period</td>
</tr>
<tr>
<td>6-4</td>
<td>Number of New Individual Applications Denied During the Period for Any Reason</td>
</tr>
<tr>
<td>6-5</td>
<td>Number of New Individual Applications Denied During the Period - Health Status or Condition</td>
</tr>
<tr>
<td>6-6</td>
<td>Number of Renewal/Reissue Individual Applications Denied During the Period for Any Reason</td>
</tr>
<tr>
<td>6-7</td>
<td>Number of Renewal/Reissue Individual Applications Denied During the Period - Health Status or Condition</td>
</tr>
<tr>
<td>6-8</td>
<td>Number of New Individual Applications Approved During the Period</td>
</tr>
<tr>
<td>6-9</td>
<td>Number of Renewal/Reissue Individual Applications Approved During the Period</td>
</tr>
<tr>
<td>6-10</td>
<td>Number of Individual Applications Pending at the End of the Period</td>
</tr>
<tr>
<td>6-11</td>
<td>Number of applications initiated via phone</td>
</tr>
<tr>
<td>6-12</td>
<td>Number of applications completed via phone</td>
</tr>
<tr>
<td>6-13</td>
<td>Number of applications initiated face-to-face</td>
</tr>
<tr>
<td>6-14</td>
<td>Number of applications completed face-to-face</td>
</tr>
<tr>
<td>6-15</td>
<td>Number of applications initiated online (Electronically)</td>
</tr>
<tr>
<td>6-16</td>
<td>Number of applications completed online (Electronically)</td>
</tr>
<tr>
<td>6-17</td>
<td>Number of New Individual Applications initiated by Mail During the Period</td>
</tr>
<tr>
<td>6-18</td>
<td>Number of New Individual Applications completed by Mail During the Period</td>
</tr>
<tr>
<td>6-19</td>
<td>Number of New Individual Applications initiated by Any Other Method During the Period</td>
</tr>
<tr>
<td></td>
<td>Description</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>6-20</td>
<td>Number of New Individual Applications completed by Any Other Method During the Period</td>
</tr>
<tr>
<td>6-21</td>
<td>Commissions paid during reporting period (Dollar Amount of Commissions Incurred During the Period)</td>
</tr>
<tr>
<td>6-22</td>
<td>Unearned Commissions returned to company on policies/certificates sold during the period?</td>
</tr>
<tr>
<td>6-23</td>
<td>Other remunerations collected during the period (Dollar Amount of Fees Charged to Applicants and Policyholders During the Period)</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Claims Paid - provide the total number of claims paid during the reporting period for individual policyholders and/or group certificate holders residing in the state for which reporting is being completed.
**Waiting Period**: Period of time a covered person who is entitled to receive benefits for sicknesses must wait before coverage is provided. This applies to waiting periods that are per policy or per condition.

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

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

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

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

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

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

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

**Other Remuneration** - Any monetary consideration provided by the insurer through the course of the insurance transaction. This is not commissions and are separate amounts paid for as a result of the insurance transaction.
Regulatory Information Retrieval System (RIRS) Proposed Coding Structure Changes

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

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

<table>
<thead>
<tr>
<th>Record Type (New)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
</tr>
<tr>
<td>XXX</td>
</tr>
<tr>
<td>XXX</td>
</tr>
<tr>
<td>XXX</td>
</tr>
<tr>
<td>XXX</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modification Indicator (New)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
</tr>
<tr>
<td>Y</td>
</tr>
<tr>
<td>N</td>
</tr>
</tbody>
</table>
## Line of Business (New)

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

## Origin of Action (Revised)

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1002</td>
<td>FINRA</td>
<td>Reporting by a state insurance department of an action taken by FINRA associated with a domicile or resident entity or individual subject to the jurisdiction of said state insurance department.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1003</td>
<td>Market Analysis</td>
<td>Action resulting from market analysis, including but not limited to actions resulting from Baseline, Level 1, or Level 2 market analysis reviews.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1005</td>
<td>Complaint Investigation</td>
<td>Action resulting from an investigation of one or more complaints against the entity or individual.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1007</td>
<td>Field Investigation</td>
<td>Action resulting from a regulatory investigation and verification of circumstances through direct communication with an entity or individual. These investigations often involve on-site work and would include investigations completed by those in fraud and/or investigation units of the department.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1008</td>
<td>Public Inquiry</td>
<td>Concern resulting from close examination of a matter to determine information or truth provided by an outside party (other than the Insurance Department, insurer, or producer).</td>
<td>Delete</td>
<td>Used by 12 states, 17 times. Proposed alternative: (1055) “Third Party Information”</td>
</tr>
<tr>
<td>1010</td>
<td>Routine Dept. Action</td>
<td>Action resulting from recurring insurance</td>
<td>Keep</td>
<td>May also consider Code 1020</td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1013</td>
<td>Financial</td>
<td>Action resulting from activity associated with or related to financial aspects of the entity, including, but not be limited to, actions taken as result of financial filings (e.g., Risk Based Capital (RBC) filings), financially hazardous conditions, suspensions, rehabilitation, liquidations, mergers, domestications, etc.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1015</td>
<td>Information/Action by Other State(s)</td>
<td>Action resulting from information or an action taken against the Entity or individual by another state’s Department of Insurance or other state agency.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Other States Action”</td>
</tr>
<tr>
<td>1016</td>
<td>Annual Statement Filing</td>
<td>Action resulting from the review of an insurers financial annual statement or market conduct annual statement.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Annual Statement”</td>
</tr>
<tr>
<td>1018</td>
<td>Information/Referral from Another State Agency</td>
<td>Action resulting from information or referral from another state agency within the entering state.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1020</td>
<td>Insurer Report</td>
<td>Action taken as the result of any type of report filed with the Department of Insurance not explicitly contemplated by another origin code. This would include, but not be limited to Statistical Filings and other state mandated filings.</td>
<td>Keep</td>
<td>May also consider Code 1010</td>
</tr>
<tr>
<td>1023</td>
<td>Statistical Filing</td>
<td>Action resulting from litigation or other legal proceeding. This would include, but not be limited to, actions resulting from class actions lawsuits and other legal proceedings.</td>
<td>Delete</td>
<td>Used by 10 states, 59 times. Proposed alternative: (1020) “Insurer Report”</td>
</tr>
<tr>
<td>1025</td>
<td>Legal</td>
<td>Action resulting from litigation or other legal proceeding. This would include, but not be limited to, actions resulting from class actions lawsuits and other legal proceedings.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1030</td>
<td>Market Conduct Exam</td>
<td>Action resulting from a market conduct examination, including but not limited actions resulting from targeted, comprehensive, or desk examinations.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1035</td>
<td>Financial Exam</td>
<td>Action resulting from a financial examination of a regulated entity, including but not limited to actions taken because of routine examinations and premium tax audits.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1040</td>
<td>Workers Comp Exam</td>
<td>Concern resulting from examination of a workers compensation insurer’s business practices and operations in order to determine its compliance with state insurance laws and regulations.</td>
<td>Delete</td>
<td>Used by 3 states, 7 times. Proposed alternatives: (1030) “Market Conduct Exam”, (1035) “Financial Exam”, or both.</td>
</tr>
<tr>
<td>1050</td>
<td>Bankruptcy Notices</td>
<td>Concern resulting from a notice that an insurer or producer has filed for legal insolvency, indicating that the insurer is unable to meet financial obligations to customers and stockholders, or that a producer or agency has financial issues that may impact compliance with state insurance laws and regulations.</td>
<td>Delete</td>
<td>Used by 5 states, 6 times. Proposed alternative: (1025) “Legal”</td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>1055</td>
<td>Third Party Information</td>
<td>Action resulting from information obtained from an outside source that is not explicitly contemplated by another origin code. This would include, but not be limited to actions resulting from information contained in media coverage and other sources of public information.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1060</td>
<td>Licensing / Company Administration</td>
<td>Action resulting from a regulated entity’s licensing status. This would include but not be limited to actions resulting from the submission of applications by the regulatory entity, failure of the entity to provide information in response to an application.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Licensing Administration”</td>
</tr>
<tr>
<td>1063</td>
<td>Background Check</td>
<td>Action resulting from the review of a background check of a producer or employee of a regulated entity. This would include but not be limited to actions stemming from a review of criminal, financial, or disciplinary events regardless of the source that are not explicitly contemplated by another origin code.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>1065</td>
<td>Other*</td>
<td>Action taken that was prompted by information, an activity or event not contemplated by another origin code.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Other if checked you must enter description, up to 100 characters”</td>
</tr>
<tr>
<td>XXXX</td>
<td>Form/Rate/Rule Filing</td>
<td>Action taken as a result of a review/analysis of a regulated entity’s policy form, rate, and/or rule filing. This would include a review/analysis of underwriting guidelines where such filings are required to be made.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Information/Referral from Federal Agency</td>
<td>Action resulting from information or referral from a Federal agency.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Market Conduct Initiative</td>
<td>Action resulting from a market conduct initiative along the continuum of regulatory responses, including but not limited actions resulting from interrogatories, targeted information gathering (i.e. surveys, data calls, etc.), and policy &amp; procedure reviews.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Multi-state Regulatory Action/Settlement</td>
<td>Action resulting from a multi-state regulatory action and/or settlement of a regulated entity. This would include, but not be limited to, actions resulting from a multi-state examination, settlement or other coordinated activity along the continuum or regulatory responses.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Prior Dept. Action</td>
<td>An action taken as the direct result of a prior action taken against the entity or individual. This would include but not be limited to failure to comply with a previous order, lifting of prior orders, suspensions, or restrictions.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Self-reported Information</td>
<td>Action taken as the result of information voluntarily reported by the entity or individual.</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>

*If checked, you must enter a description of up to 100 characters.
# Reason for Action (Revised)

The Reason for Action field is meant to provide information about the reason (allegations) for the regulatory action. The code(s) used should be reflective of allegations associated with the action (i.e. the nature of the violation found). Information about the origin (source) and/or disposition (outcome) of the action should be reported in those respective fields. (max 20)

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

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

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

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

### Marketing & Sales

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Marketing &amp; Sales</td>
<td>Finding of cause resulting from an entity’s activities involving the marketing, advertising and sales of products that are regulated by the Department of Insurance.</td>
<td>Delete</td>
<td>Proposed alternative: use new, more specific code(s) related to marketing and sales</td>
</tr>
<tr>
<td>2012</td>
<td>Unsuitable / Inappropriate Replacement</td>
<td>Failure to comply with mandated replacement and/or suitability statutes and/or regulations.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Life Insurance Replacement Violation” Typically related to life insurance or annuities</td>
</tr>
<tr>
<td>2014</td>
<td>Misrepresentation of Insurance Produce / Policy</td>
<td>Deceptive representations regarding the nature of an insurance product.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>Misleading Advertising</td>
<td>Use of advertising that does not comply with applicable state statutes and/or regulations, including but not limited to false and/or misleading advertising.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Advertising”</td>
</tr>
<tr>
<td>2045</td>
<td>Rebating</td>
<td>Improperly providing monetary inducements to purchase coverage.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2111</td>
<td>Inappropriate Sales or</td>
<td>Inappropriate sales and/or solicitation of</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
</tr>
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</tr>
<tr>
<td>2112</td>
<td>Inappropriate Sales or Solicitation on a Military Installation**</td>
<td>Inappropriate sales or solicitation of insurance products on a military installation, including but not limited to violations of the Military Sales Practices Model Regulation or similar state statute and/or regulation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Disclosure / Outline of Coverage Inadequate / Not Timely / Not Provided</td>
<td>Inadequate procedures to provide full disclosure or appropriate outline of coverage to consumers in connection with the sale of an insurance product.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Failure to Provide Adequate Producer Training, Education, Compliance Oversight</td>
<td>Training materials and communications with producers fail to comply with statute or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Illustrations Inadequate / Not Timely / Not Provided</td>
<td>Sales materials and exhibits fail to contain all required information, disclaimers, or are otherwise misleading.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Marketing &amp; Sales Issue*</td>
<td>Any of marketing and sales violation not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Unfair Marketing &amp; Sales Practice*</td>
<td>Any other unfair marketing and sales practice not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>

### Operations & Management

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2028</td>
<td>TPA Violation</td>
<td>Finding of cause resulting from non-compliance with a state’s Third Party Administrator (TPA) laws and regulations.</td>
<td>Delete</td>
<td>Proposed alternative: (XXXXX) “Failure to Adequately Supervise MGAs, TPAs, or Other 3rd Party Contractor”</td>
</tr>
<tr>
<td>2039</td>
<td>Failure to Maintain Adequate Books &amp; Records</td>
<td>Records are incomplete, inaccessible, inconsistent, or disordered, or fail to conform to state record retention laws.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Failure to Maintain Books &amp; Records”</td>
</tr>
<tr>
<td>2065</td>
<td>Notice of Financial Impairment from Another State</td>
<td>Notification from another state of financial impairment.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2070</td>
<td>Financial Impairment</td>
<td>Finding of cause resulting from an insurer having insufficient assets, capital, policyholder surplus, or reserves to meet financial obligations to customers and stockholders and is therefore ineligible to transact insurance business in the state.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2072</td>
<td>Cure of Financial Impairment</td>
<td>Used when Financial Impairment was reported, where an insurer was found to be ineligible to transact insurance business, has remedied the problem; is now considered solvent and eligible to transact insurance business.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2080</td>
<td>Dissolution</td>
<td>Finding of cause resulting from notification that a producer firm or insurer has been dissolved, disbanded, or liquidated as a corporation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2100</td>
<td>No Certificate of Authority</td>
<td>Finding of cause resulting from notification that an insurer engaging in the business of insurance in a state without authorization from the Department of Insurance.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2101</td>
<td>Exceeded Certificate of Authority</td>
<td>Engaging in activities not contemplated within the scope of authority of an existing certificate of</td>
<td>Code Name Change</td>
<td>Previous Code Name “Certification Violation”</td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
</tr>
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</tr>
<tr>
<td></td>
<td></td>
<td>authority. This could include, but not be limited to, writing lines of business not covered by the existing certificate of authority and/or exceeding geographical boundaries associated with the existing certificate of authority.</td>
<td></td>
<td>Change</td>
</tr>
<tr>
<td>2102</td>
<td>Unauthorized Insurance Business</td>
<td>Finding of cause resulting from an entity engaging in actions that are regulated as the business of insurance without authorization from the Department of Insurance in the state.</td>
<td>Delete</td>
<td>Proposed alternative: (2100) “No Certificate of Authority” and/or (2101) “Exceeded Certificate of Authority”</td>
</tr>
<tr>
<td>XXXX</td>
<td>Failure to Adequately Supervise MGAs, TPAs, or Other 3rd Party Contractor</td>
<td>Failure to exercise an appropriate level of oversight of third parties that assume a business function and act on behalf of an insurer. Example: An MGA that is not operating in accordance with statutes and/or regulations regarding the supervisory responsibility for the local and field operations of an insurer.</td>
<td></td>
<td>New</td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Appeals Practices / Procedures</td>
<td>Improper or inadequate procedures to appeal unsatisfactory claim outcomes. Examples: First-level appeals are reviewed by a qualified medical practitioner. Second-level review processes conform to applicable statute and/or regulation.</td>
<td></td>
<td>New</td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate External / Independent Review Practices / Procedures</td>
<td>Failure to provide appropriate cost-free access to an independent external body to review medical determinations in relations to the terms of a policy or applicable statute and/or regulation.</td>
<td></td>
<td>New</td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Grievance Practices / Procedures</td>
<td>Failure to adhere to policy provisions regarding the handling of complaints or appeals by consumers or health care providers.</td>
<td></td>
<td>New</td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Internal / External Audit Practices / Procedures</td>
<td>Company failed to implement proper surveillance procedures to ensure the absence of significant structural or systemic problems with core functions.</td>
<td></td>
<td>New</td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Network</td>
<td>Failure to provide timely and local access to healthcare providers in accordance with policy provisions or state and/or federal requirements. Example: A health plan network that is not in accordance with requirements mandated by statute and/or regulation related to a network adequacy.</td>
<td></td>
<td>New</td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Provider Credentialing / Monitoring</td>
<td>Failure to ensure that contracted providers are properly licensed and practicing within the scope of their license and at the contracted location.</td>
<td></td>
<td>New</td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Safeguards for Security of Data &amp; Information</td>
<td>Failure to adequately preserve the privacy of confidential or sensitive information. This would include but not be limited to, improper disclosure within a regulated entity, failure of procedures to maintain the integrity of company information stored in electronic or other media, failure to provide appropriate privacy disclosures to consumers, or to notify consumers of security breaches. Example: Failure to maintain adequate information controls, data backup and recovery systems, or to restrict access to sensitive information.</td>
<td></td>
<td>New</td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate Utilization Review</td>
<td>improper procedures or practices associated</td>
<td></td>
<td>New</td>
</tr>
<tr>
<td>Code</td>
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<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>XXXX</td>
<td>Quality Assurance Violation</td>
<td>Inappropriate or inadequate procedures or practices associated with conducting quality assessments and improving health outcomes, including adequately communicating such procedures to health care providers.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Operations &amp; Management Issue*</td>
<td>Any other management and operations issue not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>
### Producer Licensing

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
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<th>Code Status</th>
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</tr>
</thead>
<tbody>
<tr>
<td>2026</td>
<td>Premium Finance Act Violation</td>
<td>Finding of cause resulting from non-compliance with the premium finance act, including but not limited to licensing, record-keeping, policy notices and contractual charges.</td>
<td>Delete</td>
<td>Used by 4 states, 5 times. Proposed alternative: use appropriate “other” code</td>
</tr>
<tr>
<td>2027</td>
<td>Surplus Lines Violation</td>
<td>A producer committed a violation of statutes and/or regulations related to surplus lines business.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2030</td>
<td>Failure to Meet Continuing Education Requirements</td>
<td>A producer failed to meet the mandatory continuing education requirements. This would also include instances where the producer failed to maintain one or more qualifications to hold a license.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2032</td>
<td>Continuing Education Requirements Met</td>
<td>A producer deficient in respects to meeting mandated continuing education requirements is now compliant. This would also include instances where the failure to maintain a qualification required to hold a license has been rectified.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2037</td>
<td>Failure to Notify Department of Address Change</td>
<td>A producer failed to notify the department of a change in address in accordance with statutes and/or regulations. This would include instances where the producer failed to notify the department in a timely manner.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2042</td>
<td>Failure to Pay Child Support / Student Loans</td>
<td>A producer license was denied, suspended, or revoked due to the producer failing to pay child support and/or student loans.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Failure to Pay Child Support”</td>
</tr>
<tr>
<td>2055</td>
<td>Producer / Adjuster / Other Not Properly Licensed</td>
<td>A producer is not properly licensed to transact business for a given line of insurance; or adjuster not properly licensed according to statute or regulation.</td>
<td>Code Name Change</td>
<td>Previous Code Name “No License”</td>
</tr>
<tr>
<td>2056</td>
<td>Demonstrated Lack of Fitness or Trustworthiness</td>
<td>Action taken on a producer license due to a demonstrated lack of fitness and/or trustworthiness. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2058</td>
<td>Misstatement on Application</td>
<td>Action taken on a producer license due to a misstatement on the application. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2059</td>
<td>Failure to Make Required Disclosure on Application</td>
<td>Action taken on a producer license due to the failure to make a required disclosure on the application. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Failure to Make Required Disclosure on application”</td>
</tr>
<tr>
<td>2060</td>
<td>Producer / Adjuster / Other Not Properly Appointed</td>
<td>A producer or adjuster is not properly appointed to an insurer as required by statute or regulation.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Not Appointed”</td>
</tr>
<tr>
<td>2061</td>
<td>Selling for Unlicensed Insurer</td>
<td>A producer solicited on behalf of an unlicensed insurer.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2062</td>
<td>Allowed Business from Agent Not Appointed / Licensed</td>
<td>Finding of cause resulting from an insurer accepting policy applications from producers at a time when they were not licensed or under appointment with that insurer as required by the state’s laws and the company’s requirements.</td>
<td>Delete</td>
<td>Proposed alternative: (2055) “Producer / Adjuster / Other Not Properly Licensed” and/or (2060) “Producer / Adjuster / Other Not Properly Appointed”</td>
</tr>
<tr>
<td>2063</td>
<td>Employed Unlicensed Individuals</td>
<td>Finding of cause resulting from employees of a producer or insurer conducting the business of insurance without required authorization or license from the Department of Insurance.</td>
<td>Delete</td>
<td>Proposed alternative: (2055) “Producer / Adjuster / Other Not Properly Licensed”</td>
</tr>
<tr>
<td>2064</td>
<td>Paid Commission to Un-appointed Agents</td>
<td>Finding of cause resulting from an insurer or producer providing payment or sharing of commissions to producers who are not properly licensed.</td>
<td>Delete</td>
<td>Proposed alternative: (2060) “Producer / Adjuster / Other Not Properly Appointed”</td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
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</tr>
<tr>
<td>2097</td>
<td>Bail Bond Forfeiture Judgment</td>
<td>Action taken on a producer license was due to a bail bond forfeiture judgment. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2075</td>
<td>Failure to Report Other State Action</td>
<td>Action was taken on a producer license due to the failure to report an action taken by another state. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2104</td>
<td>Failure to Remit Premiums to Insurer</td>
<td>A producer failed to remit premiums to an insurer.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2105</td>
<td>Misappropriation of Premium</td>
<td>A producer misappropriated premium.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2106</td>
<td>Forgery / Fraud</td>
<td>A producer committed forgery and/or fraud. This would include, but not be limited to, forgery of an insurance application, providing false evidence insurance, misrepresentation to insurer to obtain policy benefits and/or commission, and other acts of dishonest or fraud. Example: Misrepresentation to insurer to obtain a life insurance policy with the intent to sell interests in the proceeds.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Forgery”</td>
</tr>
<tr>
<td>2107</td>
<td>Criminal Record / History</td>
<td>Action taken on a producer license due a criminal record and/or history. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2108</td>
<td>Criminal Proceedings</td>
<td>Action taken on a producer license due to criminal proceedings. Action could include, but not be limited to, licensure denial, suspension, revocation, or probation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Producer / Adjuster Not Properly Terminated</td>
<td>Failure to adhere to all statutes and regulations regarding the termination of a producer, such as notification requirements to both the producer and the relevant regulation bodies.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Producer / Adjuster Licensing Issue*</td>
<td>Any other violation with respect to licensure and appointment of producers or adjusters not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Failure to Account for Premium Funds</td>
<td>Failure to maintain records showing the deposit, handling, and proper remittance premium funds.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Failure to Maintain Separate Fiduciary Account</td>
<td>Failure to create a fiduciary account for the deposit and remittance of premiums separate from agency operating funds.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Commingling of Premiums with Personal Funds</td>
<td>Failure to keep premium funds separate from personal funds.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Fiduciary/Accounting Violation*</td>
<td>A fiduciary violation not included in an above category, not described by any other reason code, or combination of reason codes</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>

### Underwriting & Rating

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>Underwriting</td>
<td>Finding of cause resulting from the process of selecting, classifying, and rejecting risks in order to assign appropriate rates to insureds.</td>
<td>Delete</td>
<td>Proposed alternative: use new, more specific code(s) related to underwriting</td>
</tr>
<tr>
<td>2050</td>
<td>Rate Violation</td>
<td>Finding of cause resulting from use of premium rates not filed with the Department of Insurance,</td>
<td>Delete</td>
<td>Proposed alternative: use new,</td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
</tr>
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<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>XXXX</td>
<td>Inadequate or Excessive Rate</td>
<td>Rates are either excessive or inadequate in relation to expected exposure presented by the risk and/or expected losses, as defined by statute and/or regulation. Example: Inconsistent application of scheduled rating plan across eligible risks.</td>
<td>New</td>
<td>more specific code(s) related to rating violations</td>
</tr>
<tr>
<td>XXXX</td>
<td>Incorrect Application of Rate</td>
<td>Actual rates charged deviate from the insurer’s established rates or rating plan. This would include, but not be limited to, instances where rates charged are not in accordance with state mandates, filed, do not adhere to filings, and/or improper documentation of modifications exists. Example: Inconsistent application of scheduled rating plan across eligible risks.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Rates Not Filed / Approved</td>
<td>The use of rates that have not been filed or approved by the state insurance department as required by statute or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Rates Unfairly Discriminatory</td>
<td>Like risks are charged different rates in a way not justified by expected loss costs.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Use of Prohibited Rating Factors</td>
<td>Use of factors for rating prohibited by statute or regulation.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Rating Issue*</td>
<td>Any improper rating practice not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>2053</td>
<td>Forms Not Filed &amp;/or Approved</td>
<td>The use of insurance forms that have not been properly filed or approved by the appropriate regulatory authority.</td>
<td>Code Name</td>
<td>Previous Code Name “Use of Unapproved Forms”</td>
</tr>
<tr>
<td>XXXX</td>
<td>Improper Question on Application</td>
<td>Insurance application contains improper questions or otherwise not in accordance with applicable statutes and/or regulations.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Mandated Coverages / Offerings Not Provided</td>
<td>Failure to provide coverage for benefits required by statute or regulation. This would include, but not be limited to, using forms that do not comply with statutes and/or regulations regarding mandated and/or required coverages.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Other Forms Issue*</td>
<td>Any other form violation not described by any other reason code and/or combination of reason codes.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>Cancellation / Non-Renewal Notice Inadequate / Not Timely / Not Provided</td>
<td>Notice of the termination of coverage was not issued, was not issued within timeframes prescribed by statute or policy provisions. This would include instances where notices are inadequate and/or did not contain information required by statutes and/or regulations.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Failure to Send Required Cancellation / Non-Renewal Notice”</td>
</tr>
<tr>
<td>XXXX</td>
<td>Mandatory Disclosures / Notifications Inadequate / Not Timely / Not Provided</td>
<td>Improper issuance of disclosures or notifications, in violation of policy provisions, statute, or regulation. This would include notices of mandated coverage, disclosure of preexisting condition exclusions, or disclosure that credit insurance is optional and not a condition for loan approval. It does not include cancellation or nonrenewal notices, which have a separate code.</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Unfairly Discriminatory Underwriting Practices / Procedures</td>
<td>Underwriting practices that treat like risks differently and violate statutes and/or regulations regarding the fair treatment of risks.</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>
### Miscellaneous

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Market Conduct Examination</td>
<td>Finding of cause resulting from examination of the business practices and operations of an entity in order to determine its compliance with state insurance laws and regulations.</td>
<td>Delete</td>
<td>Describes origin of action. Proposed alternative: (1030) “Market Conduct Exam” Origin of Action code and select the appropriate Reason Code(s) that apply to underlying reason for the action.</td>
</tr>
<tr>
<td>2074</td>
<td>Other States Action</td>
<td>Finding of cause resulting from another state’s Department of Insurance activity about an issue which also affects the entering state.</td>
<td>Delete</td>
<td>Describes origin of action. Proposed alternative: (1015) “Other States Action” Origin of Action code and select the appropriate Reason Code(s) that apply to underlying reason for the action.</td>
</tr>
<tr>
<td>2029</td>
<td>Unfair Insurance Practices Act Violation</td>
<td>Finding of cause resulting from unfair methods of competition or deceptive acts being used, from this Act or the Unfair Trade Practices Act as applied to the business of insurance.</td>
<td>Delete</td>
<td>Proposed alternative: use new, more specific code(s) related to unfair insurance practices.</td>
</tr>
<tr>
<td>2035</td>
<td>Failure to Cooperate with Examination / Investigation / Inquiry</td>
<td>Other failure to cooperate with an examination or investigation. This would include, but not be limited to, failure to respond to appropriate requests for information and/or providing inaccurate or misleading information.</td>
<td>Code Name Change</td>
<td>Previous Code Name “Failure to Respond” If the issue is late or incomplete response, then use 2036.</td>
</tr>
<tr>
<td>2036</td>
<td>Late or Incomplete Response</td>
<td>Failure to respond timely and/or failure to provide a complete response in response to a request for information. This would include, but not be limited to failure to submit timely and complete mandated filings such as statistical reports and annual reports.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
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</tr>
<tr>
<td>2038</td>
<td>Failure to Comply with Previous Order</td>
<td>Failure to comply with an order pertaining to corrective action, as determined by a follow-up examination, investigation, or other means.</td>
<td>Keep</td>
<td>Proposed alternative: use new, more specific code(s) related to fiduciary violations</td>
</tr>
<tr>
<td>2040</td>
<td>Failure to Timely File</td>
<td>Failure to make a filing in a timely manner.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2085</td>
<td>Failure to Pay Tax</td>
<td>Failure to pay tax.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2087</td>
<td>Failure to Pay Fees</td>
<td>Failure to pay fees.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2090</td>
<td>Failure to Pay Fine</td>
<td>Failure to pay fine.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2095</td>
<td>Failure to Pay Assessment</td>
<td>Failure to pay an assessment.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2103</td>
<td>Fiduciary Violation</td>
<td>Finding of cause resulting from producers violating positions of trust in relation to insurers and policyholders.</td>
<td>Delete</td>
<td>Proposed alternative: use new, more specific code(s) related to fiduciary violations</td>
</tr>
<tr>
<td>2110</td>
<td>Reconsideration</td>
<td>The Department of Insurance has re-evaluated a Regulatory Action because of new information received or because the entity has corrected the cause of action.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>2115</td>
<td>Other Miscellaneous*</td>
<td>Any other reason not described by any other reason code and/or combination of reason codes.</td>
<td>Code Name Change Previous Code Name “Other* (enter up to 100 char)”</td>
<td></td>
</tr>
</tbody>
</table>

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

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

**Disposition for Action (Revised)**

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Definition</th>
<th>Code Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3001</td>
<td>License, Denied</td>
<td>The entity or individual applied for a new license or attempted to renew a license and it was denied</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3003</td>
<td>License, Suspended</td>
<td>The entity or individual’s license was suspended. The entity or individual is temporarily prohibited from engaging in the business of insurance.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3004</td>
<td>License, Cancelled</td>
<td>The entity or individual’s license was cancelled.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3006</td>
<td>License, Revoked</td>
<td>The entity or individual’s license was revoked; The entity or individual is prohibited from engaging in the business of insurance.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3009</td>
<td>License, Probation</td>
<td>The entity or individual’s license is subject to a probationary period during which the entity or individual is obligated to comply with certain standards and/or conditions specified by the issuing authority or the license can be cancelled, revoked or suspended.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3010</td>
<td>License, Conditional</td>
<td>The entity or individual’s license is issued on a conditional basis under which the entity or individual must meet certain standards and/or conditions specified by the issuing authority before an unrestricted license can be issued. Failure to meet the conditions may result in license being cancelled, revoked, or suspended by the issuing authority.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3011</td>
<td>License, Supervision</td>
<td>The entity or individual’s license is under supervision of the issuing authority and the</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
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</tr>
<tr>
<td>3012</td>
<td>License, Reinstatement</td>
<td>The license of an entity or individual was reinstated.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3013</td>
<td>License, Granted</td>
<td>A license was granted to an entity or individual as a result of an administrative process regarding a prior action to deny, cancel or revoke a license.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3014</td>
<td>License, Surrendered</td>
<td>The entity or individual’s license was ordered to surrender the license.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3015</td>
<td>License, Voluntarily Surrendered</td>
<td>The entity or individual’s license was voluntarily surrendered by the entity or individual. This disposition is typically associated with situations where the entity or individual agreed to voluntarily surrender the license in lieu of the issuing authority pursuing additional administrative action.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3016</td>
<td>License, Other*</td>
<td>Any other disposition related to an entity or individual license not described by any other disposition code or combination of codes.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3021</td>
<td>Certificate of Authority, Denied</td>
<td>The entity’s application for a certificate of authority or an expansion of an existing certificate of authority was denied by the issuing authority.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3023</td>
<td>Certificate of Authority, Suspended</td>
<td>The regulated entity’s certificate of authority was suspended for a specific time period. During this time period, the entity is prohibited from engaging in the business of insurance in the affected jurisdiction.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3025</td>
<td>Certificate of Authority, Suspension Extended</td>
<td>The suspension of regulated entity’s certificate of authority was extended beyond the initial suspension period. The temporary prohibition from engaging in the business of insurance in the affected jurisdiction is continued.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3026</td>
<td>Certificate of Authority, Revoked</td>
<td>The regulated entity’s certificate of authority was revoked. The entity prohibited from engaging in the business of insurance in the affected jurisdiction.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3028</td>
<td>Certificate of Authority, Expired</td>
<td>The entity failed to take the appropriate action to renew or continue its certificate of authority.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3029</td>
<td>Certificate of Authority, Probation</td>
<td>The regulated entity’s certification of authority is subject to a probationary period during which the entity is obligated to comply with certain standards and/or conditions specified by the issuing authority or the certificate of authority can be cancelled, revoked or suspended.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3031</td>
<td>Certificate of Authority, Reinstated</td>
<td>The regulated entity’s certificate of authority was reinstated.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3034</td>
<td>Certificate of Authority, Surrendered</td>
<td>The entity surrendered its certificate of authority.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3036</td>
<td>Certificate of Authority, Other*</td>
<td>Any other disposition related to a certificate of authority not described by any other disposition code or combination of codes.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3042</td>
<td>Cease and Desist from Violations</td>
<td>The entity was ordered to cease and desist from violations.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Code Name</td>
<td>Definition</td>
<td>Code Status</td>
<td>Notes</td>
</tr>
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<td>-------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>3043</td>
<td>Cease and Desist from all Insurance Activity</td>
<td>The entity or individual was ordered to cease and desist from engaging in the business of insurance.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3044</td>
<td>Remedial Measures Ordered</td>
<td>The entity or individual was ordered to take specific action in order to remediate a situation which caused harm to one or more persons as a result of one or more acts taken by the entity or individual.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3045</td>
<td>Consent Order</td>
<td>The entity or individual entered into a voluntary agreement in order to resolve the issue regulatory issue that is the subject of the action.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3046</td>
<td>Stipulated Agreement/Order from a commissioner</td>
<td>The entity or individual entered into a stipulated agreement which was approved via a formal process (i.e. approved by an administrative law judge or hearing examiner) in order to resolve the issue regulatory issue that is the subject of the action.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3047</td>
<td>Previous Order Vacated / Stayed / Set Aside</td>
<td>A previous order under which the entity or individual was subject has been set aside, nullified, cancelled, or rescinded. Or an order that postpones or suspends a previous order.</td>
<td>Code Name</td>
<td>Previous Code Name “Previous Order Vacated”</td>
</tr>
<tr>
<td>3048</td>
<td>Ordered to Provide Requested Information</td>
<td>The entity or individual has been ordered to produce information requested by the jurisdiction under its statutory authority.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3049</td>
<td>Stayed Order</td>
<td>The Department of Insurance stops a previously issued order from being put into effect.</td>
<td>Delete</td>
<td>Used by 3 states, 10 times. Proposed alternative: (3047) “Previous Order Vacated / Stayed / Set Aside”</td>
</tr>
<tr>
<td>3051</td>
<td>Final Agency Order</td>
<td>The final agency order was issued against the entity or individual.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3052</td>
<td>Ordered to Comply with Specific Statute or Regulation</td>
<td>The entity or individual was ordered comply with a specific insurance statute, rule, and/or regulation.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3055</td>
<td>Reprimanded / Censured</td>
<td>The entity or individual was formally reprimanded or censured.</td>
<td>Code Name</td>
<td>Previous Code Name “Reprimanded”</td>
</tr>
<tr>
<td>3060</td>
<td>Hearing Waiver</td>
<td>The entity or individual waived their right to a hearing.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3065</td>
<td>Show Cause</td>
<td>An order directing the entity or individual to appear before the reporting jurisdiction to explain why they took or failed to act or why the reporting jurisdiction should or should not grant some relief.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3070</td>
<td>Re-exam</td>
<td>The Department of Insurance orders a follow-up examination of an entity to ensure compliance with state laws and regulations.</td>
<td>Delete</td>
<td>Used by 4 states, 11 times. Proposed alternative: (3105) “Other”</td>
</tr>
<tr>
<td>3075</td>
<td>Rescission of</td>
<td>The Department of Insurance retracts a previous action or order. An additional Disposition code must be selected to identify what was rescinded. If Other is selected, text explanation must be entered into the Other action disposition field.</td>
<td>Keep</td>
<td></td>
</tr>
<tr>
<td>3076</td>
<td>Involuntary Forfeiture</td>
<td>The Department of Insurance requires the surrender of the authority of an individual or firm to engage in the business of insurance in the state because of a crime, offense, or</td>
<td>Delete</td>
<td>Used by 0 states, 0 times. Proposed alternatives: (3102) “Monetary Penalty” or (3103)</td>
</tr>
</tbody>
</table>

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

* If checked, you must enter a description of up to 100 characters.
Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation

Mutual Recognition of Jurisdictions (E) Working Group
Process for Evaluating Jurisdictions that Recognize and Accept
the Group Capital Calculation

1. **Group Capital Calculation.** On December 9, 2020, the NAIC adopted revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). These revisions implement the Group Capital Calculation (GCC) filing requirements for insurance groups at the level of the ultimate controlling person for the purposes of evaluating solvency at the group level. The revisions specifically provide that the requirement to file the NAIC’s GCC applies to U.S.-based groups, while a group headquartered outside the U.S. is exempt from the GCC (subject to limited exceptions)¹ if its group-wide supervisor “recognizes and accepts” the GCC for U.S. groups doing business in that jurisdiction. Likewise, a U.S. group subject to a group capital calculation specified by the Federal Reserve Board is exempt from the GCC. This process codifies the concepts of mutual recognition and one group/one group-wide supervisor.

2. **NAIC Listing Process.** Section 4L(2) of Model #440 provides two ways a non-U.S. jurisdiction may meet the standards for its insurance groups to be exempt from the GCC:

   (a) If the jurisdiction has been determined to be a Reciprocal Jurisdiction for purposes of credit for reinsurance, which includes a requirement that the jurisdiction “recognizes the U.S. state regulatory approach to group supervision and group capital”;² or

   (b) If the jurisdiction has otherwise been determined to recognize and accept the GCC by procedures specified in regulation.

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

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

² Model #440. § 4L(2)(c).
3. **Covered Agreements.** The “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” was signed on September 22, 2017. On December 18, 2018, a similar Covered Agreement was signed with the United Kingdom (UK) (collectively “Covered Agreements”). The Covered Agreements include, inter alia, the elimination of reinsurance collateral requirements for certain reinsurers licensed and domiciled in participating jurisdictions, and limit the worldwide application of prudential group insurance measures on insurance groups based in participating jurisdictions. In relevant part, the Covered Agreements provide that U.S. insurers and reinsurers can operate in the EU and UK without subjecting the U.S. parent to the host jurisdiction’s group-level governance, solvency and capital, and reporting requirements, and also provide the same protections for EU and UK insurers and reinsurers operating in the U.S. However, the Covered Agreements only exempt U.S., EU and UK insurance groups from each other’s worldwide group capital requirements if the home supervisor performs worldwide group capital assessments on its own insurance groups and has the authority to impose preventive and corrective measures.

4. **Reciprocal Jurisdictions.** In response to the Covered Agreements, the NAIC also amended the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) to provide that jurisdictions that are subject to in-force covered agreements are considered to be “Reciprocal Jurisdictions,” and large, financially strong reinsurers that are based in those jurisdictions are not required to post reinsurance collateral. In addition, a “Qualified Jurisdiction” under Section 2E of Model #785 may become a Reciprocal Jurisdiction if, among other requirements, it “recognizes the U.S. state regulatory approach to group supervision and group capital.” By the terms of the Covered Agreements, insurance groups based in EU Member States and the UK are entitled to exemption from the extraterritorial application of the U.S. GCC, and Section 4L(2)(c) of Model #440 recognizes that other Reciprocal Jurisdictions, which have made the same commitment, are entitled to the same treatment.

5. **Other Jurisdictions that Recognize and Accept.** In addition, because most of the requirements for Reciprocal Jurisdiction status are not relevant to group capital and group supervision, Section 4L(2)(d) of Model #440 provides an alternative pathway for the exemption. The ultimate controlling person of an insurance holding company system whose non-U.S. group-wide supervisor is not in a Reciprocal Jurisdiction is exempted from filing the GCC as long as the jurisdiction of its group-wide supervisor “recognizes and accepts” the GCC, as specified by the commissioner in regulation. Section 21D of Model #450 provides that a non-U.S. jurisdiction is considered to “recognize and accept” the GCC if it satisfies all of the following criteria:
(a) The non-U.S. jurisdiction recognizes the U.S. state regulatory approach to group supervision and group capital, by providing confirmation by a competent regulatory authority, in such jurisdiction, that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction;

(b) Where no U.S. insurance groups operate in the non-U.S. jurisdiction, that non-U.S. jurisdiction indicates formally in writing to the lead state with a copy to the International Association of Insurance Supervisors that the group capital calculation is an acceptable international capital standard. This will serve as the documentation otherwise required in Section 21D(1)(a);

(c) The non-U.S. jurisdiction provides confirmation by a competent regulatory authority in such jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC. The commissioner shall determine, in consultation with the NAIC Committee Process, if the requirements of the information sharing agreements are in force;

(d) Notwithstanding these exemptions, Section 4L(2)(e) of Model #440 provides that a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system from a Reciprocal Jurisdiction or “Recognize and Accept” Jurisdiction where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. Section 21E(1) of Model #450 then provides that to assist with a determination under Section 4L(2)(e) of Model #440, the list will also identify whether a jurisdiction that is exempted under either Sections 4L(2)(c) or 4L(2)(d) requires a group capital filing for any U.S.-based insurance group’s operations in that non-U.S. jurisdiction.
6. **Mutual Recognition of Jurisdictions (E) Working Group.** On March 8, 2021, the Financial Condition (E) Committee repositioned the Qualified Jurisdiction (E) Working Group to report directly to the Committee and revised the name of the group to the Mutual Recognition of Jurisdictions (E) Working Group. The Working Group received the additional charge of developing a process for evaluating jurisdictions that meet the NAIC requirements for recognizing and accepting the GCC (“Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation,” or “Recognize and Accept” Process). A separate process exists for evaluating Qualified and Reciprocal Jurisdictions (“Process for Evaluating Qualified and Reciprocal Jurisdictions”), and it is intended that the “Recognize and Accept” Process will closely mirror this process. The Committee charged this Working Group with developing and implementing the “Recognize and Accept” Process due to this Working Group’s experience and expertise in evaluating the insurance regulatory systems of non-U.S. jurisdictions and their recognition of U.S. group-wide supervision.

7. **List of Jurisdictions that Recognize and Accept the GCC.** The Mutual Recognition of Jurisdictions (E) Working Group will evaluate non-U.S. jurisdictions in accordance with this “Recognize and Accept” Process. A list of “Recognize and Accept” Jurisdictions is published through the NAIC committee process (“NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation”; “Recognize and Accept’ List”; or “List”). The creation of the List does not constitute a delegation of regulatory authority to the NAIC. Although a state must consider this List under Section 21E(3) of Model #450 in its determination of whether a non-U.S. insurance group is exempt from filing an annual GCC, the List is not binding and the ultimate authority to designate a “Recognize and Accept” Jurisdiction resides solely in each state.

   (a) The List will include all Reciprocal Jurisdictions that recognize the U.S. state regulatory approach to group supervision and group capital. [See discussion in paragraph 9.]

   (b) The evaluation of non-U.S. jurisdictions that are non-Reciprocal Jurisdictions as “Recognize and Accept” Jurisdictions will be conducted in accordance with the provisions of Section 4L(2) of Model #440 and Section 21 of Model #450, and any other relevant guidance developed by the NAIC. [See discussion in paragraphs 10 and 11.]

   (c) As specified in Section 21E(1) of Model #450, the List will also identify which “Recognize and Accept” Jurisdictions require a group capital filing for a U.S.-based insurance group’s operations in that jurisdiction. [See discussion of Subgroup Capital Calculation in paragraph 13.]
(d) Upon final inclusion of a jurisdiction on the List, any confidential documents reviewed by the Mutual Recognition of Jurisdictions (E) Working Group in its evaluation of the jurisdiction will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential. The NAIC will maintain the List on its public website and in other appropriate NAIC publications.

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

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

(a) **Initiation of Evaluation.** Formal notification of the Mutual Recognition of Jurisdictions (E) Working Group’s intent to initiate the evaluation process will be sent by the NAIC to the supervisory authority in the jurisdiction selected. The process of evaluation and all related documentation are private and confidential matters between the NAIC and the applicant jurisdiction, unless otherwise provided in this document. Upon receipt of confirmation by a competent regulatory authority of the non-U.S. jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group:

i. Will direct NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise to review the materials received from the jurisdiction. Upon completing its review of the evaluation materials, the internal reviewer(s) will report initial findings to the Mutual Recognition of Jurisdictions (E) Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation. Copies of the initial findings may also be made available to the Federal Insurance Office (FIO) and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.

ii. Will issue public notice on the NAIC website inviting public comments with respect to consideration of the jurisdiction as a “Recognize and Accept” Jurisdiction.
iii. Will consider public comments from state regulators, U.S. insurance groups, and any other interested parties.

iv. May review other public materials deemed relevant to making a determination.

v. Will invite each non-U.S. jurisdiction, or its designee, to provide any additional information it deems relevant to making a determination.

vi. Relevant U.S. state and federal authorities will be notified of the Mutual Recognition of Jurisdictions (E) Working Group’s decision to evaluate a jurisdiction.

(b) Preliminary Evaluation Report. NAIC staff will prepare a Preliminary Evaluation Report for review by the Mutual Recognition of Jurisdictions (E) Working Group. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a “Recognize and Accept” Jurisdiction. Upon review by the Working Group, the results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review. At that time, a copy of the Preliminary Evaluation Report will also be shared with the Group Capital Calculation (E) Working Group in regulator-to-regulator session. The Group Capital Calculation (E) Working Group will also be kept advised of any new developments in the evaluation of this jurisdiction.

(c) Final Evaluation Report. Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. The Mutual Recognition of Jurisdictions (E) Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session.

(d) Summary of Findings and Determination. Upon approval of the Final Evaluation Report, the Mutual Recognition of Jurisdictions (E) Working Group will issue a public statement and a summary of its findings with respect to its determination. At this time, the Working Group will release the Summary of Findings and Determination for public comment. Once the Working Group has finally adopted the Summary of Findings and Determination in open session after opportunity for public comment, it will submit the summary of its findings and its recommendation to the Financial Condition (E) Committee at an open meeting. Upon approval by the Committee, the summary and recommendation will be submitted to the Executive (EX) Committee and Plenary, as well as to the Federal Insurance Office (FIO), United States Trade Representative (USTR) and other relevant federal authorities for informational purposes. Upon approval as a “Recognize and Accept” Jurisdiction by the Executive
Committee and Plenary, the jurisdiction will be added to the NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation.

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

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

(a) The Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination the representations in the written confirmation are true and accurate.

(b) The jurisdiction must also have an acceptable Memorandum of Understanding to be included on the “Recognize and Accept” List, as described in paragraph 12 of this Process.
NAIC staff will work with the Mutual Recognition of Jurisdictions (E) Working Group and the applicant jurisdiction to prepare an acceptable confirmation letter for this purpose. The NAIC will publish a form letter in the Appendix: Letter Templates that a competent regulatory authority of a non-U.S. jurisdiction may use to provide confirmation pursuant to Section 21D(1)(a), Section 21D(1)(b) and 21D(2) of Model #450 as well as a template letter that any “Recognize and Accept” Jurisdiction, including a Reciprocal Jurisdiction, may use to provide confirmation, pursuant to Section 21(E)(1) of Model #450, as to whether or not it requires a group capital filing for any U.S. based insurance group’s operations. NAIC Staff will work with the jurisdiction to modify these forms if necessary for a particular jurisdiction.

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

(a) The Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm that, to the best of its determination, the representations in the written confirmation are true and accurate.

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

(c) NAIC staff will work with the Mutual Recognition of Jurisdictions (E) Working Group and the applicant jurisdiction to prepare an acceptable confirmation letter for this purpose.

12. Memorandum of Understanding.
Section 21D(2) of Model #450 requires a non-Reciprocal Jurisdiction that “recognizes and accepts” the GCC to provide confirmation by a competent regulatory authority that information regarding insurers, and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner of any U.S.-
based insurance group doing business in that jurisdiction, in accordance with a memorandum of understanding or similar document between the commissioner and the jurisdiction. Acceptable MOUs include, but are not limited to, the International Association of Insurance Supervisors Multilateral Memorandum of Understanding (“IAIS MMoU”) or other multilateral memoranda of understanding coordinated by the NAIC. The Mutual Recognition of Jurisdictions (E) Working Group will review such memoranda of understanding and include an opinion in the Summary of Findings and Determination as to whether the jurisdiction has met this condition to be included on the “Recognize and Accept” List.

(a) The lead state will act as a conduit for information between the “Recognize and Accept” Jurisdiction and other states that have an insurer from that jurisdiction, and will share information with these states consistent with the terms governing the further sharing of information included in the applicable MOU, and pursuant to the NAIC Master Information Sharing and Confidentiality Agreement. The jurisdiction must also confirm in writing that it is willing to permit this lead state to act as the contact for purposes of sharing information concerning all insurers within the group.

(b) If a jurisdiction has not been approved by the IAIS as a signatory to the MMoU, it must either (1) enter into an MOU with the lead state, or (2) enter into an MOU with a state that has agreed to serve as a single point of contact for multiple lead states, similar to the procedure for sharing information under the Process for Evaluating Qualified and Reciprocal Jurisdictions. The MOU must also provide for appropriate confidentiality safeguards with respect to the information shared among the jurisdictions.

(c) The same requirements and procedures will apply to a Reciprocal Jurisdiction that is subject to a case-by-case “recognize and accept” review, unless the necessary information-sharing procedures are already specified in the applicable covered agreement.

13. Prudential Oversight and Solvency Monitoring. Section 4L(2)(e) of Model #440 directs a lead state commissioner to require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system based in a “Recognize and Accept” Jurisdiction if, after any necessary consultation with other supervisors or officials, the commissioner deems such a “subgroup” calculation to be appropriate for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. Section 21E(1) of Model #450 provides that to assist with such a determination, the “Recognize and Accept” List will also identify whether a listed jurisdiction requires a group capital filing for any U.S. based insurance group’s operations in that jurisdiction. As part of Paragraph 8, Procedure for Evaluation of Non-U.S. Jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential
documents to confirm whether or not any “Recognize and Accept” Jurisdiction requires a subgroup group capital filing for a U.S.-based insurance group’s operations, and a discussion and findings on this review will be included in the Preliminary Evaluation Report, Final Evaluation Report and Summary of Findings and Determination. If the Working Group has evidence indicating that a jurisdiction requires a subgroup group capital filing for any U.S.-based insurance group’s operations in that jurisdiction, it will attempt to obtain written confirmation of the existence and scope of any such requirement from a competent regulatory authority in that jurisdiction, but it is recognized that such a confirmation is not an essential element of the Working Group’s determination. The NAIC will identify such jurisdictions on the “Recognize and Accept” List, and may include an explanatory note in cases where a simple “Yes” or “No” response does not adequately describe the jurisdiction’s requirements. States may rely on this List when making determinations under Section 4L(2)(e) of Model #440.

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

(a) Upon determination by a lead state commissioner that a non-U.S. jurisdiction no longer meets one or more of the requirements to “recognize and accept” the GCC, the lead state commissioner may provide a recommendation to the Working Group that the jurisdiction be removed from the “Recognize and Accept” List. Upon review and after consultation with the “Recognize and Accept” Jurisdiction, the Working Group may remove the jurisdiction from the List, which must then be confirmed by the Financial Condition (E) Committee and the NAIC Executive (EX) Committee and Plenary.

(b) Upon determination by a lead state commissioner that a non-U.S. jurisdiction requires a group capital filing for any U.S. based insurance group’s operations in that non-U.S. jurisdiction, the lead state commissioner may provide a recommendation to the Working Group that the non-U.S. jurisdiction be identified as such on the “Recognize and Accept” List. Upon receipt of any such notice, the Mutual Recognition of Jurisdictions (E) Working Group will also consider whether it is necessary to re-evaluate the jurisdiction’s “Recognize and Accept” status.

(c) The Mutual Recognition of Jurisdictions (E) Working Group will also give due consideration to any notice from a U.S.-based insurance group that it has been
required to perform a group capital calculation, at either the group-wide or subgroup level, in a jurisdiction on the “Recognize and Accept” List.

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

Appendix: Letter Templates

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

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

As the competent regulatory authority for [non-U.S. Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories the following:

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

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

- [Non-U.S. Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

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

As the competent regulatory authority and lead insurance regulatory supervisor for [non-U.S. Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories, with a copy to the International Association of Insurance Supervisors (IAIS), the following:

- [Non-U.S. Jurisdiction] recognizes the Group Capital Calculation as defined under Section 4L(2) of the NAIC Insurance Holding Company System Regulatory Act (#440) as an acceptable international capital standard.

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

- [Non-U.S. Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.
C. Jurisdictions with Subgroup Capital Requirements. Paragraph 13 of the Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation provides that the Mutual Recognition of Jurisdictions (E) Working Group will attempt to obtain written confirmation from a competent regulatory authority in any jurisdiction where the Working Group has evidence indicating that the jurisdiction requires a subgroup group capital filing for any U.S. based insurance group’s operations in that jurisdiction. The NAIC will identify such jurisdictions on the “Recognize and Accept” List, and will provide an explanation and discussion on such determination in its Summary of Findings and Determination. States may rely on this List when making determinations under Section 4L(2)(e) of Model #440.
ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers

Reinsurance Financial Analysis (E) Working Group
ReFAWG Review Process for Passporting
Certified and Reciprocal Jurisdiction Reinsurers
(“ReFAWG Review Process”)

1. ReFAWG Review Process

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

a. In November 2011, the NAIC adopted revisions to its Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) which reduce the prior reinsurance collateral requirements for non-U.S. licensed reinsurers that are licensed and domiciled in Qualified Jurisdictions and establish a certification process for reinsurers under which a Certified Reinsurer is eligible for collateral reduction with respect to contracts entered into or renewed subsequent to certification. The authority to issue individual ratings of certified reinsurers is reserved to the NAIC member jurisdictions under their respective statutes and regulations. While this forum is intended to strengthen state regulation and prevent regulatory arbitrage, it is not within the authority of the Working Group to assign collateral requirements for individual reinsurers.

b. On June 25, 2019, the NAIC adopted further revisions to the models, which implement the reinsurance collateral provisions of the Covered Agreements with the European Union (EU) and the United Kingdom (UK). The revisions eliminate reinsurance collateral requirements and local presence requirements for EU and UK reinsurers that maintain a minimum amount of own-funds equivalent to $250 million USD and a solvency capital requirement (SCR) of 100% under Solvency II. The revisions also incorporate the “Reciprocal Jurisdiction” concept. Reciprocal Jurisdiction status is afforded to (1) jurisdictions subject to an in-force Covered Agreement within the U.S.; (2) accredited U.S. jurisdictions; and (3) Qualified Jurisdictions if they meet certain requirements in the credit for reinsurance models. ReFAWG has also been given additional responsibilities with respect to these “Reciprocal Jurisdiction Reinsurers.” ReFAWG will coordinate its efforts with the Mutual Recognition of Jurisdictions (E) Working Group (formerly known as the Qualified Jurisdictions (E) Working Group).

c. Issues upon which the Working Group may provide advisory support and assistance include but are not limited to:

i. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for
reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.

ii. Provide a forum for discussion, among NAIC jurisdictions, of reinsurance issues related to specific companies, entities or individuals.

iii. Support, encourage, promote and coordinate multi-state efforts in addressing issues related to certified reinsurers, including but not limited to multi-state recognition of certified reinsurers.

iv. Provide analytical expertise and support to the states with respect to certified reinsurers and applicants for certification.

v. Interact with domiciliary regulators of ceding insurers and certifying states to assist and advise on the most appropriate regulatory strategies, methods and actions with respect to certified reinsurers.

vi. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.

vii. Ensure the public passporting website remains current.

viii. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective approaches for the financial solvency surveillance to assist the states in their work to protect the interests of policyholders.

2. **Lead States and Passporting Process**

   a. A reinsurer seeking recognition as either a Certified Reinsurer or a Reciprocal Jurisdiction Reinsurer must submit certain information to each state in which it seeks such recognition. A reinsurer may decide to make a filing with a Lead State and use the NAIC Passporting process to facilitate multi-state recognition or a reinsurer may decide to submit the information to each state as a separate application. Under the ReFAWG Review Process, ReFAWG will assist the states with the initial review of this information and provide guidance to the states in making their review of the reinsurer to determine whether it has met the regulatory requirements to be recognized as a Certified Reinsurer and/or a Reciprocal Jurisdiction Reinsurer.

   b. **Passporting for Certified Reinsurers** - In addition to this assistance to individual states, ReFAWG will also assist with a passporting process for the states. “Passporting” refers to the process under which a state has the discretion to defer to the certification of a reinsurer (and the rating assigned to that certified reinsurer) by another state. Under this process, a reinsurer will apply to an initial state for certification, referred to as the “Lead State,” which will begin its analysis of the reinsurer and notify ReFAWG of the application. The Lead State will complete its initial analysis and will submit filing information and other documentation to ReFAWG for a peer review. Upon completion of the confidential peer review process, ReFAWG will make its recommendation concerning both the certified status of the reinsurer and its rating. The Lead State then makes the final determination regarding certification, upon which the Lead State notifies ReFAWG and the certified reinsurer is eligible to apply for passporting into other states. States are encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings.
c. **Passporting for Reciprocal Jurisdiction Reinsurers** - A similar Passporting Process is in place with respect to Reciprocal Jurisdiction Reinsurers as outlined in Sections 5 and 6 below. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination with respect to compliance with this section. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings.

d. **Discretion to Defer to Lead State** - If an NAIC accredited jurisdiction has determined that the conditions set forth for recognition as a Reciprocal Jurisdiction Reinsurer have been met, the commissioner of any other state has the discretion to defer to that jurisdiction’s determination and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit. The commissioner may accept financial documentation filed with the Lead State or with the NAIC and is encouraged to support a uniform submission and approval process among the states of the NAIC. ReFAWG and the Mutual Recognition of Jurisdictions (E) Working Group will coordinate efforts to obtain financial information regarding both Certified Reinsurers and Reciprocal Jurisdiction Reinsurers and disseminate it to the states.

e. **Communication with ReFAWG** - The ReFAWG Review Process is designed to facilitate communication of relevant information with respect to individual reinsurers or reinsurance related issues by allowing interested state insurance regulators the opportunity to monitor the ReFAWG meetings and discussion. It should be noted that the process for engaging ReFAWG in the consideration of an application is intended to be flexible. Specific circumstances may necessitate discussion between ReFAWG and any states that have received any application in order to determine an appropriate lead state on a case-by-case basis.

f. **Change of Lead State** - The Lead State for a Certified Reinsurer and/or a Reciprocal Jurisdiction Reinsurer may change based upon mutual agreement between the current lead state and any other state where the reinsurer is recognized, with input to be provided by ReFAWG. Upon a change in lead state, NAIC staff will provide timely notification to all states. In order to facilitate a change of lead state from one state to another, both states should discuss the rationale for the change during a regulator-only ReFAWG meeting. NAIC Staff will update the lead state and note such change on NAIC systems and send notice to ReFAWG and interested regulators.

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

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

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

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

a. **Qualified Jurisdiction** - The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction. The applicant must be in good standing and provide a copy of the certificate of authority or license to transact insurance and/or reinsurance business.

b. **Capital and Surplus** - The assuming insurer must maintain capital and surplus of no less than $250,000,000 as reported within its audited financial statement. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

c. **Financial Strength Ratings** - The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. The applicant must provide the rating agency report. If the rating is a group rating, the rationale for the group rating must be provided. Initial or Affirmed financial strength rating dates must be within 15 months of the application date/renewal filing date. Acceptable rating agencies include: A.M. Best, Fitch Ratings, Moody’s, Standard & Poor’s or any other Nationally Recognized Statistical Rating Organization by the SEC. *Kroll is not recognized as an acceptable rating organization in Model #786 but has been recognized as an acceptable rating organization by the Reinsurance (E) Task Force.*
d. The following table outlines the necessary ratings needed to meet a secure level:

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Collateral Required</th>
<th>A.M. Best</th>
<th>Standard &amp; Poor’s</th>
<th>Moody’s</th>
<th>Fitch</th>
<th>Kroll</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure – 1</td>
<td>0%</td>
<td>A++</td>
<td>AAA</td>
<td>Aaa</td>
<td>AAA</td>
<td>AAA</td>
</tr>
<tr>
<td>Secure – 2</td>
<td>10%</td>
<td>A+</td>
<td>AA+, AA, AA-</td>
<td>Aa1, Aa2, Aa3</td>
<td>AA+, AA, AA-</td>
<td>AAA, AA, AA-</td>
</tr>
<tr>
<td>Secure – 3</td>
<td>20%</td>
<td>A</td>
<td>A+, A</td>
<td>A1, A2</td>
<td>A+, A</td>
<td>A+, A</td>
</tr>
<tr>
<td>Secure – 4</td>
<td>50%</td>
<td>A-</td>
<td>A-</td>
<td>A3</td>
<td>A-</td>
<td>A-</td>
</tr>
<tr>
<td>Secure – 5</td>
<td>75%</td>
<td>B++, B+</td>
<td>BBB+, BBB, BBB-</td>
<td>Baa1, Baa2, Baa3</td>
<td>BBB+, BBB, BBB-</td>
<td>BBB+, BBB, BBB-</td>
</tr>
</tbody>
</table>

e. **Protocol for Considering a Group Rating** - Section 8B(4) of the Credit for Reinsurance Model Regulation (#786) provides, in relevant part: “Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate....”

Understanding the rating agency basis for utilizing a group rating is a key factor in determining whether an applicant’s group rating may be considered appropriate. The recommended protocol for understanding the rationale involves one or more of the following protocol steps:

i. For reasons set forth in the rating agency report or its published ratings standards or guidelines, the rating agency utilizes the group rating as a consequence of finding that the company had sufficient interconnectivity with the group;

ii. For reasons set forth in the rating agency report or its published ratings standards or guidelines, the rating agency enhances the group rating due to the subsidiary’s potential benefit of capital support from one or more affiliated companies;

iii. The group rating was utilized because the subsidiary derives benefit from its inclusion within a financially strong and well-capitalized insurance group;
iv. The lead state has contacted the rating agency and was provided a written explanation for the use of the group rating;

v. Other factors deemed appropriate by the Reinsurance Financial Analysis (E) Working Group; or

vi. To assist the Lead State in the assessment of the appropriateness of the use of a group rating, applicants are encouraged to provide their rational for the use of a group rating.

f. Changes in Ratings

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

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

As part of the ongoing review process, other information may come to the attention of a certifying state and/or ReFAWG that warrants consideration with respect to a certified reinsurer’s rating/status. While ReFAWG cannot require a state to delay any action with respect to a certified reinsurer’s rating/status, certifying states are strongly encouraged to notify ReFAWG prior to taking any related action, as the ReFAWG process will serve to provide a proactive regulatory mechanism for communication of such information, discussion among regulators with respect to changes being considered on the basis of subjective rating criteria, and possible coordination of applicable effective dates if such changes are enacted. Upon receipt of any such information, ReFAWG will send notification to the NAIC Chief Financial Regulators listing and may coordinate an interim meeting as deemed appropriate in order to discuss the issue(s).
g. **Schedule F/S (Ceded Reinsurance)** – Applicants domiciled in the U.S. must provide the most recent NAIC Annual Statement Blank Schedule F (property/casualty) and/or Schedule S (life and health). Applicants domiciled outside the U.S. must provide Form CR-F (property/casualty) and/or Form CR-S (life and health), completed in accordance with the instructions.

h. **Disputed and/or Overdue Reinsurance Claims** - The applicant must provide a detailed explanation regarding reinsurance obligations to U.S. cedents that are in dispute and/or more than 90 days past due that exceed 5% of its total reinsurance obligations to U.S. cedents as of the end of its prior financial reporting year or reinsurance obligations to any of the top 10 U.S. cedents (based on the amount of outstanding reinsurance obligations as of the end of its prior financial reporting year) that are in dispute and/or more than 90 days past due exceed 10% of its reinsurance obligations to that U.S. cedent. The applicant must then provide a description of its business practices in dealing with U.S. ceding insurers and a statement that the applicant commits to comply with all contractual requirements applicable to reinsurance contracts with U.S. ceding insurers.

i. **Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer** - The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. Use of multi-beneficiary trust must include: (1) approval from the domiciliary regulator; (2) the form of the trust that will be used as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant’s certified reinsurer status (if applicable).

j. **Regulatory Actions** – The applicant must provide a description of any regulatory actions taken against the applicant. Include details on all regulatory actions, fines, and penalties. Further, a description of any changes in with respect to the provisions of the applicant’s domiciliary license should be provided.

k. **Audited Financial Report and Actuarial Opinion** – As filed with its non-U.S. jurisdiction supervisor, with a translation into English, the applicant must file audited financial statement for the current and prior year and an actuarial opinion (must be stand-alone, or the functional equivalent under the Supervisor’s applicable Actuarial Function Holder Regime).

l. **Solvent Schemes of Arrangement** - The applicant must provide a description of any past, present, or proposed future participation in any solvent scheme of arrangement, or similar procedure, involving U.S. ceding insurers.

m. **Form CR-1** - The applicant must provide a state lead state specific Form CR-1, which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form.

n. **Other Requirements** - The applicant must commit to comply with other reasonable requirements deemed necessary for certification by the certifying state. Further, the applicant must provide a statement that it agrees to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.
o. **Public Notice** - The commissioner is required to post notice on the insurance department’s website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The commissioner may not take final action on the application until at least 30 days after posting such notice. The commissioner will consider any comments received during the public notice period with respect to this application.

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

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

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

a. **Qualified Jurisdiction** - The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction.

b. **Verification of Certification Issued by an NAIC Accredited Jurisdiction** – The applicant must provide a copy of the approval letter or other documentation provided to the applicant by the NAIC accredited jurisdiction. The letter should include the state, rating and collateral percentage assigned, effective date, lines of business, and the applicant’s statement on compliance. ReFAWG may also verify a certification issued by an NAIC accredited jurisdiction through its internal processes.

c. **Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer** - The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. Use of multi-beneficiary trust must include: (1) approval from the domiciliary regulator; (2) the form of the trust that will be used as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant’s certified reinsurer status (if applicable).

d. **Form CR-1** - The applicant must provide a state lead state specific Form CR-1, which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form.

e. **Other Requirements** - The applicant must commit to comply with other reasonable requirements deemed necessary for certification by the certifying state. Further, they must provide a statement that they agree to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.

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

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

**Annual Verification of Minimum Standards:**

<table>
<thead>
<tr>
<th>Timeline Event</th>
<th>Required Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Documents Filed with Lead State</td>
<td>June 30</td>
</tr>
<tr>
<td>Required Passporting Documents Uploaded to NAIC ReFAWG Database</td>
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</tr>
<tr>
<td>NAIC Staff Re-Verification Process and Conference Calls</td>
<td>September 1 – November 30</td>
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<tr>
<td>All Passporting Re-Verifications Completed</td>
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<tr>
<td>Effective Date of Passporting Re-Verification</td>
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</tr>
<tr>
<td>Applications for Passporting</td>
<td>1/1/xx to 12/31/xx</td>
</tr>
</tbody>
</table>

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

a. **Status of Reciprocal Jurisdiction** - The assuming insurer must be licensed to write reinsurance by, and have its head office or be domiciled in, a Reciprocal Jurisdiction that is listed on the *NAIC List of Reciprocal Jurisdictions*. A “Reciprocal Jurisdiction” is a jurisdiction, as designated by the commissioner, that meets one of the following: (1) a non-U.S. jurisdiction that is subject to an in-force Covered Agreement with the United States; (2) a U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Standards and Accreditation Program; or (3) a Qualified Jurisdiction that has been determined by the commissioner to meet all applicable requirements to be a Reciprocal Jurisdiction. The Reciprocal Jurisdiction Reinsurer should identify which type of jurisdiction it is domiciled in and provide any documentation to confirm this status if requested by the commissioner.

b. **Minimum Capital and Surplus** - The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction: no less than $250,000,000 (USD); or if the assuming insurer is an association, including incorporated and individual unincorporated underwriters: minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least $250,000,000 (USD); and a central fund containing a balance of the equivalent of at least $250,000,000 (USD). The assuming insurer’s supervisory authority must confirm to the Lead State commissioner on an annual basis according to the methodology of its domiciliary jurisdiction that the assuming insurer satisfies this requirement. The Mutual Recognition of Jurisdictions (E) Working Group will coordinate the
confirmations of the domiciliary jurisdictions with ReFAWG with respect to individual Reciprocal Jurisdiction Reinsurers.

c. **Minimum Solvency or Capital Ratio** - The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio: The ratio specified in the applicable in-force Covered Agreement where the assuming insurer has its head office or is domiciled; or if the assuming insurer is domiciled in an accredited state, a risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, calculated in accordance with the formula developed by the NAIC; or if the assuming insurer is domiciled in a Reciprocal Jurisdiction that is a Qualified Jurisdiction, such solvency or capital ratio as the commissioner determines to be an effective measure of solvency. The assuming insurer’s supervisory authority must confirm to the Lead State commissioner on an annual basis that the assuming insurer complies with this requirement. The Mutual Recognition of Jurisdictions (E) Working Group will coordinate the confirmations of the domiciliary jurisdictions with ReFAWG with respect to individual Reciprocal Jurisdiction Reinsurers.

d. **Form RJ-1** - The assuming insurer must provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.

e. **Audited Financial Report** - The assuming insurer’s annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report as provided under Section 9C(5)(a) of Model #786.

f. **Solvency and Financial Condition Report or Actuarial Opinion** – The applicant must submit a solvency and financial condition report or actuarial opinion, if filed with the assuming insurer’s supervisor as provided under Section 9C(5)(b) of Model #786.

g. **Overdue Reinsurance Claims** – The applicant must submit a list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States as provided under Section 9C(5)(c) of Model #786. The commissioner shall request the reinsurer to provide the information required to demonstrate the reinsurer’s practice of prompt payment of claims under its reinsurance agreements prior to entry into a reinsurance agreement, and annually thereafter, in order to demonstrate compliance with Section 9C(6) of Model #786.

h. **Assumed and Ceded Reinsurance Schedules** – The applicant must submit information regarding the assuming insurer’s assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer as provided under Section 9C(5)(d) of Model #786. Applicants domiciled in the U.S. must provide the most recent NAIC Annual Statement Blank Schedule F (property/casualty) and/or Schedule S (life and health). Applicants domiciled outside the U.S. may provide this information using Form CR-F (property/casualty) and/or Form CR-S (life and health), which ReFAWG considers sufficient to meet this requirement.
i. **Prompt Payment of Claims** - The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met: (1) more than fifteen percent (15%) of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the commissioner; (2) more than fifteen percent (15%) of the assuming insurer’s ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer $100,000, or as otherwise specified in a Covered Agreement; or (3) the aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds $50,000,000, or as otherwise specified in a Covered Agreement.

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

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

a. **Form RJ-1** - The assuming insurer must provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.

b. **Verification of Determination Issued by an NAIC Accredited Jurisdiction** – The applicant must provide a copy of the approval letter or other documentation provided to the applicant by the NAIC accredited jurisdiction. The letter should include the state, effective date, and lines of business.

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

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

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

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

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

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

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

   a. Under Section 8A(5) Model #786, credit for reinsurance shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer with respect to Certified Reinsurers. Under Section 2F(7) of the Credit for Reinsurance Model Law (#785), credit shall be taken with respect to Reciprocal Jurisdiction Reinsurers only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements to be designated a Reciprocal Jurisdiction Reinsurer, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.

   b. It is expected that certain assuming insurers may be considered to be Certified Reinsurers for purposes of in-force business or business with existing liabilities and Reciprocal Jurisdiction Reinsurers with respect to reinsurance agreements entered into, amended, or renewed on or after the effective date. In addition, these same reinsurers may also have certain blocks of business that are fully collateralized under the prior provisions of Model #785 and Model #786. The NAIC Blanks have been amended to reflect the status of these reinsurers with respect to each type of insurance assumed.

   c. With respect to those reinsurers that are currently Certified Reinsurers but are seeking recognition by ReFAWG as Reciprocal Jurisdiction Reinsurers for passporting purposes, the same process as outlined in paragraphs 3-6 of this ReFAWG Review Process must be followed. A Form RJ-1 must be filed with each state in which the reinsurer seeks recognition as a Reciprocal Jurisdiction Reinsurer, and the reinsurer must meet all other applicable requirements. However, states may share this information with other states through the NAIC and the ReFAWG Review Process, and previously filed information used in the review of the reinsurer as a Certified Reinsurer may also be utilized in its review as a Reciprocal Jurisdiction Reinsurer. For example, a Reciprocal Jurisdiction Reinsurer may cross reference information/documentation that has been filed with...
respect to its status as a Certified Reinsurer, so that it is not necessary to file duplicative documents. ReFAWG will take full advantage of the passporting process, with the intent of reducing the amount of documentation filed with the states and reduce duplicate filings.

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

11. Commissioner Shall Create and Publish Lists

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

To: Financial Regulation Standards and Accreditation (F) Committee

From: Financial Condition (E) Committee

Date: March 8, 2021

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

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

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

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

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

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

To: Financial Condition (E) Committee

From: Group Capital Calculation (E) Working Group

Date: February 25, 2021

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

Executive Summary

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

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

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

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

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

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

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

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

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

The current accreditation standard for Model #440 and Model #450 requires state adoption on a substantially similar basis. Therefore, the Group Capital Calculation (E) Working Group supports the attached proposed significant elements (Attachment A) be adopted by NAIC-accredited jurisdictions in a “substantially similar” manner, as that term is defined in the Accreditation Interlineations of the NAIC Financial Regulation Standards and Accreditation Program. The Financial Regulation Standards and Accreditation (F) Committee should consider a waiver of procedure as provided for in the Accreditation Program Manual and expeditiously consider adoption of this standard. The Group Capital Calculation (E) Working Group recommends that the accreditation standard become effective Nov. 7, 2022, the end of the 60-month period contemplated under the Covered Agreement, with enforcement of the standard to commence Jan. 1, 2023. However, the Working Group is also supportive of the effective date being bifurcated to allow those states that are not the Group Wide Supervisor of a group with operations in the EU or UK to be subject to a later effective date in line with the normal accreditation timeline, which would result in an effective date of January 1, 2026.
There were also revisions made to Section 8 of Model #440 regarding Confidential Treatment. The Group Capital Calculation (E) Working Group strongly supports the use of language similar to that contained in Section 8G of Model #440. This language was considered very critical to the GCC as its very important that members of the insurance industry (or regulators) not be allowed to make the results of the GCC public in any way as they are designed as regulatory-only tools. Unlike RBC that has regulatory trigger points, the GCC does not, and the regulators of these groups believed it would be detrimental if these tools were used by insurers as a means to advertise their relative solvency strength.

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

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

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

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

*Insurance Holding Company Systems – continued*

<table>
<thead>
<tr>
<th>Changes to Existing</th>
<th>New</th>
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<tbody>
<tr>
<td>k. Filing requirements for the enterprise risk filing similar to those specified in Section 4L(1) of the Model #440?</td>
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<td>l. Filing requirements for the group capital calculation filing similar to those specified in Section 4L(2) of Model #440?</td>
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<tr>
<td>i. The ultimate controlling person of every insurer subject to registration shall annually file a group capital calculation completed in accordance with the NAIC Group Capital Calculation Instructions as directed by the lead state commissioner similar to section 4L(2)?</td>
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<td>ii. Provision for exempting an insurance holding company system that has only one insurer within its holding company structure, that only writes business [and is only licensed] in its domestic state and assumes no business from any other insurer, similar to 4L(2)(a)?</td>
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<td>iii. Provision for exempting an insurance holding company system that is required to perform a group capital calculation specified by the U.S. Federal Reserve? If the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the GCC, similar to 4L(2)(b)?</td>
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<td>iv. Provision for exempting an insurance holding company system whose non-U.S. group-wide supervisor is located within a Reciprocal Jurisdiction that recognizes the U.S. state regulatory approach to group supervision and group capital, similar to 4L(2)(c)?</td>
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<td>v. Provision for exempting an insurance holding company system that provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program and whose non-U.S. group-wide supervisor that is not in a Reciprocal Jurisdiction recognizes and accepts the GCC as the worldwide group capital assessment for U.S. insurance groups who operate in that jurisdiction, similar to 4L(2)(d)?</td>
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<tr>
<td>vi. Provision that gives the lead state the authority to require the GCC for U.S. operations of any non-U.S. based insurance holding company system where after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes, similar to 4L(2)(e)?</td>
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*Changes to Existing*  
c. Provisions for protecting confidential information submitted to the commissioner, including provisions maintaining confidentiality for information shared with state, federal and international regulators similar to Section 8? If sharing confidential information with the NAIC and third-party consultants is permitted, appropriate confidentiality protections should be included.

*New*  
m. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?

n. Filing requirements for the group capital calculation filing similar to those specified in Section 21 of Model #450?  
i. Provision that gives the lead state the authority to exempt the filing of the group capital calculation provided the criteria are similar to those allowed under Section 21A of Model #450?

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

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ii. Provision that gives the lead state the authority to accept a limited group capital filing provided the criteria are similar to those allowed under Section 21B of Model #450?

   See above comment regarding modifications.

iii. Provision that gives the lead state the authority to require the group capital calculation of any group that previously met an exemption or submitted a limited filing if any insurer in the holding company system either triggers an RBC action level event, is deemed in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer, similar to those allowed under Section 21C of Model #450?

iv. Provision that sets forth the criteria for a jurisdiction to be included on the NAIC listing that “recognize and accept the group capital calculation” similar to that required under Section 21D and Section 21E of Model #450?
MEMORANDUM

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

Executive Summary

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

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

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

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

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

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

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

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

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

We are not currently aware of any states that have adopted the 2020 revisions to Model #440, although we have been advised that many states have begun their legislative processes for adoption of these revisions.
A statement as to the provisions needed to meet the minimum requirements of the standard. That is, whether a state would be required to have “substantially similar” language or rather a regulatory framework. If it is being proposed that “substantially similar” language be required, the referring committee, task force or working group shall recommend those items that should be considered significant elements:

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

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

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

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

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

**Insurance Holding Company Systems – continued**

Changes to Existing

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

New

c. Define “NAIC Liquidity Stress Test Framework” similar to that in Section 1K?

d. Define “Scope Criteria” similar to that in Section 1M?

l. Filing requirements for the liquidity stress test filing similar to those specified in Section 4L(3) of Model #440:

i. The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year’s Liquidity Stress Test to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook similar to Section 4L(3)?

ii. Insurers meeting at least one threshold of the Scope Criteria for a specific data year are scoped into that year’s NAIC Liquidity Stress Test Framework unless the lead state, after consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the Framework for that data year similar to Section 4L(3)(a)? Insurers that do not trigger at least one threshold of the Scope Criteria are considered scoped out of the NAIC Liquidity Stress Test Framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should be scoped into the Framework for that data year?

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

Changes to Existing

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

m. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?
The following significant elements were modified from the initial March 8, 2021 E Committee referral and exposed by the F Committee on Aug. 14, 2021 for a 1-year exposure beginning January 1, 2022 (pending approval by Plenary at the Fall National Meeting). The modifications to n(i) and n(ii) allow Commissioners to grant exemptions to the group capital calculation to groups meeting the standards set forth in Model Regulation #450 Section 21A and Section 21B without the requirement to file at least once.

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

6. Insurance Holding Company Systems (Group Capital Calculation)

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

Changes to Existing

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

New

l. Filing requirements for the group capital calculation filing similar to those specified in Section 4L(2) of Model #440?

i. The ultimate controlling person of every insurer subject to registration shall annually file a group capital calculation completed in accordance with the NAIC Group Capital Calculation Instructions as directed by the lead state commissioner similar to section 4L(2)?

ii. Provision for exempting an insurance holding company system that has only one insurer within its holding company structure, that only writes business [and is only licensed] in its domestic state and assumes no business from any other insurer, similar to 4L(2)(a)?

iii. Provision for exempting an insurance holding company system that is required to perform a group capital calculation specified by the U.S. Federal Reserve? If the Federal Reserve Board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the GCC, similar to 4L(2)(b)?

iv. Provision for exempting an insurance holding company system whose non-U.S. group-wide supervisor is located within a Reciprocal Jurisdiction that recognizes the U.S. state regulatory approach to group supervision and group capital, similar to 4L(2)(c)?

v. Provision for exempting an insurance holding company system that provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program and whose non-U.S. group-wide supervisor that is not in a Reciprocal Jurisdiction recognizes and accepts the GCC as the worldwide group capital assessment for U.S. insurance groups who operate in that jurisdiction, similar to 4L(2)(d)?

vi. Provision that gives the lead state the authority to require the GCC for U.S. operations of any non-U.S. based insurance holding company system where after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes, similar to 4L(2)(e)?

Changes to Existing

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

n. Filing requirements for the group capital calculation filing similar to those specified in Section 21 of Model #450?

i. Provision that gives the lead state the authority to exempt the filing of the group capital calculation provided the criteria are similar to those allowed under Section 21A of Model #450?
   o Although not required for accreditation, in order to grant an exemption, is the filing required at least once?

ii. Provision that gives the lead state the authority to accept a limited group capital filing provided the criteria are similar to those allowed under Section 21B of Model #450?
   o Although not required for accreditation, in order to grant an exemption, is the filing required at least once?

iii. Provision that gives the lead state the authority to require the group capital calculation of any group that previously met an exemption or submitted a limited filing if any insurer in the holding company system either triggers an RBC action level event, is deemed in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer, similar to those allowed under Section 21C of Model #450?

iv. Provision that sets forth the criteria for a jurisdiction to be included on the NAIC listing that “recognize and accept the group capital calculation” similar to that required under Section 21D and Section 21E of Model #450?

6. Insurance Holding Company Systems (Liquidity Stress Test)

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

Insurance Holding Company Systems – continued

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

New
c. Define “NAIC Liquidity Stress Test Framework” similar to that in Section 1K?

d. Define “Scope Criteria” similar to that in Section 1M?

p. Filing requirements for the liquidity stress test filing similar to those specified in Section 4L(3) of Model #440:

vii. The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC Liquidity Stress Test Framework shall file the results of a specific year’s Liquidity Stress Test to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook similar to Section 4L(3)?

viii. Insurers meeting at least one threshold of the Scope Criteria for a specific data year are scoped into that year’s NAIC Liquidity Stress Test Framework unless the lead state, after consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should not be scoped into the Framework for that data year similar to Section 4L(3)(a)? Insurers that do not trigger at least one threshold of the Scope Criteria are considered scoped out of the NAIC Liquidity Stress Test Framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC Financial Stability Task Force or its successor, determines the insurer should be scoped into the Framework for that data year?
ix. Provision requiring compliance with the NAIC Liquidity Stress Test Framework’s instructions and reporting templates for the specific data year and any lead state insurance commissioner determinations in consultation with the Financial Stability Task Force or its successor, provided within the Framework similar to Section 4L(3)(b)?

Changes to Existing

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

q. Provision prohibiting the making, publishing, disseminating, circulating or placing before the public in any way the group capital calculation and resulting group capital ratio under Section 4L(2) and/or the liquidity stress test along with its results and supporting disclosures required under Section 4L(3), by any insurer, broker, or other person engaged in any manner of the insurance business, except if the sole purpose of the announcement is to rebut a materially false statement, similar to Section 8G of Model #440?
State Implementation Reporting of NAIC-Adopted Model Laws and Regulations

Executive (EX) Committee

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

Life Insurance and Annuities (A) Committee

- Amendments to the *Annuity Disclosure Model Regulation* (#245)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2021 Summer National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the *Suitability in Annuity Transactions Model Regulation* (#275)—These revisions were adopted by the Executive (EX) Committee and Plenary during the February 13, 2020, conference call. Seven states have enacted the revisions to this model.

- Amendments to the *Standard Nonforfeiture Law for Individual Deferred Annuities* (#805)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. 14 states have adopted the revisions to this model.

Health Insurance and Managed Care (B) Committee

- Amendments to the *Accident and Sickness Insurance Minimum Standards Model Act* (#170)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2019 Spring National Meeting. NAIC staff are not aware of any state activity regarding this model.

- Amendments to the *Health Maintenance Organization Model Act* (#430)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. One state has enacted this model.

- Amendments to the *Insurance Holding Company System Regulatory Act* (#440)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Six states have adopted the revisions to this model.

- Amendments to the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450)—These revisions were adopted by the Executive (EX) Committee and Plenary at the 2020 Fall National Meeting. Two states have adopted the revisions to this model.

- Adoption of the *Limited Long-Term Care Insurance Model Act* (#642)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. One state has enacted this model.

- Adoption of the *Limited Long-Term Care Insurance Model Regulation* (#643)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. One state has enacted this model.
Property and Casualty Insurance (C) Committee

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

- Adoption of the Travel Insurance Model Act (#632)—This model was adopted by the Executive (EX) Committee and Plenary at the 2018 Fall National Meeting. Six states have enacted this model.

Financial Condition (E) Committee

- Amendments to the Credit for Reinsurance Model Law (#785)—These revisions were adopted by the Executive (EX) Committee and Plenary during the June 26, 2019, conference call. 46 states have enacted this model.

- Amendments to the Credit for Reinsurance Model Regulation (#786)—These revisions were adopted by the Executive (EX) Committee and Plenary during its June 26, 2019, conference call. 22 states have enacted this model.
# EXECUTIVE (EX) COMMITTEE

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The Executive (EX) Committee met in San Diego, CA, Dec. 14, 2021. The following Committee members participated: David Altmaier, Chair (FL); Dean L. Cameron, Vice Chair (ID); Chlora Lindley-Myers, Vice President (MO); Andrew N. Mais, Secretary-Treasurer (CT); Raymond G. Farmer, Most Recent Past President (SC); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Michael Conway (CO); Doug Ommen (IA); James J. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Mike Chaney (MS); Glen Mulready (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); and Larry D. Deiter (SD).

1. **Adopted the Dec. 12 Report of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee**

Commissioner Altmaier reported that the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee met Dec. 12 in joint session. The meeting was held in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC) and paragraph 6 (consultations with NAIC staff members) of the NAIC Policy Statement on Open Meetings.

During this meeting, the Committee and Subcommittee adopted its Dec. 7, Oct. 26, and Summer National Meeting minutes, which included the following action: 1) approved the proposed NAIC 2022 budget and recommended that it be considered by the full membership during the joint meeting of the Executive (EX) Committee and Plenary during the Fall National Meeting; 2) held a public hearing on the proposed NAIC 2022 budget with interested parties; 3) approved exposure of the proposed NAIC 2022 budget for a public comment period; and 4) approved the 2021 NAIC Staffing Request Fiscal.

The Committee and Subcommittee also adopted the report of the Audit Committee, which met Dec. 7 and took the following action: 1) received an overview of the Oct. 31 financial statements; 2) received an update on the 2021 financial audit and the 2021/2022 Service Organization Control (SOC) 1 and SOC 2 audits; 3) received an update on database filing fee payments and the Zone financials; 4) received an update on the Enterprise Resource Planning project; and 5) received an update on the operating reserve analysis project.

The Committee and Subcommittee also adopted the report of the Audit Committee, which met Dec. 7 and took the following action: 1) received an overview of the Oct. 31 financial statements; 2) received an update on the 2021 financial audit and the 2021/2022 Service Organization Control (SOC) 1 and SOC 2 audits; 3) received an update on database filing fee payments and the Zone financials; 4) received an update on the Enterprise Resource Planning project; and 5) received an update on the operating reserve analysis project.

The Committee and Subcommittee also adopted the report of the Internal Administration (EX1) Subcommittee, which met Nov. 22 and took the following action: 1) received the Sept. 30 Long-Term Investment Portfolio and Defined Benefit Pension Plan Portfolio reports; 2) adopted a recommendation to increase the liability driven investment (LDI) percentage for the Defined Benefit Plan portfolio; and 3) adopted the report of the Information Systems (EX1) Task Force, which met Nov. 18 and took the following action: a) adopted its Summer National Meeting minutes; b) received an operational report on the System for Electronic Rates & Forms Filing (SERFF) Modernization Project; and c) received a cybersecurity update.

The Committee and Subcommittee also adopted the report of the Internal Administration (EX1) Subcommittee, which met Nov. 22 and took the following action: 1) received the Sept. 30 Long-Term Investment Portfolio and Defined Benefit Pension Plan Portfolio reports; 2) adopted a recommendation to increase the liability driven investment (LDI) percentage for the Defined Benefit Plan portfolio; and 3) adopted the report of the Information Systems (EX1) Task Force, which met Nov. 18 and took the following action: a) adopted its Summer National Meeting minutes; b) received an operational report on the System for Electronic Rates & Forms Filing (SERFF) Modernization Project; and c) received a cybersecurity update.

The Committee and Subcommittee also adopted the report of the Internal Administration (EX1) Subcommittee, which met Nov. 22 and took the following action: 1) received the Sept. 30 Long-Term Investment Portfolio and Defined Benefit Pension Plan Portfolio reports; 2) adopted a recommendation to increase the liability driven investment (LDI) percentage for the Defined Benefit Plan portfolio; and 3) adopted the report of the Information Systems (EX1) Task Force, which met Nov. 18 and took the following action: a) adopted its Summer National Meeting minutes; b) received an operational report on the System for Electronic Rates & Forms Filing (SERFF) Modernization Project; and c) received a cybersecurity update.

Director Cameron made a motion, seconded by Commissioner Mais, to adopt the Dec. 12 report of the joint meeting of the Executive (EX) Committee and the Internal Administration (EX1) Subcommittee. The motion passed unanimously.

2. **Adopted its Dec. 7, Oct. 26, and Oct. 12 Minutes**

Director Lindley-Myers, made a motion, seconded by Director Cameron, to adopt the Committee’s Dec. 7, Oct. 26, and Oct. 12 interim meeting report (Attachment One). The motion passed unanimously.
3. **Adopted the Reports of its Task Forces**

The Committee received written reports from: 1) the Climate and Resiliency (EX) Task Force; 2) the Government Relations (EX) Leadership Council; 3) the Innovation and Technology (EX) Task Force; 4) the Long-Term Care Insurance (EX) Task Force; and 5) the Special (EX) Committee on Race and Insurance.

Commissioner Godfread provided an additional oral report from the Innovation and Technology (EX) Task Force concerning its work on a new letter committee. Commissioner Godfread reported that NAIC members discussed the importance of raising the visibility, as well as prioritizing and organizing the work of the many NAIC committees specific to innovation, technology and cybersecurity regardless of what committee is working on it. The intention is to provide more consistency and collaboration and ensure the coordination of related workstreams.

As the chair of the Innovation and Technology (EX) Task Force Commissioner Godfread was asked to create an ad hoc drafting group to put together proposed charges for a new NAIC letter committee, the Innovation, Cybersecurity, and Technology (H) Committee. Superintendent Dwyer chaired the Drafting Group, and Commissioner Birrane and Director Daniels served as vice chairs.

Commissioner Godfread thanked all the states that participated in the drafting process: Arizona, California, Connecticut, Georgia, Iowa, Maryland, Michigan, North Dakota, New Mexico, Ohio, Rhode Island, Tennessee, and Wisconsin. These states held their first meeting on Sept. 27, and a “strawman” charges draft was reviewed. It was exposed publicly, and an open public comment meeting was held on Nov. 19. The ad hoc drafting group considered another draft based on comments received on Nov. 30. The final version was completed and posted on the NAIC website. The charges will be considered for adoption during the Plenary meeting along with a bylaw amendment to establish the new committee.

Additionally, Commissioner White reported that the Long-Term Care Insurance (EX) Task Force adopted some important deliverables. The Task Force adopted the Long-Term Care Insurance Multi-State Rate Review Framework (MSA Framework). The MSA Framework is a cornerstone project for the Task Force that delivers on the charge to develop a consistent national approach for reviewing current long-term care insurance (LTCI) rates that result in actuarially appropriate increases being granted by the states in a timely manner. The Task Force gathered insights from a pilot project as the basis and spent most of this past year developing the MSA Framework. It is expected that the MSA process will continue to undergo work and enhancements in the future. It is anticipated that the members will be asked to consider adoption of the MSA Framework in the spring of 2022, with anticipated full implementation by September 2022.

Commissioner White also highlighted two other important work products that were developed by the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup and adopted by the Long-Term Care Insurance (EX) Task Force during its Dec. 12 meeting: 1) the “RBO Consumer Notices Checklist” intended to establish a consistent approach to drafting and reviewing LTCI reduced benefit options (RBO) policyholder communications; and 2) a document titled “Issues Related to LTC Wellness Benefits” outlining issues and observations in innovation of wellness benefits aimed at reducing the need for long-term care (LTC).

Director Farmer made a motion, seconded by Commissioner Altman, to adopt the reports of the: 1) the Climate and Resiliency (EX) Task Force; 2) the Government Relations (EX) Leadership Council; 3) the Innovation and Technology (EX) Task Force; 4) the Long-Term Care Insurance (EX) Task Force; and 5) the Special (EX) Committee on Race and Insurance (Attachment Two). The motion passed unanimously.

4. **Adopted its 2022 Proposed Charges**

Director Cameron reported that the Committee’s 2022 proposed charges for consideration are largely the same from year to year. The Committee’s task forces will continue work on climate and resiliency, LTC, and race and insurance.

Director Cameron noted that the Committee is not adopting charges for the Innovation and Technology (EX) Task Force, as it anticipates adoption by the joint Executive (EX) Committee and Plenary of the formation of the new “H” Committee.

Director Cameron made a motion, seconded by Director Wing-Heier, to adopt the Committee’s 2022 proposed charges (Attachment Three). The motion passed unanimously.
5. Received a Status Report on the NAIC State Ahead Strategic Plan Implementation

Commissioner Altmaier provided an update on NAIC State Ahead implementation efforts. State Ahead is a three-year strategic plan for the organization intended to further advance the products, services, and support the NAIC provides to state insurance regulators in order to better meet the changing regulatory landscape. Overall, NAIC staff continue to make good progress on the many State Ahead projects (Attachment Four). Planning has begun at the member level for the next iteration of the strategic plan.

6. Received a Report of Model Law Development Efforts

Commissioner Altmaier presented a written report on the progress of ongoing model law development efforts (Attachment Five).

7. Heard a Report from the NIPR Board of Directors

Director Deiter reported that the National Insurance Producer Registry (NIPR) Board of Directors met Dec. 12. During this meeting, the Board approved NIPR's 2022 budget with projected revenues of $61.4 million and expenses of $56.4 million, including the approval of five additional technical employees.

The Board also heard an update on the progress of NIPR’s three-year strategic plan, including the recent implementation of moving NIPR’s technical applications to cloud-based technology, which is a key element of the strategic plan.

This year marks NIPR’s 25th anniversary. In October 1996, NIPR was incorporated to ease the inefficiency of state-based insurance regulation on agents and brokers by developing a comprehensive source of data and an electronic licensing system to be used for all states’ producer licensing.

As NIPR enhanced the simplicity of its products, more states, producers and compliance professionals used it, creating year-over-year growth. Today, as the central hub around which producer credentialing revolves, NIPR will close 2021 with the strongest revenue year in its history processing more than 42 million transactions and moving more than $1.1 billion in fees to state insurance departments helping to fulfill its mission of cost-effective, streamlined, and uniform producer licensing.

Director Dieter noted that NIPR Deputy Director, Laurie Wolf, was honored at NIPR's 25th anniversary celebration for her impact on the industry over the last 32 years. Ms. Wolf has been a part of NIPR’s history since the beginning and is widely recognized as the national subject matter expert (SME) on producer licensing. After starting her career in the insurance industry, she spent 19 years serving as the director of the Agent Licensing and Investigation Division for the North Dakota Insurance Department where she worked tirelessly on NAIC committees and working groups to further the cause of improved producer licensing. She has served as NIPR’s deputy director for 13 years. Her expertise has allowed NIPR to successfully understand and tackle the needs and challenges faced by state insurance producer licensing departments. Director Deiter thanked Ms. Wolf for her contributions to NIPR and the producer licensing community.

8. Heard a Report from the Compact

Superintendent Dwyer reported that the Interstate Insurance Product Regulation Commission (Compact) met Dec. 12 and elected Commissioner Birrane to serve as chair, Director Eric Dunning (NE) to serve as vice chair, and Commissioner Allan L. McVey (WV) to serve as Treasurer.

The 2022 Management Committee will include the three officers as well as: Illinois, Massachusetts, Michigan, Minnesota, New Jersey, Ohio, Pennsylvania, Rhode Island, Texas, Virginia, and Wyoming.

The Compact also approved 2022 committee assignments, appointed company and industry representatives to four open seats on the Industry Advisory Committee, and appointed Anna Howard (Cancer Action Network—CAN) to a vacant seat on the Consumer Advisory Committee.

The Compact also adopted changes to its individual LTC Uniform Standards, specifically with respect to separating requirements for in-force rate increase requests for Compact-approved products into a standalone standard. This change will facilitate the ability of Compacting States to opt out of the in-force rate schedule standard while continuing to participate in the other individual LTC Uniform Standards. These amendments were adopted after several discussions of options to respond to South Carolina’s request to reduce or eliminate the 15% threshold when the Compact has authority to approve an in-force rate
increase request. The 15% threshold stays in place but allows flexibility for a Compacting State to opt out of all in-force rate increase requests on Compact-approved products.

The Governance Committee also brought forward several amendments to the Compact’s Bylaws, many of them recommended during the independent governance review performed by Squire Patton Boggs in 2020.

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

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

EXECUTIVE (EX) COMMITTEE
December 7, 2021 / October 26, 2021 / October 12, 2021

Summary Report

The Executive (EX) Committee met Dec. 7, Oct. 26, and Oct. 12, 2021, in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings. During these meetings, the Committee:

1. Approved the NAIC proposed 2022 budget and recommended the proposed 2022 budget be considered by the full membership during the joint meeting of the Executive (EX) Committee and Plenary during the Fall National Meeting.

2. Approved the 2021 NAIC Staffing Request Fiscal.

3. Approved the release of the NAIC proposed 2022 budget for public review and comment.

4. Approved the release of the 2021 NAIC Staffing Request Fiscal for public comment.

5. Reappointed Commissioner Andrew N. Mais (CT) to the International Association of Insurance Supervisors (IAIS) Executive Committee for a two-year term.

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REPORT OF THE EXECUTIVE (EX) COMMITTEE TASK FORCES

Climate and Resiliency (EX) Task Force—The Climate and Resiliency (EX) Task Force met Dec. 14 and took the following action: 1) heard a recommendation from the Technology Workstream; 2) heard a presentation regarding the proposed redesigned NAIC Climate Risk Disclosure Survey; 3) heard status reports from the Solvency, Innovation, and Pre-Disaster Mitigation Workstreams; 4) heard a federal update; and 5) heard an international update.

Government Relations (EX) Leadership Council—The Government Relations (EX) Leadership Council did not meet at the Fall National Meeting. The Leadership Council meets weekly in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss federal legislative and regulatory developments affecting insurance regulation.

Innovation and Technology (EX) Task Force—The Innovation and Technology (EX) Task Force met Dec. 13 and took the following action: 1) adopted minutes from the Summer National Meeting and reports of the Big Data and Artificial Intelligence (EX) Working Group, the Speed to Market (EX) Working Group, and the E-Commerce (EX) Working Group; 2) heard an update on Colorado’s SB 21-169 legislation from Commissioner Michael Conway (CO); 3) heard presentations from two insurtech coalitions—the American InsurTech Council (AITC) and the InsurTech Coalition; 4) heard an update on the progress of the Ad Hoc Drafting Group working on proposed charges for a new Innovation, Cybersecurity, and Technology (H) Committee; 5) heard reports from various NAIC committees working on related or potentially overlapping workstreams, such as the Special (EX) Committee on Race and Insurance, the Privacy Protections (D) Working Group, and the Accelerated Underwriting (A) Working Group; 6) heard a presentation from MIB on its algorithmic bias testing for life insurers; and 7) received an update on the System for Electronic Rates & Forms Filing (SERFF) modernization project.

The Big Data and Artificial Intelligence (EX) Working Group met Nov. 12 in regulator-to-regulator session, pursuant to paragraph 6 (consultation with NAIC staff members related to technical guidance) of the NAIC Policy Statement on Open Meetings, to: 1) discuss preliminary, aggregate analysis of industry responses to a survey on private passenger automobile (PPA) insurers’ use and governance of big data, as used in an artificial intelligence (AI) and machine learning (ML) system; and 2) discuss the use of the NAIC’s Regulatory Data Collection system to survey the use of AI/ML in other lines of business. The survey was conducted under the examination authority of Connecticut, Illinois, Iowa, Louisiana, Nevada, North Dakota, Pennsylvania, Rhode Island, and Wisconsin. The Working Group also met Dec. 3 and took the following action: 1) reviewed its 2022 proposed charges; 2) received a presentation on how to leverage the lessons learned in developing the regulatory framework for cybersecurity to the development of a regulatory framework for AI; 3) received two presentations on how state insurance regulators could regulate AI, including how to monitor and mitigate AI bias and enable AI transparency; 4) received a presentation on the PPA AI/ML survey results; 5) discussed the next line of insurance to survey; and 6) discussed the development of a 2022 workplan.

The E-Commerce (EX) Working Group met Oct. 7 and took the following action: 1) heard presentations from industry organizations and consumer groups about various issues facing insurers and consumers in electronic transactions in light of the regulations and bulletins issued by state insurance regulators as a result of the COVID-19 pandemic; and 2) heard from state insurance department representatives regarding their ongoing efforts at regulatory reform in electronic transactions and other related areas and discussed using these presentations and information to develop a survey to send to the states and industry organizations regarding these issues. The survey responses may also be helpful in the drafting of a white paper and/or model bulletin if determined appropriate.

The Speed to Market (EX) Working Group met Nov. 16 and took the following action: 1) adopted its June 30 and June 29 minutes; 2) adopted the Regulatory Review of Predictive Models white paper edits to Chapter Three of the Product Filing Review Handbook. These proposed edits were previously adopted by the Casualty Actuarial and Statistical (C) Task Force, which was charged with proposing modifications to reflect current best practices for the regulatory review of Generalized Linear Models (GLM) predictive analytics; and 3) discussed contacts and resources for updates to the Product Requirements Locator (PRL) tool.
Long-Term Care Insurance (EX) Task Force—The Long-Term Care Insurance (EX) Task Force met Dec. 12 in joint session with the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup and took the following action: 1) adopted its Oct. 29 minutes, which included adoption of the 2022 proposed charges for the Task Force and its subgroups; and 2) adopted its Summer National Meeting minutes.

During the Dec. 12 meeting, the Long-Term Care Insurance (EX) Task Force: 1) received the reports of its subgroups: a) the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, which met Dec. 12, Nov. 15, and Sept. 10 to: i) hear comments from state insurance regulators and interested parties on the Long-Term Care Insurance (LTCI) Multistate Actuarial Rate Review Framework (MSA Framework) exposure draft; and ii) adopt the MSA Framework; b) the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup, which met Dec. 7, Nov. 19, Oct. 19, Oct. 4, Sept. 27, and Aug. 23 to receive comments on and adopt the documents titled “Issues Related to LTC Wellness Benefits” and “RBO Consumer Notices Checklist”; and c) the Long-Term Care Insurance Financial Solvency (EX) Subgroup, which reported on industry trends and factors affecting reserve levels; 2) adopted the MSA Framework; 3) adopted the “Issues Related to LTC Wellness Benefits” document; and 4) adopted the “RBO Consumer Notices Checklist” document.

During the Dec. 12 meeting, the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup: 1) adopted its Nov. 15 and Sept. 28 minutes; 2) heard comments on the MSA Framework from state insurance regulators and interested parties; and 3) adopted the MSA Framework.

Special (EX) Committee on Race and Insurance—The Special (EX) Committee on Race and Insurance met Dec. 14 and took the following action: 1) adopted its Summer National Meeting minutes; 2) heard reports from its five workstreams; and 3) heard presentations from interested parties.

- Workstream One of the Special Committee is focused on researching and analyzing the level of diversity and inclusion within the insurance sector. The Workstream met in regulator-to-regulator session in October to hear a presentation from California and New York regarding their respective diversity, equity, and inclusion (DE&I) efforts and the diversity-related industry data that these states are collecting. The Workstream also held a public call with stakeholders in November to better understand industry diversity-related programs, how companies are measuring progress, and what state insurance regulators can do to support these efforts.

- Workstream Two of the Special Committee continues gathering responses to the survey intended to examine, at the zone level, best practices and initiatives state insurance departments may consider when promoting DE&I in their offices. Once responses have been gathered, the Workstream will discuss a method and forum to share diversity and inclusion information among state insurance regulators. On Oct. 18, Evelyn Boswell, NAIC Director of Diversity, Equity, and Inclusion, held the first State Diversity Leader’s Forum. The Forum provides a space for diversity leaders in each state that has a diversity leader, to come together and discuss best practices in promoting diversity in their respective insurance departments.

- Workstream Three of the Special Committee is focused on property/casualty (P/C) insurance issues. The Workstream met Dec. 1 and heard from numerous interested parties about definitions contained within Charge F having to do with unfair discrimination, disparate treatment, proxy discrimination, and disparate impact. The Workstream expects to begin drafting a white paper to define relevant terms and determine next steps.

- Workstream Four of the Special Committee met in regulator-to-regulator session in October to discuss how best to develop a work plan. The Workstream members concluded that there is a need for data to drive discussion and advance understanding of these issues and next steps. The Workstream expects to meet in January to discuss how it fits into the larger work of the Special Committee and the other Workstreams as it moves forward to address the issues identified in its charges.

- Workstream Five of the Special Committee met Dec. 3, Nov. 18, Oct. 14, Sept. 9 and Aug. 26 to discuss issues related to data collection and provider networks, provider directories, and cultural competency. During these meetings, the Workstream discussed the comments received on its draft Principles for Data Collection document received by the public comment period ending Aug. 19. The Workstream discussed revisions to the draft document based on the comments received. The Workstream also exposed a draft outline for its proposed white paper on provider networks, provider directories, and cultural competency for a public comment period. The Workstream hopes to finalize the
Principles for Data Collection document by the end of 2021 and begin work in early 2022 on its white paper on
provider networks, provider directories, and cultural competency.
2022 Proposed Charges

EXECUTIVE (EX) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Andrew J. Beal/Kay Noonan
2022 Proposed Charges

CLIMATE AND RESILIENCE (EX) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Jennifer Gardner
2022 Proposed Charges

GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

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

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Ethan Sonnichsen/Brian R. Webb/Brooke Stringer
LONG-TERM CARE INSURANCE (EX) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Long-Term Care Insurance (EX) Task Force will:
   A. Once adopted by the NAIC Executive (EX) Committee and Plenary, monitor, and evaluate the progress of the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document. Monitor state insurance department rate review actions subsequent to implementation of the MSA Framework and MSA rate review recommendations.
   B. Complete an evaluation and recommend options to provide consumers with choices regarding modifications to LTCI contract benefits where policies are no longer affordable due to rate increases.
   C. Monitor the work performed by other NAIC solvency working groups and assist in the timely multi-state coordination and communication of the review of the financial condition of LTC insurers.

   Staff Support: Jeff Johnston, Jane Koenigsman

2. The Long-Term Care Insurance Multistate Rate Review (EX) Subgroup will:
   A. Finalize the development of the MSA rate review process as outlined in the MSA Framework document which outlines a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. Implement the MSA rate review process once adopted by the NAIC Executive (EX) Committee and Plenary.
   B. Evaluate the progress of the MSA rate review process and provide ongoing maintenance and enhancements, as deemed necessary.
   C. The Subgroup should complete its charges by the 2022 Fall National Meeting.

   Staff Support: Eric King

3. The Long-Term Care Reduced Benefit Options (EX) Subgroup will:
   A. Complete an evaluation and/or recommendation of options to help consumers manage the impact of rate increases. This includes:
      1. Finalizing development of a process to evaluate innovative options that allow for insurers to offer benefits that lessen the likelihood of an insured needing long-term care services, including evaluation of the suitability of and regulatory barriers to proposed options.
      2. The potential development of mechanisms to help regulators and consumers objectively compare reduced benefit options (RBOs), including comparison of accepting a rate increase and retaining current benefits to electing an offered RBOs.
      3. Finalizing the Consumer Notices Checklist for RBOs.
   B. Support and provide expertise to the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup regarding evaluation of RBOs.
   C. The Subgroup should complete its charges by the 2022 Fall National Meeting.

   Staff Support: Eric King
2022 Proposed Charges

SPECIAL (EX) COMMITTEE ON RACE AND INSURANCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Special (EX) Committee on Race and Insurance will:
   A. Serve as the NAIC’s coordinating body on identifying issues related to: 1) race, diversity, and inclusion within the insurance sector; 2) race, diversity, and inclusion in access to the insurance sector and insurance products; and 3) practices within the insurance sector that potentially disadvantage people of color and/or historically underrepresented groups.
   B. Coordinate with existing groups such as the Big Data and Artificial Intelligence (EX) Working Group and the Casualty Actuarial and Statistical (C) Task Force and encourage those groups to continue their work on issues affecting people of color and/or historically underrepresented groups, particularly in predictive modeling, price algorithms, and artificial intelligence (AI).
   C. (Workstream One) Continue research and analysis to identify issues and develop specific recommendations on action steps state insurance regulators and companies can take to improve the level of diversity and inclusion in the industry, including:
     1. Seek additional engagement from stakeholders to understand the efficacy of diversity-related programs, how companies measure their progress, and what state insurance regulators can do to support these efforts.
     2. Collect input on any existing gaps in available industry diversity-related data.
   D. (Workstream Two) In coordination with the Executive (EX) Committee, receive reports on NAIC diversity, equity, and inclusion (DE&I) efforts. Serve as the coordinating body for state requests for assistance from the NAIC related to DE&I efforts.
   E. (Workstream Two) Research best practices among state insurance departments on DE&I efforts and develop forums for sharing relevant information among states and with stakeholders, as appropriate.
   F. Continue research and analysis of insurance, legal, and regulatory approaches to addressing unfair discrimination, disparate treatment, proxy discrimination, and disparate impact. Make recommendations for statutory or regulatory changes and additional steps, including:
     1. (Workstream Four) The impact of traditional life insurance underwriting on traditionally underserved populations, considering the relationship between mortality risk and disparate impact.
     2. (Workstream Three) Developing analytical and regulatory tools to assist state insurance regulators in defining, identifying, and addressing unfair discrimination in property/casualty (P/C) insurance, including issues related to:
        a. Rating and underwriting variables, such as socioeconomic variables and criminal history, including:
           1. Identifying proxy variables for race.
           2. Correlation versus causation, including discussion of spurious correlation and rational explanation.
           3. Potential bias in underlying data.
           4. Proper use of third-party data.
        b. Disparate impact considerations.
   G. (Workstreams Three, Four, and Five) Consider enhanced data reporting and record-keeping requirements across product lines to identify race and other sociodemographic factors of insureds, including consideration of legal and privacy concerns. Consider a data call to identify insurance producer resources available and products sold in specific ZIP codes to identify barriers to access.
   H. Continue research and analysis related to insurance access and affordability issues, including:
     1. (Workstream Four) The marketing, distribution, and access to life insurance products in minority communities, including the role that financial literacy plays.
2. (Workstream Four) Disparities in the number of cancellations/rescissions among minority policyholders.
3. (Workstream Five) Measures to advance equity through lowering the cost of health care and promoting access to care and coverage, with a specific focus on measures to remedy impacts on people of color, low income and rural populations, and historically marginalized groups, such as the LGBTQ+ community, individuals with disabilities, and Alaska Native and other Native and Indigenous people.
4. (Workstream Five) Examination of the use of network adequacy and provider directory measures (e.g., provider diversity, language, and cultural competence) to promote equitable access to culturally competent care.
5. (Workstream Five) Conduct additional outreach to educate consumers and collect information on health and health care complaints related to discrimination and inequities in accessing care.
6. (Workstream Three) Whether steps need to be taken to mitigate the impact of residual markets, premium financing, and nonstandard markets on historically underrepresented groups.
7. Make referrals for the development of consumer education and outreach materials, as appropriate.

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

LIFE INSURANCE AND ANNUITIES (A) COMMITTEE – NEW CHARGES

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

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

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

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

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

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

The Producer Licensing (D) Task Force will receive a report on the availability of producer licensing exams in foreign languages, the steps exam vendors have taken to mitigate cultural bias, and the number and location of producers by company compared to demographics in the area.
2022 Proposed Charges

INTERNAL ADMINISTRATION (EX1) SUBCOMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

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

Ongoing Support of NAIC Programs, Products or Services

1. The **Information Systems (EX1) Task Force** will:
   
   A. Serve as the Internal Administration (EX1) Subcommittee’s project-independent technology monitor and consultant. This involves monitoring the development, deployment and operation of NAIC information technology (IT) systems and services for state insurance regulators and, based on this effort, providing reports and recommendations to the Subcommittee, as appropriate. To achieve this, the Task Force will receive regular portfolio and technical operational reports.
   
   B. Provide consultation to NAIC technology staff, as well as the interpretation of intent and specific technology direction, where needed. For example, from time to time, NAIC technology staff may request approval of a specific technology approach, such as a proposal to drop support for a particular version of software. The Task Force will provide direction in such matters, either directly or through a working group. Task Force members will also communicate current and future state technology changes planned for their state to alert NAIC technology staff of potential impacts and requirements for NAIC systems and services used by state insurance regulators.
   
   C. Review, with technical recommendations for the Subcommittee: 1) Fiscal Impact Statements Appendix A for all *State Ahead* projects, as well as others involving a technology component exceeding $100,000 or 1,150 hours of technology staff development and which is not limited to the support of the internal operations; and 2) project requests that involve technology being submitted to the Subcommittee or directly to the Executive (EX) Committee.
2022 PROPOSED NAIC AUDIT COMMITTEE
Committee Charter

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

3. Review and approve needs-based funding allocations, as needed.

4. Review and update the Committee charter on at least an annual basis.

E. Conduct other activities when necessary, including:

1. Arrange for the independent auditor to be available to the full Executive (EX) Committee and the Internal Administration (EX1) Subcommittee, as needed.

2. Review and approve requests for any management consulting engagement to be performed by the independent auditor, and be advised of any other study undertaken at the request of management that is beyond the scope of the audit engagement letter.

3. Conduct and/or authorize investigations into any matters within the Committee’s scope of responsibilities. The Committee shall be empowered to retain independent counsel and other professionals to assist in the conduct of any investigation.

4. Ensure that members of the Committee receive the appropriate orientation to the Committee and receive a copy of the policy manual.

NAIC Support Staff: Jim Woody

NAIC Support Staff Hub/Member Meetings/Fall 2021/Cmte/Ex/Att 3 ExCmteProposedCharges.docx
Draft: 12/13/21

Model Law Development Report

Amendments to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)—Amendments to Model #171 are required for consistency with the federal Affordable Care Act (ACA). Therefore, they did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee. At the 2015 Fall National Meeting, the Regulatory Framework (B) Task Force discussed the proposed revisions to this model. The Task Force met Feb. 11, 2016, and appointed the Accident and Sickness Insurance Minimum Standards (B) Subgroup to work on revisions to this model. The Subgroup has been meeting on a regular basis since the 2016 Spring National Meeting, and it plans to continue meeting until it completes its work. During its meetings, the Subgroup has discussed several issues, including its approach for revising the model’s disability income insurance coverage provisions, and it decided preliminarily to review the Interstate Insurance Product Regulation Commission’s (Compact’s) approach. After pausing its work due to the ACA’s potential repeal, replacement, or modification—and the possible impact on the provisions of this model, as well as the Subgroup’s preliminary proposed revisions to the model—the Subgroup began meeting again in May 2018. Revisions to the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170) were adopted by the full NAIC membership at the 2019 Spring National Meeting. The Subgroup has been meeting to consider revisions to Model #171 for consistency with the revised Model #170 since the 2019 Summer National Meeting discussion on comments received on Sections 1–5 of Model #171. In December 2019, the Subgroup set a public comment period ending Feb. 7, 2020, to receive comments on Sections 6–7 of Model #171. Due to the COVID-19 health emergency, the Subgroup has not scheduled any meetings. Any future meetings will depend on when a new co-chair is appointed and the duration of the COVID-19 health emergency. As requested, the Subgroup received comments from stakeholders on Sections 6–7 of Model #171. A new Subgroup co-chair has been appointed. The Subgroup met June 7, 2021, to discuss the status of the proposed revisions to Model #171 and its next steps. The Subgroup decided to establish a new public comment period ending July 2, 2021, to receive comments on Sections 1–7 of Model #171. The Subgroup does not plan to meet at the 2021 Fall National Meeting. Since the 2021 Summer National Meeting, the Subgroup has been meeting to discuss possible revisions to Model #171 based on the comments received by the July 2, 2021, public comment deadline. During some of these meetings, the Subgroup heard from industry presenters about the products currently covered under Model #171 and the products to be covered under Model #171 after it is revised.

Amendments to the Life Insurance Disclosure Model Regulation (#580)—The Executive (EX) Committee met June 19, 2017, and approved a Request for NAIC Model Law Development to incorporate a policy overview document requirement into Model #580 and the Life Insurance Illustrations Model Regulation (#582) in order to improve the understandability of the life insurance policy summary and narrative summary already required by Section 5A(2) of Model #580 and Section 7B of Model #582. While the Life Insurance Illustration Issues (A) Working Group of the Life Insurance and Annuities (A) Committee was originally planning to revise both Model #580 and Model #582, it will now revise only Model #580. The Working Group has been meeting to develop language to add a requirement for a one- to two-page consumer-oriented policy overview. The Working Group continued to make progress during meetings in late 2019 and early 2020, and it received an extension from the Committee at the 2021 Spring National Meeting to continue its work. The Working Group completed alternative draft versions of model law revisions and a sample policy overview document for term life policies. One version shows the model and sample pre-underwriting, and the other shows the model and sample under existing model law timing requirements. The Working Group developed these alternative versions to aid the Committee in providing guidance to the Working Group with respect to the timing of the delivery of the policy overview document. Discussion of this issue is on the Committee’s agenda at the 2021 Fall National Meeting.

Amendments to the Mortgage Guaranty Insurance Model Act (#630)—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #630 at the 2013 Summer National Meeting. The Mortgage Guaranty Insurance (E) Working Group has developed proposed changes to the model, which have been exposed for comment, and subsequent changes have been made to address the comments. However, the Working Group has been focused on the development of a capital model, which is currently incorporated as a requirement in the model, but further changes are expected to be made to that model before adoption can occur. The Working Group previously received an extension to continue work on the capital model until the 2022 Spring National Meeting. Because the work on the capital model is not completed, an additional request for extension is expected in the future.
Amendments to the Nonadmitted Insurance Model Act (#870)—The Executive (EX) Committee approved a Request for NAIC Model Law Development for amendments to Model #870 at the 2021 Spring National Meeting. The amendments will modernize the model and bring it into alignment with the federal Nonadmitted and Reinsurance Reform Act. The Surplus Lines (C) Task Force met Aug. 5, 2021, and appointed a drafting group to work on the revisions to Model #870.

New Model: Pet Insurance Model Act—The Executive (EX) Committee approved a Request for NAIC Model Law Development at the 2019 Summer National Meeting. The Pet Insurance (C) Working Group held numerous meetings to draft the model law to define a regulatory structure for pet insurance and address issues such as producer licensing, policy terms, coverages, claims handling, premium taxes, disclosures, arbitration, and preexisting conditions. The Working Group adopted the Pet Insurance Model Act on Aug. 4, 2021, and the Property and Casualty Insurance (C) Committee adopted it on Nov. 10, 2021. The Executive (EX) Committee and Plenary is expected to consider the model at the 2021 Fall National Meeting.
CLIMATE AND RESILIENCY (EX) TASK FORCE

Climate and Resiliency (EX) Task Force Dec. 14, 2021, Minutes ......................................................................................... 4-24
Technology Workstream Center of Excellence (COE) Recommendation (Attachment One) .............................................. 4-28
Catastrophe Modeling COE Proposal (Attachment One-A) ................................................................................................. 4-30
Center for Insurance Policy and Research (CIPR) COE Frequently Asked Questions (FAQ) (Attachment One-B) ............... 4-35
Draft Climate Risk Disclosure Survey (Attachment Two) ............................................................................................... 4-41
The Climate and Resiliency (EX) Task Force met in San Diego, CA, Dec. 14, 2021. The following Task Force members participated: Ricardo Lara, Co-Chair, Mike Peterson, Bryant Henley, and Camillo Pizzaro (CA); Raymond G. Farmer, Co-Chair, Michael Wise and Michelle Proctor (SC); Colin M. Hayshida, Co-Vice Chair (HI); James J. Donelon, Co-Vice Chair, represented by Nick Lorusso (LA); Kathleen A. Birrane, Co-Vice Chair, and Alexander Borkowski (MD); Mark AfaIe, Co-Vice Chair, and Sarah Smith (WI); Andrew R. Stolfi, Co-Vice Chair (OR); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Michael Conway (CO); Andrew N. Mais represented by George Bradner and Wanchin Chou (CT); Karima M. Woods and Sharon Shipp (DC); Trinidad Navarro represented by Frank Pyle (DE); David Altmair and Susanne Murphy (FL); Amy L. Beard represented by Victoria Hastings (IN); Gary D. Anderson (MA); Eric A. Cioppa (ME); Grace Arnold (MN); Jon Godfread represented by Matt Fischer (ND); Eric Dunning (NE); Russel Toal represented by Jennifer Catechis (NM); Barbara D. Richardson (NV); Adrienne A. Harris and Yue Chen (NY); Judith L. French (OH); Jessica K. Altman (PA); Elizabeth Kelleheer Dwyer (RI); Scott A. White (VA); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler and Jay Bruns (WA); and Jeff Rude (WY). Also participating were: Elizabeth Perri (AS); Susan Berry (IL); Troy Downing (MT).

1. **Adopted its 2021 Summer National Meeting Minutes**

Commissioner Altmair made a motion, seconded by Commissioner Altman, to adopt the Task Force’s Aug. 15 minutes (see *NAIC Proceedings – Summer 2021, Climate and Resiliency (EX) Task Force*). The motion passed unanimously.

2. **Heard a Recommendation from the Technology Workstream**

Mr. Lorusso said the Technology Workstream was charged with applying technology, such as predictive modeling, to understand and evaluate climate and natural catastrophe risk exposures. He said other groups at the NAIC are also considering catastrophe models within their work. The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk Based Capital (E) Working Group is evaluating wildfire models to consider adding wildfire for informational purposes only into the risk-based capital (RBC) framework. The Catastrophe Insurance (C) Working Group is planning to consider revisions to the *Catastrophe Computer Modeling Handbook*.

Mr. Lorusso said the Technology Workstream met Sept. 20 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff regarding technical guidance) of the NAIC Policy Statement on Open Meetings, to consider the need for support services related to the use of catastrophe models in insurance, including discussion of what other NAIC committees had planned and the relevant research of the Center for Insurance Policy and Research (CIPR). Acknowledging the benefit of a shared resource for state insurance regulators regarding catastrophe models, on Sept. 21 the Technology Workstream exposed a proposal (Attachment One-A) for the CIPR to create a Catastrophe Model Center of Excellence (COE). The Workstream collected comments until its open meeting on Nov. 4, where it heard comments on the proposal and addressed the questions received. Following the Nov. 4 meeting, the Workstream issued a frequently asked questions (FAQ) document (Attachment One-B) to address the comments and clarify the intent of the COE. The Workstream held another open meeting on Nov. 22 to adopt a recommendation (Attachment One) for the NAIC’s CIPR to create a COE.

Commissioner Lara said the Task Force plans to meet during an interim meeting before the 2022 Spring National Meeting to consider the recommendation for adoption.

3. **Heard a Presentation Regarding the Proposed Redesigned NAIC Climate Risk Disclosure Survey**

Commissioner Stolfi (OR) said the Climate Risk Disclosure Workstream met on Nov. 19 to expose its proposed redesigned NAIC Climate Risk Disclosure Survey. He said the Workstream was charged to consider appropriate climate risk disclosures within the insurance sector, including an evaluation of the NAIC Climate Risk Disclosure Survey and evaluation of alignment with other sectors and international standards. Commissioner Stolfi said the NAIC adopted the Climate Risk Disclosure Survey in 2010, which includes eight questions regarding how insurers consider climate-related risks in their risk and investment management practices, including how insurers identify and assess climate-related risks and their potential impact to the company’s business strategies. It also considers how insurers engage with stakeholders on the topic of risk management. The survey is voluntary for states to use. For the past several years, six states participated in the survey, which represented approximately 70% of the market measured by direct written premium. In 2021, 15 states participated, representing nearly 80%...
of the market. All insurers writing at least $100 million in direct written premium with business in any participating state are required to complete the survey annually. For the past two years, insurers were allowed to submit using the Financial Stability Board’s (FSB’s) Task Force on Climate-Related Financial Disclosure (TCFD) in lieu of the eight survey questions. In 2020, eight TCFD reports were filed with the California Department of Insurance (DOI) as part of the annual reporting requirement. In 2021, 28 TCFD reports were received.

The TCFD includes four themes: 1) governance; 2) strategy; 3) risk management; and 4) metrics and targets. The FSB created the TCFD in 2015 and formally adopted its reporting framework in 2017. Internationally, multiple jurisdictions have proposed or finalized laws and regulations to require disclosure aligned with TCFD recommendations, some coming into effect as early as 2022. The Financial Stability Oversight Council (FSOC) published a Report on Climate-Related Financial Risk in October, which, among other things, said that regulators across the financial system should review their existing public disclosure requirements and consider updating and standardizing them to promote the consistency, comparability, and decision-usefulness of information on climate-related risks and opportunities. Furthermore, it was recommended that disclosures build on the four core elements of the TCFD.

Commissioner Stolfi said the Climate Risk Disclosure Workstream decided to align its redesigned survey to the TCFD recommendations and include insurance-specific questions. He then described the proposed survey questions and their origin (Attachment Two). All questions provide for a narrative response. Several questions are repeated as closed-ended, yes or no, or multiple-choice. This information is requested to quickly discern steps companies are taking to manage their climate-related risks and provide trending over time.

Commissioner Stolfi said comments are due on the proposed survey by Jan. 10. The Workstream plans to meet again in early 2022 to review the comments received and consider the revised survey for adoption. The Workstream will report its final recommendation to the Task Force before the 2022 Spring National Meeting.

Director French asked if there would there be room for explanation for insurers that do not have a clear answer for the closed-ended questions. Commissioner Stolfi said that the closed-ended questions always include a narrative question as well. The insurer filling out the survey can use the narrative question to explain their answers within the closed-ended question. Director French asked if the survey would continue to remain voluntary for states or if the objective is for the majority of states to participate. Commissioner Stolfi welcomed other states to opt in, but he said the recommendation of the Workstream is for the survey to continue to be voluntary for states.

4. Received a Status Report from the Solvency Workstream

Commissioner Birrane said the Solvency Workstream is focused on climate-related financial risk and the prudential oversight by U.S. insurance regulators to ensure that the risk is identified, analyzed, and appropriately addressed. The Workstream met on Sept. 30 to hear a presentation from the New York Department of Insurance regarding its Guidance for New York Domestic Insurers on Managing the Financial Risks from Climate Change. The Workstream also heard a summary of prior panel discussions and heard feedback from industry regarding the financial solvency tools to consider for updates related to climate risk. The Workstream then held three regulator-to-regulator discussions pursuant to paragraph 6 (consultations with NAIC staff regarding technical guidance) to discuss financial solvency tools.

The Workstream met in an open meeting on Nov. 8 to expose a list of questions to gather thoughts from regulators and interested parties regarding potential updates on financial solvency tools related to climate risk. Comments on the questions were due on Dec. 8. NAIC staff have begun compiling the comments for the Workstream to review during a future meeting. The Solvency Workstream will review the comments received and consider the need for enhancements to financial solvency tools. After a transparent, collaborative, iterative process, the Solvency Workstream hopes to make its final recommendations to the Task Force in the first quarter of 2022.

5. Received a Status Report from the Innovation Workstream

Commissioner Hayashida said the Innovation Workstream has met twice since the Summer National Meeting. On Sept. 9, the Workstream met to hear from Sola Insurance about a parametric product offered as an endorsement to a homeowners policy. The product uses data from the National Weather Service to detect tornado activity.

The Workstream also met Oct. 6 to hear a presentation from Guy Carpenter about community-based insurance for disaster resilience. He said Guy Carpenter is part of a project team, led by the Wharton Risk Management and Decision Processes Center, to increase the financial resilience of lower to middle income households in New York City to escalating flood risk.
through inclusive insurance programs. The Center for NYC Neighborhoods will buy a parametric risk transfer policy to fund an emergency disaster relief grant program. The New York City Mayor’s Office of Resilience (MOR) sought out the public-private partnership to prepare for flooding.

6. **Received a Status Report from the Pre-Disaster Mitigation Workstream**

Ms. Smith said the Pre-Disaster Mitigation Workstream has been focused on its charge to collect and share resources with consumers and other stakeholders, seeking out best practices to encourage consumer risk awareness. In August, the Workstream distributed a list of mitigation actions to reduce the risk of future loss. Comments were collected on the list of mitigation actions, and the Workstream met Oct. 5 to hear comments received. The National Association of Mutual Insurance Companies (NAMIC) commented that the actions of individual home and property owners may be less effective than actions taken at a community or municipal level. On Oct. 5, the Workstream also heard a presentation from Leslie Chapman-Henderson (Federal Alliance for Safe Homes [FLASH]) regarding its recently released *Buyer’s Guide to Resilient Homes*.

Ms. Smith said the Workstream also met Nov. 18 to hear a presentation from Dave Snyder (American Property and Casualty Insurance Association—APCIA) and Karen Collins (APCIA) regarding industry-led mitigation efforts. During that meeting, the Workstream also heard about grass roots campaigns in Wisconsin and South Carolina to increase consumer awareness, encourage stronger building codes, and incentivize building retrofits through grant programs to increase the resilience of vulnerable communities. The Wisconsin Office of the Insurance Commissioner developed a campaign, “Stronger Wisconsin,” to share information with consumers about measures to protect themselves from increasingly common weather events from severe winter storms to flooding. The campaign is bridging the gap between state agencies, municipalities, and consumers. The Workstream is considering a workshop in spring 2022 to build on its earlier work with building codes, mitigation, and resiliency funding, this time with a focus on wildfire.

Amy Bach (United Policyholders—UP) said UP has been working closely with the California DOI regarding risk reduction resources for property owners and mitigation measures with the Insurance Institute for Business & Home Safety (IBHS). She also mentioned the Federal Advisory Committee on Insurance (FACI) is working on parallel efforts to consider the availability of insurance products and addressing the protection gap through public-private partnerships and other mechanisms.

7. **Heard an Update on Federal Activities**

Brooke Stringer (NAIC) said President Joe Biden’s May 2021 executive order on climate-related financial risk mandated a range of federal studies to analyze the risks climate change poses to the U.S. financial system and lays the groundwork for eventual policy changes. She said the Order directs the Federal Insurance Office (FIO) to assess climate-related issues or gaps in insurance supervision and the potential for major disruptions of insurance coverage in regions of the country particularly vulnerable to climate-related impacts. The NAIC submitted a comment letter in response to the FIO’s request for information underscoring the long-running history and focus of state insurance regulators to assist consumers and protect policyholders while maintaining well-functioning markets.

Ms. Stringer said that in October, the Financial Stability Oversight Council (FSOC) released its *Report on Climate-Related Financial Risk*, which included several policy recommendations to build capacity and expand efforts to address climate-related financial risks, fill data gaps, enhance public climate-related disclosures, and assess climate-related risks to financial stability. The FSOC intends to form two new committees to help financial regulators better understand climate-related risks to the financial system.

The U.S. Securities and Exchange Commission (SEC) remains focused on climate risk disclosure. SEC Chair Gary Gensler directed SEC staff to develop a mandatory climate risk disclosure proposal for the Committee’s consideration by the beginning of 2022. Ms. Stringer also said the Build Back Better reconciliation bill is making its way through the U.S. Congress. It includes President Biden’s policy priorities, including $555 billion for initiatives to combat climate change and promote clean energy production and resilience investments. Build Back Better has been passed in the U.S. House of Representatives but not the U.S. Senate.

Finally, Ms. Stringer said the NAIC is supportive of the Disaster Mitigation and Tax Parity Act, introduced by Sen. Dianne Feinstein (D-CA) and Rep. Mike Thompson (D-CA). If enacted, the Act would ensure that state-based disaster mitigation grants receive the same federal tax exemptions as federal mitigation grants.
8. **Heard an Update on International Activities**

Ryan Workman (NAIC) said the International Association of Insurance Supervisors (IAIS) held its annual conference in November, which included a panel focused on emerging good practices in climate risk scenario analysis for insurers and steps supervisors can take to advance scenario analysis as an effective risk assessment tool for insurers. He said the IAIS created a Climate Risk Steering Group. Commissioner Stolfi is the NAIC representative for that group, and Ms. Yue (Nina) Chen (New York Department of Financial Services [DFS]) serves as vice chair. The Steering Group has three workstreams. The first will develop a gap analysis of the IAIS global standards for insurance supervision to consider whether changes are needed to account for climate-related risk. The second will share examples of effective practices for developing climate scenario analysis in the insurance sector. The third will consider how to integrate climate related financial risks in the annual data collected as part of the Global Monitoring Exercise (GME).

Mr. Workman said the Sustainable Insurance Forum (SIF) met in October to discuss: 1) impacts of climate-related risks on the insurability of assets; 2) broader sustainability issues, including its scoping study *Nature-Related Risks in the Global Insurance Sector*; and 3) climate risks in the actuarial process. Director Farmer is the NAIC representative. Maryland recently became an SIF member, joining California, New York, Vermont, and Washington.

Mr. Workman said in October, the EU-U.S. Insurance Dialogue Project held a public virtual meeting. Commissioner Birrane and Commissioner Doug Ommen (IA) represented the NAIC. In October, they developed two working groups focused on climate-related topics to include: 1) climate risk financial oversight, including climate risk disclosures, supervisory reporting, and other financial surveillance; and 2) climate risk and resilience, including innovative technology, pre-disaster mitigation and adaptation efforts, and modelling.

Finally, Mr. Workman said in early November, the NAIC participated in the COP26 Sustainable Insurance Series hosted by the UN Environment Programme’s (UNEP) Principles for Sustainable Insurance Initiative (PSI). The event was held in conjunction with the United Nation’s (UN’s) COP26 Summit. Commissioner Altmaier, Commissioner Birrane, Director Farmer, Commissioner Kreidler, Commissioner Lara, and Commissioner Mais participated in panels focused on the actions of insurance supervisors regarding climate-related risk and resiliency, including coordination through the NAIC.

Having no further business, the Climate and Resiliency (EX) Task Force adjourned.
MEMORANDUM

TO: Members of the Climate and Resiliency (EX) Task Force

FROM: Technology Workstream of the Climate and Resiliency (EX) Task Force

DATE: Nov. 22, 2021

RE: Recommendation for the NAIC’s Center for Insurance Policy and Research to Create a Catastrophe Model Center of Excellence

The NAIC Climate and Resiliency (EX) Task Force charged the Technology Workstream to apply technology, such as predictive modeling tools, to understand and evaluate climate and natural catastrophe risk exposures. In particular, the Technology Workstream was tasked with determining whether technical support services were needed by state insurance departments regarding the industry’s use of catastrophe models.

The Workstream met Aug. 6, June 7, and March 24 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings, to hear about NAIC activities related to the use of catastrophe models in insurance. Content included a 2020 Center for Insurance Policy and Research (CIPR) research paper, Application of Wildfire Mitigation to Insured Property Exposure, which explores the economic benefits and costs of employing wildfire resilience strategies in nine communities in California, Colorado, and Oregon. Analysis was conducted using the RMS North America Wildfire Models highlighting the benefit of working with catastrophe model vendors for regulatory resilience priorities. Acknowledging the benefit of having a central resource for state insurance regulators regarding catastrophe models, as well the need for its discussed support services, on Sept. 21, the Technology Workstream issued a request for comments on a proposal (Appendix A) for the NAIC’s CIPR to create a Catastrophe Model Center of Excellence (COE). Comments were collected up to its open meeting on Nov. 4, during which the Workstream heard comments on the proposal, answered questions, and clarified the intent of the COE. The Workstream met again on Nov. 22 to provide an overview of a Frequently Asked Questions document (Appendix B), developed to provide answers to the questions received during the open comment period, as well as to provide additional clarification regarding the role of the COE and services to be provided if the proposal is adopted through the Executive (EX) Committee and Plenary.

If adopted, the COE would: 1) facilitate insurance department access to catastrophe modeling documentation and provide assistance in distilling the technical information received; 2) provide general technical education/training materials on the mechanics of commercial models and treatment of perils and risk exposures; and 3) conduct applied research analysis using various model platforms to proactively answer the regulatory “so what” questions that may need to be addressed for regulatory resilience priorities.

The support services offered through the COE will not take the place of individual state insurance department activities involving catastrophe models such as model and rate filing review, nor would the...
COE approve vendor models. The COE will engage with all vendors willing to participate for all perils with technical documentation available for state insurance regulators. The COE will establish a governance structure to ensure that the COE remains transparent and impartial. The COE will periodically report to relevant NAIC committees, including the Technology Workstream of the Climate and Resiliency (EX) Task Force and the Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee.

Furthermore, the COE will provide only fact-based information and relevant objective analysis, as requested. The COE will conduct research using catastrophe models to support risk mitigation and resilience efforts, critical for reducing future probable losses.

The COE will safeguard information received from participating catastrophe modeling vendors through legally binding data-use agreements. Some funding will be necessary to support the ongoing work of the COE, including staff salaries and resources for model access. The expenses associated with COE activities would be subject to the NAIC budget process.

The Technology Workstream voted on Nov. 22 to recommend that the NAIC’s CIPR create a catastrophe modeling COE. We believe this will be a valuable resource for state insurance departments and recommend that the Climate and Resiliency (EX) Task Force will consider moving the proposal forward to the joint Executive (EX) Committee and Plenary to consider for adoption during the 2022 Spring National Meeting.

Tech WS COE Recommendation
APPENDIX A

A Proposal to Establish a Catastrophe (CAT) Modeling “Center of Excellence” (COE) within the NAIC’s Center for Insurance Policy & Research (CIPR)

September 20, 2021

Introduction

The leadership and members of the NAIC have determined natural CAT risks and resiliency to be a top priority and organized several workstreams to pursue objectives intended to help ensure homes and businesses are protected from insured perils arising from natural CATs, while keeping markets stable through financially strong insurers and reinsurers. For example, the Catastrophe Risk (E) Subgroup has spent many years working to develop risk-based capital (RBC) factors for hurricane and earthquake exposures and, more recently, grappling with how best to address wildfire, flood, and convection storm perils. Separately, the Catastrophe Insurance (C) Working Group is charged with maintaining the NAIC State Disaster Response Plan, the Disaster Assistance Program, and the Catastrophe Computer Modeling Handbook. The Working Group has also commenced work to determine ways in which the private flood market can be facilitated and monitored by the state insurance regulators. The Climate and Resiliency (EX) Task Force has taken on significant work, which will require a deeper understanding of all aspects of climate and natural CAT risks. Further, many state insurance regulators are taking on new roles in working to create risk resilient communities within their jurisdictions.

Given these increased pressures and new roles, state insurance regulators need to improve their understanding of the CAT modeling technologies used by insurers and reinsurers. This means having access to the same knowledge, insights, and tools used by insurers. In doing so, state insurance regulators can more effectively engage with insurers and state and federal policymakers when discussing how best to maintain critical insurance coverages for their states' economies and developing new regulatory policy. The NAIC can play an instrumental role fulfilling these needs.

In this regard, the Technology Workstream of the Climate and Resiliency (EX) Task Force was assigned the task of considering the potential application of technology, such as early warning systems and predictive modeling tools, to better understand and thereby evaluate insurers' climate and natural CAT risks.
risk exposures. In particular, the Technology Workstream was tasked with determining whether technical support services were needed by state insurance departments regarding the industry’s use of CAT models.

To help facilitate the members’ consideration of such a need, NAIC/CIPR staff conducted two presentations on June 7 and Aug. 6, 2021, wherein staff laid out a range of support services for state insurance departments when encountering the use of commercial CAT models by insurers in rate making processes, solvency functions, and/or other insurance business decisions (e.g., strategic, reinsurance, claims management). NAIC/CIPR staff addressed potential support services in the areas of: 1) facilitating access to CAT modeling documentation; 2) providing technical education and training; and 3) conducting applied research to proactively address regulatory climate risk and resilience priorities. Finally, an additional related benefit highlighted is the ability to provide future support services for other modeled CAT risk beyond climate and natural CATs, including casualty/liability, cyber, terrorism, and infectious diseases such as pandemics. This additional support work could potentially influence other NAIC related committee activities, as appropriate.

**Proposal**

As outlined in the introduction above, the time has arrived for the NAIC to establish a permanent support group—i.e., the NAIC CAT Modeling COE—to provide the NAIC and state system of insurance regulation with the necessary technical expertise, tools, and information to effectively regulate the insurers and reinsurers exposed to catastrophic events for a secure and stable insurance marketplace. We believe this COE would be best positioned within the NAIC’s CIPR given CIPR’s: 1) existing knowledge, expertise, and recent NAIC applied research track record in this field; and 2) its ability to effectively work with modelers and state insurance regulators from a neutral perspective within the NAIC. Below is a complementary and integrated series of technical support services envisioned by the COE:

1) Facilitating insurance department access to CAT modeling documentation and assistance in the distilling of this information.

2) Providing general technical education/training materials on the mechanics of commercial models and treatment of perils and risk exposures.

3) Conducting applied research analysis utilizing various model platforms to proactively answer the regulatory “so what” questions that may need to be addressed for regulatory resilience priorities.

The first element from above provides for the CAT Modeling COE to facilitate insurance department access to CAT modeling documentation and other information, as well as centralizing accumulated knowledge and expertise to aid in the deciphering and distillation of CAT models. The COE would assist
with managing both CAT model vendor relationships and insurance department needs. As such, the COE would be briefed on the modeling technologies and inputs in a similar fashion as insurers and reinsurers are and have access to the same modeling documentation to develop internal expertise. This knowledge and expertise would then be actively shared with state insurance regulators for use in regulatory processes and other considerations. Critically, this information would be collected and stored on an NAIC regulator-only technological platform with proper CAT modeling vendor Data Use Agreements (DUAs) in place to allow for proprietary model information sharing, part of which has been a stumbling block to regulatory access to date.

The second element from above provides for technical education/training materials on the mechanics of commercial models and treatment of perils and risk exposures for state insurance regulators. Importantly, this technical training would be utilized to enhance regulatory operational activities, thereby bringing the science to operations. For example, it would allow for state insurance departments and the NAIC to reimagine the NAIC *Catastrophe Computer Modeling Handbook*, which could become the foundational authoritative literature on state insurance regulator use of CAT models. As state insurance regulators gain more practice with these models, the NAIC is also well-positioned to develop best practices on industry use, as well as state insurance regulator use. Consequently, the NAIC *Financial Condition Examiners Handbook* and the *NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual* could be improved to account for the latest developments and best practices in CAT risk assessment. Further from a solvency perspective, both the development of related RBC CAT charges and climate stress testing would benefit greatly from such a technical foundation.

The third element from above provides for conducting applied research analysis to utilize various model platforms to proactively answer the regulatory “so what” questions that may need to be addressed. CAT models are not limited to use by the insurance industry; they are tools for CAT risk assessment. State insurance regulators can apply these tools in much the same way as the industry, albeit for regulatory resilience priorities (e.g., how to increase the uptake and proliferation of home hardening activities related to hurricane and wildfire risk). Such mitigation activities are critical to reduce expected losses and improve the availability and affordability of coverage currently and in a future warming climate. Applied research utilizing CAT models can demonstrate the economic value of such mitigation activities, laying the proper foundation for policy discussions to address increasing property owner mitigation implementation.

Lastly, it is important to note that these identified support services will not be taking the place of individual state department of insurance (DOI) activities involving CAT models, such as model and rate filing reviews, nor will the CAT Modeling COE be approving vendor models. Rather, the support services will allow the COE to engage with state insurance regulators as a trusted partner with a sufficient level
of CAT modeling expertise to enable the conduction of ongoing CAT modeling regulatory activities more effectively.

**Plan of Action**

In the past year, many of the above support services have already transpired and/or are currently underway. These include: 1) regulator-only technological platform infrastructure development and DUA executions; 2) NAIC Insurance Summit and CIPR events focused on CAT modeling education concerning wildfire and flood models, CAT model climate change incorporation and climate risk assessment, and casualty CAT modeling; 3) successful completion of a California, Colorado, and Oregon DOI wildfire mitigation report and wildfire CAT model technical documentation done in conjunction with the Insurance Institute for Business & Home Safety (IBHS) and Risk Management Solutions (RMS), which was further leveraged by the Catastrophe Risk (E) Subgroup for wildfire RBC factor development and the Catastrophe Insurance (C) Working Group *Catastrophe Computer Modeling Handbook* updates.

Therefore, this proposal will not be to start such CAT modeling COE support service activities, but rather to build upon and leverage these activities for further enhancement and formalization at the NAIC.

Following the meeting of the Technology Workstream on Aug. 6, 2021, the proposal was released to the member states for further comments and questions. Comments were considered, and a revised proposal was approved for public exposure by the Technology, Solvency, and Pre-Disaster Mitigation Workstreams on Sept. 20, 2021.

Following the Sept. 20 regulator-only meeting, the proposal was released to interested parties for further comment and questions for 30 days. Comments will be considered by the Technology Workstream following this feedback and revisions may be made to the proposal, as agreed upon.

If the proposal advances through the above process steps, it will be prepared for recommendation to the Climate Risk and Resiliency (EX) Task Force at the NAIC 2021 Fall National Meeting in San Diego, CA.

We anticipate there would be no new charges associated with creation of the COE; i.e., the expenses associated with the COE resources would be effectively absorbed by the NAIC budget and have no special assessments, fee for services, etc. These resources may include: 1) recruiting a vendor/insurance department CAT modeling relationship manager and a CAT model research analyst; 2) funding for education/training development and implementation and the licensing and/or running of models for applied research to support and/or enhance regulatory operational activities; and 3) addressing regulatory resilience priorities.
**Conclusion**

In the face of extreme weather and the future climate significantly affecting property insurance markets, state insurance regulators need to have access to the same knowledge, insights, and CAT modeling tools used by insurers and reinsurers to assess and address climate risk and resiliency; i.e., knowledge and tools that are available for state insurance regulators to access, understand, and utilize. To accomplish this, we propose that the NAIC establish a permanent support group—i.e., the NAIC CAT Modeling COE—housed within the NAIC’s research unit; i.e., CIPR. We have laid out a proposal and plan of action that would build upon the work that the NAIC/CIPR has already been conducting around climate and CAT risks and allows the NAIC/CIPR to bring science to the operation of the DOIs in a way that is additive to the existing regulatory system, easy to access, and tailored to the needs of the state insurance regulators.

We welcome feedback on the proposal and plan of action. Please send questions or comments to Jennifer Gardner at jgardner@naic.org.
NAIC/Center for Insurance Policy and Research (CIPR) Catastrophe Model
Center of Excellence (COE)
Frequently Asked Questions (FAQ)
November 16, 2021

Governance & Oversight

Topic: Vendor and Insurer Continued Engagement with Departments of Insurance (DOIs)

Is the intent for the COE to become the primary point of contact between state insurance regulators and modelers?

No. As stated in the proposal, “identified support services will not be taking the place of state DOI activities involving CAT models, such as model and rate filing reviews, nor will the CAT Modeling COE be approving vendor models.” However, we do envision the COE providing access to CAT modeling expertise to support state insurance regulator understanding, training, etc.

Will state insurance regulators continue to be open to discussions with modelers (and insurers) about models?

Yes. In fact, the COE will seek to improve communication between state insurance regulators and modelers/insurers, supplying state insurance regulators with expertise and information to help facilitate such discussions.

Topic: Transparency and Potential Bias of Modeled Results/Usage

How will the COE engage with interested stakeholders to remain transparent?

Most NAIC support resources interact with a committee for reporting and oversight. In this instance, at least for now, we propose that the catastrophe resource center will report to the Technology Workstream under the Climate and Resiliency (EX) Task Force, as well as coordinate with the Property and Casualty Insurance (C) Committee.

How will the COE work to ensure impartiality of vendor models?
The COE will make every effort to engage with all vendors willing to participate for all perils with available technical documentation. Furthermore, the COE will establish a governance structure to ensure that partiality is not provided to any model or vendor.

**Would the COE be engaging to connect learnings from the CAT model to specific insurer rate-making, solvency, and/or business—i.e., strategic, reinsurance, claims management—decisions?**

The COE support services will not take the place of state DOI activities involving CAT models, such as model and rate filing reviews, nor will the CAT Modeling COE be approving vendor models. The COE will work to understand models objectively from a general sense, not for individual rate filings or solvency assessments. We acknowledge that each insurer has their own risk profile that would need to be considered on an individual basis, which is outside the scope of the COE.

**Topic: Objective Science**

**Would the kind of information the COE conveys be facts-based or would it include opinions or analysis?**

The information provided to the state DOIs would be fact-based with relevant objective analysis, as requested. Providing this type of information to states highlights the importance of the placement of the COE within the NAIC’s independent research center, the CIPR.

**Topic: Addressing Regulatory “So What” Questions Through Applied Research**

**What are regulatory “so what” questions in support service #3 of the proposal conducting applied research analysis?**

State insurance regulators are responsible for maintaining well-functioning competitive insurance markets. Forward-looking models can be utilized to help analyze market performance, especially regarding the need for improved resilience. As stated in the proposal, CAT models are tools for catastrophe risk assessment. State insurance regulators can apply these tools in much the same way as the industry, albeit for regulatory resilience priorities. For example, models can be used to identify high-risk areas and where proliferation of home hardening activities can improve resilience to natural hazards, including hurricane, flood, severe convective storm, tornado, wildfire, and earthquake. Such mitigation activities are critical to reduce probable losses. Lower losses over time can improve the availability and affordability of coverage in the future. Applied research utilizing CAT models can demonstrate the economic value of mitigation activities. One
description provided via public comments that we considered useful is, “conducting applied research analysis that utilizes or analyzes the potential to utilize CAT models to further public and private risk mitigation and resiliency efforts; benefits and opportunities at the individual consumer or business; or public agency at the community, regional, state, or national level.”

**Regarding conducting applied research analyses utilizing CAT models, we would like to understand the research and support expectations from the COE on modelers.**

We envision working with modelers on applied research activities as applicable. We are requesting funding to allow for modeler engagement.

**Depending on the expected level of granularity for COE work, additional questions may be relevant, such as whether the COE (NAIC/CIPR) would need to be prepared to go to a hearing to testify or respond to discovery?**

It is not anticipated that the COE would maintain granular information about individual insurer use of CAT models. The level of detail would be around the actual CAT model to provide education and training to state DOIs.

**Will the COE be used to conduct research and analysis into the markets for CAT models. Will conflicts of interest or market failures distort the use of CAT models?**

No. It is not envisioned that the COE would set out to conduct this type of research and analysis.

**Implementation Considerations**

**Topic: COE Communication of Various Results, Information, and Observations to DOIs**

Given the complexity of models and breadth of expertise required to build and maintain them, there is a risk that any third party cannot adequately communicate the nuances and justification of models. Will the COE plan to coordinate model presentations from the modelers, rather than only relaying this information second-hand?

Yes. The COE would plan to coordinate model presentations from modelers.

**How will information, observations, and/or questions about models be conveyed to state insurance departments? What kind of output will be generated?**

We plan to hire a relationship manager responsible for communicating with the CAT model vendors and state insurance regulators. A regulator-only technology platform will help facilitate information sharing with state insurance regulators.
Research output could take multiple forms depending upon the nature of the analysis undertaken.

**What kinds of data fields will be included? Will others provide input into the design?**

The data fields selected would be contingent on the models being used and the research project under consideration. Data fields would follow from model inputs and outputs.

**Will the COE reviews and/or output be designed to be geography-specific?**

Yes. That is possible.

**Once a model has been reviewed, what renewal process is envisioned?**

Models will not be reviewed, nor would they be posted on the state insurance regulator-only website. However, model technical documentation and information will be updated as new versions of the models are released.

**Topic: Model Vendor Intellectual Property (IP) Protection**

**How will the COE safe-guard intellectual property of the participating CAT model vendors?**

All modeling documentation, access, and usage will be centralized and monitored through the COE via legally binding data use agreements. The NAIC has an extensive track record of experience in collecting and protecting proprietary information. The actual models will not be posted on the state insurance regulator website, only the model documentation will be posted.

**Topic: Interaction with Modelers and Other External Experts**

**Will modelers engage in discussions with the COE about specific models? Do you expect insurers would be involved in model-related discussions?**

Yes. The COE would be engaged with modelers on the modeling technologies and inputs in a similar fashion as insurers and reinsurers and have access to the same modeling documentation to develop internal expertise. It is possible that insurers could be involved in model-related discussions with the COE, but the COE will not review individual insurer’s use of models.

**Is the CIPR planning to license and use modeler software or engage in paid consulting studies for their research and development of processes?**
Yes, depending on COE resources and the specific research use case. The CIPR would be willing to either license modeler software and/or engage in paid consulting studies for research and educational/training purposes, as directed by the appropriate NAIC authorities.

**How will results and underlying assumptions from licensed models be communicated to state insurance regulators?**

Any use of a licensed model, including distribution of modeled results, would be subject to the model license agreement and/or model vendor negotiated research consulting contract. Underlying assumptions from the various models utilized would be collected via the model technical documentation as part of the model vendor data use agreement. Note that it is possible that the model technical documentation, including underlying model assumptions, could be collected through a COE data use agreement without an associated model-based research project. If we were to license a model, the actual model would not be posted on the state insurance regulator-only website.

**Will modelers be involved in establishing workflows, best practices, agendas, and expectations of the COE, including timing?**

We anticipate that modelers will be actively engaged with the COE staff, advising on these items as appropriate.

**How many vendors is the COE considering supporting?**

The COE will not be “supporting” vendors, but rather the COE will collect model documentation and engage with model vendors. The COE will engage with any model vendor serving insurance markets where the information is relevant to state insurance regulators.

**Does the COE anticipate looking to external experts for some of the implementation or ongoing work?**

Yes. External collaboration would be welcome, whether that be with industry experts, public agencies, or the academic community.

**Topic: Resources – Staffing and Funding**

**How many states do you expect to be interfacing with the COE?**

The COE will be a resource of the NAIC potentially interfacing with all 56 jurisdictions.
Beyond recruiting for the identified new roles of CAT modeling relationship manager and CAT model research analyst, how many people at the NAIC/CIPR will be contributing to COE activities? Do you expect that to change over time?

The CIPR director, the NAIC solvency enterprise risk management (ERM) advisor, and potentially Property and Casualty Insurance (C) Committee staff support will have a role in supporting the work of the COE. We anticipate that additional technical and administrative support resources may be necessary as the workload and demand for services evolve with demonstrated success.

Will the staffing level proposed by the NAIC be able to provide meaningful analysis in the broad category of catastrophe modeling?

Prior to the creation of the COE, CIPR and NAIC staff have provided meaningful analysis on wildfire CAT modeling and applied wildfire resilience research. We aim to build off this success and need to start somewhere. Every little bit helps for the states, as stated by one industry commenter, “[t]he staffing issues mentioned above regarding experts at the NAIC are even larger for state insurance departments. Most states are not going to have enough or the right staff to review these models. They will have to rely on others to evaluate catastrophe model validity, and most likely will have to rely heavily on the decisions and evaluations made by others.”

Have long-term plans been prepared? Are there budget implications?

No long-term plan has been developed for the COE. The expenses associated with the COE would be subject to the NAIC budget process and have no special assessments or fees for service.
PROPOSED REDESIGNED NAIC CLIMATE RISK DISCLOSURE SURVEY

PURPOSE STATEMENT

The purpose of the Climate Risk Disclosure Survey is to:

- Enhance transparency about how insurers manage climate risks and opportunities as well as identify good practices and vulnerabilities.
- Provide a baseline supervisory tool to assess how climate-related risks may affect the insurance industry.
- Promote insurer strategic management and encourage shared learning for continual improvement.
- Enable better-informed collaboration and engagement on climate-related issues among regulators and interested parties.
- Align with international climate risk disclosure frameworks to reduce redundancy in reporting requirements.


Narrative and closed ended questions follow, grouped into the Financial Stability Board’s Task Force for Climate-related Financial Disclosure (TCFD) four topics.

Can be presented as (1) two separate parts of the same survey, narrative and closed ended, with option to attach narrative answers as file if it exists already (e.g., like current TCFD reports) so that only closed ended need to be completed, or (2) closed ended questions directly incorporated into narrative questions, with possible option to attach a report and only answer closed ended questions.

*Italics* indicate that the question is copied from TCFD.
Governance – narrative questions

1. **Disclose the organization's governance around climate-related risks and opportunities.**
   - Identify and include any publicly stated climate risk goals
   - Describe where climate risk disclosure is handled within the organization’s structure, e.g., at a group level, entity level, or a combination. If handled at the group level, describe what activities are undertaken at the company level.
   A. **Describe the board's oversight of climate-related risks and opportunities.**
      - Describe who on your board or committees is responsible for the oversight of managing the climate-related financial risks.
   B. **Describe management’s role in assessing and managing climate-related risks and opportunities.**

Governance – closed ended questions answered in addition to the narrative

1. Is Climate Risk Governance done at a group level, entity level, or a combination? (Multiple-choice answers)
   - Based on answer/if group level: Are any activities undertaken at the Company Level? (Y/N)
2. Does the company have publicly stated climate risk goals? (Y/N)
3. Does your board have a member, members, a committee, or committees responsible for the oversight of managing the climate-related financial risk? (Y/N)
4. Does management have a role in assessing and managing climate-related risks and opportunities? (Y/N)

Strategy – narrative questions

2. **Disclose the actual and potential impacts of climate-related risks and opportunities on the organization's businesses, strategy, and financial planning where such information is material.**
   - Describe how the company defines materiality.
   - Describe the steps the company has taken to engage key constituencies on the climate risk and resiliency.
   - Describe the companies plan to assess, reduce, or mitigate its greenhouse gas emissions in its operations or organizations.
   A. **Describe the climate-related risks and opportunities the organization has identified over the short, medium, and long term by completing the chart below.**
      - Define short, medium, and long-term, if different than 1-5y as short term, 5-10y as medium term, and 10-30y as long term.
B. **Describe the impact of climate-related risks and opportunities on the organization's businesses, strategy, and financial planning.**
   - Discuss how the company provides products or services, or makes investments, to support the low carbon transition or help customers adapt to climate risk? (This can include underwriting and/or investments.)

C. **Describe the resilience of the organization's strategy, taking into consideration different climate-related scenarios, including a 2 degree Celsius or lower scenario.**

***Strategy - closed ended questions answered in addition to the narrative***

1. Has the company taken steps to engage key constituencies on the topic of climate risk and resiliency? (Y/N)
2. Does the company provide products or services, or make investments, to support the low carbon transition or help customers adapt to climate risk? (This can include underwriting and/or investments.) (Y/N)
3. Does the company have a plan to assess, reduce or mitigate its greenhouse gas emissions in its operations or organizations? (Y/N)

***Risk Management – narrative questions***

3. **Disclose how the organization identifies, assesses, and manages climate-related risks.**
   - Discuss how the company considers the impact of climate related risks on its underwriting portfolio, and how the company is managing its underwriting exposure with respect to physical, transition and liability risk.
   - Describe any steps the company has taken to encourage policyholders to manage their potential climate related risks.
   - Describe how the company has considered the impact of climate related risks on its investment portfolio, including what investment classes have been considered.
   
   A. **Describe the organization’s processes for identifying and assessing climate-related risks.**
      - Discuss whether the process includes an assessment of financial implications.
      - Discuss how frequently the company go through the process to assess climate-related risks.
   
   B. **Describe the organization’s processes for managing climate-related risks.**
   
   C. **Describe how processes for identifying, assessing, and managing climate-related risks are integrated into the organization’s overall risk management.**
      - Discuss whether climate-related risks are addressed through the company’s general enterprise-risk management process or a separate process.
• Discuss how frequently the company goes through the process to identify climate-related risks
• Describe the potential impact of climate related risks on the company’s underwriting portfolio and how the company is managing its exposure with respect to physical, transition and liability risk.
• Describe how the company considers the impact of climate-related risks on its investment portfolio.

Risk Management – closed ended questions answered in addition to the narrative

1. Does the company have a process for identifying climate-related risks? (Y/N)
   A. If yes, are climate-related risks addressed through the company’s general enterprise-risk management process? (Y/N)
   B. If yes, how frequently does the company go through the process to identify climate-related risks? (Multiple choice, e.g., annually, etc.)
2. Does the company have a process for assessing climate-related risks? (Y/N)
   A. If yes, does the process include an assessment of financial implications? (Y/N)
   B. If yes, how frequently does the company go through the process to assess climate-related risks? (Multiple choice)
3. Does the company have a process for managing climate-related risks? (Y/N)
4. Has the company considered the impact of climate-related risks on its underwriting portfolio? (Y/N)
5. Has the company taken steps to encourage policyholders to manage their potential climate-related risks? (Y/N)
6. Has the company considered the impact of climate-related risks on its investment portfolio? (Y/N)

Metrics and Targets – narrative questions

4. Disclose the metrics and targets used to assess and manage relevant collateralized risks and opportunities where such information is material.
   • Describe how your organization uses catastrophe modeling to manage the climate-related risks to your business.
   • Specify for which climate-risks the company uses catastrophe models to assess. (Property, Casualty, Life, Health)
   • Discuss the climate scenarios utilized by the company to analyze its underwriting risks, including which risk factors the scenarios consider, what types of scenarios are used, and what timeframes are considered.
   • Discuss the climate scenarios utilized by the company to analyze risks on its investments, including which risk factors are utilized, what types of scenarios are used, and what timeframes are considered.
     A. Disclose the metrics used by the organization to assess climate-related risks and opportunities in line with its strategy and risk management process.
In describing the metrics used by the company to assess and monitor climate risks, consider the amount of exposure to business lines, sectors, and geographies vulnerable to climate-related physical risks [answer in absolute amounts and percentages if possible], alignment with climate scenarios, [1 in 100 years probable maximum loss, Climate VaR, carbon intensity], and the amount of financed or underwritten carbon emissions)

B. **Disclose Scope 1, Scope 2, and if appropriate, Scope 3 greenhouse gas (GHG) emissions, and the related risks.**

C. **Describe the targets used by the organization to manage climate-related risks and opportunities and performance against targets.**

**Metrics and Targets – closed ended questions answered in addition to the narrative**

1. Does your company use catastrophe modeling to manage your company’s climate-related risks? (Y/N)
   A. If yes, for which climate-related risks does the company use catastrophe models? (Multiple choice: Property, Casualty, Life, Health)
   B. If yes, how does the company use catastrophe modeling to manage climate-related risks? Multiple choice: Financial solvency, underwriting, other – please describe)

2. Does the company use metrics to assess and monitor climate-related risks? (Y/N)

3. Does the company have climate-related targets? (Y/N)

4. Has the company utilized climate scenarios to analyze their underwriting risk? (Y/N)
   A. If yes, which risk factors do the scenarios consider? (Multiple choice: Physical, Transition, Liability)
   B. If yes, what type of scenarios are used? (Multiple-choice)
   C. If yes, what timeframes are considered? (Multiple-choice)
   D. If no, does the company expect to develop scenario analysis for underwriting in the future? (Open comment)

5. Has the company utilized climate scenarios to analyze their investment risk? (Y/N)
   A. If yes, which risk factors do the scenarios consider? (Multiple choice: Physical, Transition, Liability)
   B. If yes, what type of scenarios are used? (Multiple-choice)
   C. If yes, what timeframes are considered? (Multiple-choice)
   D. If no, does the company expect to develop scenario analysis for investment management in the future? (Open comment)
GOVERNMENT RELATIONS (EX) LEADERSHIP COUNCIL

The Government Relations (EX) Leadership Council did not meet at the Fall National Meeting.
The Innovation and Technology (EX) Task Force met in San Diego, CA, Dec. 13, 2021. The following Task Force members participated: Jon Godfread, Chair, and Chris Aufenthie (ND); Elizabeth Kelleher Dwyer, Vice Chair, and Matt Gendron (RI); Lori K. Wing-Heier (AK); Jim L. Riding represented by Jimmy Gunn (AL); Alan McClain (AR); Evan G. Daniels (AZ); Ricardo Lara represented by Ken Allen and Lucy Jabourian (CA); Michael Conway (CO); Andrew N. Mais (CT); Karima M. Woods represented by Michael Ross (DC); Trinidad Navarro (DE); David Altmaier represented by John Reilly (FL); Colin M. Hayashida (HI); Doug Ommen (IA); Dean L. Cameron represented by Weston Trexler (ID); Dana Popish Severinghaus represented by Eric Weyhenmeyer (IL); Amy L. Beard represented by Jerry Ehlers (IN); Vicki Schmidt represented by LeAnn Crow (KS); Sharon P. Clark represented by Vicki Lloyd (KY); James J. Donelon represented by Tom Travis (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Eric A. Cioppa represented by Benjamin Yardley (ME); Anita G. Fox represented by Chad Arnold (MI); Grace Arnold (MN); Chlora Lindley-Myers represented by Cynthia Amann (MO); Mike Chaney represented by Ryan Blakeney (MS); Troy Downing (MT); Mike Causey represented by Angela Hatchell (NC); Marlene Caride represented by Randall Currier (NJ); Russell Toal represented by Leatrice Geckler (NM); Barbara D. Richardson (NV); Judith L. French (OH); Glen Mulready represented by Teresa Green (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Raymond G. Farmer represented by Michael Wise (SC); Larry D. Deiter (SD); Carter Lawrence (TN); Cassie Brown (TX); Jonathan T. Pike (UT); Scott A. White and Rebecca Nichols (VA); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler represented by Molly Nollette (WA); Mark Afable (WI); and Allan L. McVey represented by Robert Grishaber (WV).

1. **Adopted its Summer National Meeting Minutes**

Commissioner Conway made a motion, seconded by Commissioner Altman, to adopt the Task Force’s Aug. 14 minutes (see *NAIC Proceedings – Summer 2021, Innovation and Technology (EX) Task Force*). The motion passed unanimously.

2. **Adopted its Working Group Reports**

   a. **Big Data and Artificial Intelligence (EX) Working Group**

   Commissioner Ommen gave the report of the Big Data and Artificial Intelligence (EX) Working Group. He said the Working Group met Dec. 13 and reviewed its 2022 proposed charges and briefly discussed the progress on its 2021 charges and the relevance of the Working Group’s efforts continuing under the proposed Innovation, Cybersecurity, and Technology (H) Committee. He said the Working Group has focused its efforts this year in researching the use of big data and artificial intelligence (AI) in the business of insurance and evaluating existing regulatory frameworks for overseeing and monitoring AI and machine learning (ML), including discussions on model governance. He said during its meeting, the Working Group received a presentation on how to leverage the lessons learned in developing the regulatory framework for cybersecurity to the development of a regulatory framework for the use of AI. Additionally, building on the work of the NAIC’s AI principles adopted last year, the Working Group heard a presentation from Monitaur, which is a company that has been active in developing governance and controls for AI/ML models, and SigmaRed, another company developing processes to monitor and mitigate AI bias and enhance model transparency.

   Commissioner Ommen said the Working Group received a presentation on the preliminary, aggregate analysis of industry responses to the survey on private passenger auto (PPA) insurers’ AI/ML use that was conducted under the examination authority of Connecticut, Illinois, Iowa, Louisiana, Nevada, North Dakota, Pennsylvania, Rhode Island, and Wisconsin. He said this research is intended to inform work in other areas related to the Working Group’s charges, such as evaluating the appropriateness of existing regulatory frameworks for overseeing and monitoring the use of AI/ML models. He said it was distributed to PPA insurers with national premium greater than $75 million and asked a threshold question of whether a company is using or contemplating using AI/ML; followed by questions related to the operational areas of rating, underwriting, claims, fraud detection, marketing, and loss prevention; and additional questions related to specific uses, level of deployment, level of decisions influenced, governance, and types of data used.

   Commissioner Ommen said the Working Group discussed the next line of insurance to survey, which included a discussion of conducting surveys for both homeowners and life insurance at the same time, and he said the Working Group will identify state subject matter experts (SMEs) to begin discussions for these two lines while finalizing the analysis of the PPA survey.
b. Speed to Market (EX) Working Group

Ms. Nichols gave the report of the Speed to Market (EX) Working Group. She said the Working Group met Nov. 16 and took the following action: 1) adopted its June 30 and June 29 minutes; 2) discussed and reviewed the Casualty Actuarial and Statistical (C) Task Force’s Regulatory Review of Predictive Models white paper; 3) considered its proposed edits to Chapter Three—The Basics of Property and Casualty Rate Regulation of the Product Filing Review Handbook (Handbook) for approval; and 4) adopted the Casualty Actuarial and Statistical (C) Task Force’s edits to the Handbook. She said updating the Handbook will be a priority in 2022 for the Working Group.

c. E-Commerce (EX) Working Group

Commissioner Birrane gave the report of the E-Commerce (EX) Working Group. She said the Working Group met Oct. 7 and heard from state insurance regulators, consumer representatives, industry representatives, and other stakeholders on the core concerns and considerations that should shape the scope of its work. She said the American Council of Life Insurers (ACLI) suggested the development of a handbook that would capture the regulatory framework that exists with respect to e-commerce, including variations among jurisdictions. She said the presentations informed the three surveys that were circulated to state insurance regulators and interested parties on Dec. 10: 1) a survey to identify, for each jurisdiction, the laws that regulate electronic insurance transactions, including the status of the state’s adoption of the Uniform Electronic Transactions Act (UETA); 2) a survey focused on what accommodations each jurisdiction made to allow electronic transactions to occur during the COVID-19 pandemic, as well as the basis for those accommodations and what would have to happen to allow it to become permanent; and 3) a survey directed to industry focusing on identifying specific and practical ways in which specific laws or regulatory constructs impede electronic commerce in the insurance sector. She said once the survey responses are received, the Working Group will analyze and report on the results, which will inform its next steps.

Commissioner Godfread asked if there are any questions regarding any of the working group reports. Hearing none, Superintendent Dwyer made a motion, seconded by Director Wing-Heier, to adopt the following reports: 1) the Big Data and Artificial Intelligence (EX) Working Group, including its Dec. 13 minutes (Attachment One); 2) the Speed to Market (EX) Working Group, including its Nov. 16 minutes (Attachment Two); and 3) the E-Commerce (EX) Working Group, including its Oct. 7 minutes (Attachment Three). The motion passed unanimously.

3. Heard an Update on CO SB 21-169

Commissioner Conway said the core goal of Colorado Senate Bill 21-169 is to protect Colorado consumers from insurance practices that result in unfair discrimination on the basis of race, color, national or ethnic origin, religion, sex, sexual orientation, disability, gender identity, or gender expression. He said it is focused on ensuring that external consumer data is not used in a way that unfairly discriminates against consumers. He said the core idea came from recognizing that the insurance department would not have the resources or expertise to compete with insurance companies but needed to find a way to ensure that the industry is using big data components responsibly. He said the intention is to find ways for the industry to stress test their own systems and identify the issues that may be occurring with big data systems and algorithms and find solutions for them. He said this is a problem that is bigger than just the insurance industry, and he provided examples. He said at its core, the legislation says a simple correlation to risk will not be sufficient if the underlying insurance practice also correlates to a protected class and negatively affects that class. He said it will be a balancing test that the law requires to be defined through a stakeholder process. He said the legislation is focused on personal lines of insurance, life, health, property, and casualty. He said the insurance practices subject to the legislation are marketing, underwriting, pricing, utilization management, reimbursement methodologies, and claims management. He said the risk management framework required by the law includes providing information on the external consumer data and information source used, explaining how it is used, establishing and maintaining a risk management framework, attesting to its implementation, and providing an assessment of the results of the framework or a similar process. He said the plan is to begin stakeholder meetings in mid-January 2022, and the rules will not be effective until Jan. 1, 2023. He encouraged all stakeholders to engage with the process.

4. Heard Presentations from Insurtech Coalitions

Commissioner Godfread introduced J.P. Wieske (American InsurTech Council—AITC) and Scott Harrison (AITC).

a. AITC

Mr. Harrison said the group is formally launching today, Dec. 13. He said he is the co-founder of the AITC, and he is joined by three other co-founders: Jack Friou, Thomas Mays, and Mr. Wieske. He said another co-founder, Teri Hernandez is not able
to be in attendance. He said the AITC saw the need for an organization to work with state insurance regulators as they develop new standards and regulatory frameworks for Insurtech. He said the AITC’s mission is to serve as a dedicated, independent advocacy organization, advancing the public interest through the development of ethical, technology-driven innovation in insurance. Through its advocacy efforts, it also aims to advance public policy interests of insurers, insurance carriers, brokers, and other stakeholders by providing policy research, education, and outreach to policymakers, with the public, and across all lines of insurance. Mr. Wieske said the regulation of insurance must change and the regulatory environment modernize. He said the AITC wants to work with state insurance regulators to build this new environment, and it must be state-based. He said the AITC will not be for everybody, and he expects it to be a bit more of an exclusive organization going forward, but he believes these core principles are the key to moving forward.

Director Dieter said South Dakota did an innovation waiver last year, and Mr. Wieske and Mr. Harrison were very helpful in working with the legislature in getting that bill passed.

b. **InsurTech Coalition**

Commissioner Godfread introduced the second presenter from the InsurTech Coalition, Rachel Jrade-Rice (Next Insurance). Ms. Jrade-Rice introduced the other InsurTech Coalition members: Bill Latza (Lemonade), Jeremy Deitch (Boost), and Melanie Irvin (Branch). She said the InsurTech Coalition is made up of property/casualty (P/C) insurers. She said it is more of a bottom-up type of organization that started with these companies talking about regulation and how best to interface with commissioners given their unique characteristics. She said the InsurTech Coalition’s insurers are in business to benefit the consumer and, more than thinking about the technologies, think about things in terms of the insurance product and consumer experience as a whole. She said the insurers that make up the Insurtech Coalition are focused on three things: 1) customer engagement; 2) convenience; and 3) tailored insurance products. She said the mission is to, first and foremost, be a resource and share information about how they use these technologies. She said founders of these companies recognized that there were underserved consumers in the marketplace, and they worked to bridge that insurance protection gap between what customers need, increasing accessibility and leveraging technology to build a better future. She said the focus of the InsurTech Coalition is speed to market, collaboration, and modernization.

Commissioner Godfread asked Ms. Jrade-Rice if the InsurTech Coalition is seeking additional members. Ms. Jrade-Rice said the InsurTech Coalition would welcome other members, and it is here to serve and be a resource to state insurance regulators and each other and to help everyone navigate the complex regulatory landscape.

5. **Heard a Presentation from the Ad Hoc Drafting Group on Proposed Draft Charges for a New NAIC H Committee**

Superintendent Dwyer provided an update on the progress of the Ad Hoc Drafting Group related to drafting charges for a new NAIC committee. She said she chaired the Ad Hoc Drafting Group, and it was vice chaired by Commissioner Birrane and Director Daniels. She said the process was thoughtful and deliberate, and the end product reflects the discussion and comments from all stakeholders, not just the 13 states who served on the Ad Hoc Drafting Group. She said in addition to Arizona, Maryland, and Rhode Island, the following states participated: California, Connecticut, Georgia, Iowa, Michigan, New Mexico, Ohio, North Dakota, Tennessee, and Wisconsin. She said the first meeting was held on Sept. 27, and a “strawman” charges draft was discussed, subsequently revised, and circulated to the members prior to the Commissioners’ Conference in late October. She said hearing no objections, the draft was then exposed publicly; a public open comment meeting was held on Nov. 19; and comments, both written and verbal, provided by state insurance regulators, industry, and consumer representatives were taken into consideration following that meeting. She said another meeting of the Ad Hoc Drafting Group was held on Nov. 30 to review the new draft, and the final version was completed and posted on the NAIC website. She said it is open for discussion at the Innovation and Technology (EX) Task Force meeting, will be discussed during the Executive (EX) Committee meeting, and will be brought before the full membership at the Executive (EX) Committee and Plenary for a vote.

Superintendent Dwyer said the intention is to provide more consistency and collaboration, ensure coordination on related workstreams, and provide clarity and understanding regarding who or what committee is doing what and how it aligns and coordinates with related activities taking place in other workstreams. She said in addition, a priority and focus will be given to cybersecurity. She said once a chair and vice chair are named and committee members assigned, the committee will go over its charges and develop its strategy and workplan for addressing the charges. She said that may involve some re-organization of NAIC committees, but those decisions will be made once the committee is formed.

Commissioner Godfread said the new committee, once approved and members appointed, will put the structure in place, and the working groups that come under the committee will continue the work they have been doing in the technology and cybersecurity space and innovation, but it may look just a touch different as the work is elevated up to a letter committee level.
6. Heard Updates from Other Committees and Working Groups on Related Activities

Commissioner Godfread asked representatives from other committees whose charges involve related workstreams to those of the Task Force to provide updates.

a. Special (EX) Committee on Race and Insurance

Commissioner Mais said his report focuses on activity of the Special (EX) Committee on Race and Insurance that relates to data issues. He said there has been discussion within the workstreams about data potentially being needed to ensure that unfair discrimination or bias is not occurring in the marketing, underwriting, or rating of insurance. He said Workstream Five, dealing with health, has moved the furthest down this path by drafting a “Principles for Data Collection” document that provides high-level guiding principles for the collection and treatment of data on race, ethnicity, and other demographic characteristics in the health insurance business. He said one consistent theme expressed by stakeholders is that robust data collection is a key to both quantifying existing disparities and evaluating the effectiveness of initiatives to address those disparities. He said the Workstream plans to hold one last meeting on Dec. 20 to finalize the document, then it will be forwarded to the Special Committee for consideration.

Commissioner Mais said the Special Committee is also hearing how race is considered in the banking sector during this national meeting to see what can be learned and leveraged from that regulatory process to better inform workstreams as they begin to consider what additional data may or may not be needed. He said in terms of P/C issues, Workstream Three met Dec. 1 and heard from interested parties about Charge F having to do with continuing research and analysis of insurance, legal, and regulatory approaches to addressing unfair discrimination, disparate treatment, proxy discrimination, and disparate impact. He said the Workstream believes an important first step would be to consider the drafting of a white paper to define some of these terms, as well as to set forth next steps for the Special Committee.

Commissioner Mais said during Workstream Three’s Dec. 1, the Casualty Actuarial Society (CAS) previewed several papers it will be releasing in early 2022 that will define discrimination insurance; potential influences of racial bias on P/C insurance; approaches to address racial bias in financial services, including lessons learned for the insurance industry; and methods for quantifying discriminatory effects on protected classes in insurance. He said the CAS provided an overview of those papers, and it appears they will be useful in drafting the white paper. He said the Workstream also heard from several other consumer and industry groups about how to define these terms, as well as how to audit algorithms to ensure there is no disparate impact. He said the next step will be to have another call to continue these discussions, with a goal of drafting a white paper outline and taking comments on that outline.

b. Privacy Protections (D) Working Group

Ms. Amann said the Privacy Protections (D) Working Group met Dec. 11 and had a lively discussion about privacy protections. She said this work will likely overlap with many other groups. She said during that meeting, the Working Group adopted its charges and minutes from previous meetings. She said the focus of the work going forward would include the right to: 1) opt out; 2) limit and correct information; 3) delete information; 4) data portability; 5) restrict the use of data; 6) data ownership; 7) notice; and 8) non-discrimination or non-retaliation. She said the report was re-worded to replace the word “right” with “categories of discussion,” and this is now the report of the Working Group and not a policy statement as it had previously been labeled.

a. Accelerated Underwriting (A) Working Group

Commissioner Arnold gave the report of the Accelerated Underwriting (A) Working Group. She said the Working Group has been releasing its education report on accelerated underwriting in pieces for comment. She said the latest draft was released on Nov. 8, and comments are due by Dec. 3. She said the Working Group has received four comment letters from NAIC-funded consumer representative Birny Birnbaum (Center for Economic Justice—CEJ), NAIC-funded consumer representative Brendan Bridgeland (CEJ), Sue Bartholf (American Academy of Actuaries—Academy); and David Leifer and Gabrielle Smith (ACLI). Commissioner Arnold said on the Dec. 6 call, each of the commenters had the opportunity to briefly summarize the primary points in their comments. She said she chairs an ad hoc group made up of state insurance regulators working to draft the report, but the ad hoc group has not had an opportunity get together yet to review and consider these comments. The ad hoc group plans to meet following the Fall National Meeting, and it anticipates exposing a revised draft for a public comment period prior to the 2022 Spring National Meeting.
7. **Heard a Presentation on the MIB’s Algorithmic Bias Testing for Life Insurers**

Commissioner Godfread introduced Scott Kosnoff (Faegre Drinker) and Christie Corado (MIB Group). Mr. Kosnoff said the MIB Group is a life insurance trusted partner for data; offers insights in digital solutions; and manages a contributory data exchange for life insurance application data, which is known as the MIB Group checking service. He said the MIB Group may be able to help life insurers with algorithmic accountability, especially as it relates to racial bias, and it sees four challenges in this area including: 1) due to liability concerns, most insurers are reluctant to collect, derive, or purchase the demographic information needed to test for racial bias; 2) even if that data is available, there is no agreed upon means of measuring racial bias in algorithms; 3) there is no consensus on what level of correlation with race is acceptable; and 4) there is no consensus on how to mitigate racial bias if it is determined to exist. Ms. Corado said the MIB Group can help by serving as a repository of data, including race and ethnicity information that companies may not want to collect or store from the MIB Group checking service and publicly available data. She said the MIB Group could also promote algorithmic accountability by using actuarial analysis and data analytics to test and validate life insurers’ AI algorithms and external data. She said to do this, it would need companies to provide their underwriting outcomes, and if they would, the MIB Group may be able to create industry benchmarks that will allow insurers to compare their results with industry averages. She detailed the reasons why the MIB Group may be uniquely situated to provide this type of service.

Commissioner Afable asked Mr. Kosnoff and Ms. Corado if they have determined a standard that they are using to test against. Mr. Kosnoff said no, and that is one of the big challenges identified; but if enough companies would use the MIB service, the MIB Group may start to develop the bell curve that would allow it to see what looks and feels normal versus where there are outliers.

8. **Received a Presentation on the SERFF Modernization Project**

Joy Morrison (NAIC) provided an update on the System for Electronic Rates and Forms Filing (SERFF) Modernization Project. She said SERFF is used in 53 jurisdictions and has been around for 20 years, processing over half a million filings yearly. She said the effort to modernize SERFF started a couple years ago with there being some indication that there was a need for added functionality. She said an assessment was done in 2020, and the team identified many great tools and technologies available that could be leveraged to improve the system. She said the team has done some development work that is currently being demonstrated to state insurance regulators to get their feedback. She said that input is very important, and she encouraged everyone to participate in those demos and provide input and feedback.

9. **Discussed Other Matters**

Commissioner Godfread said the Task Force had an agenda item to get an update on international work related to innovation and technology, but due to time constraints, that report will be distributed to the Task Force members after the meeting.

Commissioner Godfread thanked everyone who has participated in Task Force activities over the past five years, noting that it will be disbanded with the appointment of the new Innovation, Cybersecurity, and Technology (H) Committee. He said he wants to specifically thank one of his staff members, Mr. Aufenthie, and the vice chair, Superintendent Dwyer, for the work they have done in support of the Task Force. He also thanked the members for their continued engagement and level of interest.

Having no further business, the Innovation and Technology (EX) Task Force adjourned.

12.13ITTF Minutes Final.docx
The Big Data and Artificial Intelligence (EX) Working Group of the Innovation and Technology (EX) Task Force met in San Diego, CA, Dec. 13, 2021. The following Working Group members participated: Doug Ommen, Chair (IA); Elizabeth Keller Dwyer, Co-Vice Chair (RI); Mark Afable, Co-Vice Chair (WI); Lori K. Wing-Heier (AK); Jimmy Gunn (AL); Ken Allen (CA); Peg Brown (CO); George Bradner (CT); Frank Pyle (DE); Nicole Altieri Crockett (FL); Erica Weyhenmeyer (IL); Jerry Ehlers (IN); Victoria Lloyd (KY); Tom Travis (LA); Kathleen A. Birrane and Robert Baron (MD); Karen Dennis (MI); Grace Arnold (MN); Cynthia Amann (MO); Kathy Shortt (NC); James Fox (NH); Randy Currier (NJ); Barbra Richardson (NV); Lori Barron (OH); Glen Mulready and Teresa Green (OK); Jessica K. Altman (PA); Raymond G. Farmer (SC); Bill Huddleston (TN); Mark Worman (TX); Don Beatty (VA); Kevin Gaffney (VT); and Molly Nollette and John Haworth (WA).

1. **Reviewed its 2022 Proposed Charges**

Commissioner Ommen said the NAIC members are considering the formation of a new Innovation, Cybersecurity, and Technology (H) Committee, which includes proposed charges to continue the work of the Big Data and Artificial Intelligence (EX) Working Group. He summarized the charges as follows: 1) research the use of big data and artificial intelligence (AI) in the business of insurance and evaluate existing regulatory frameworks for overseeing and monitoring their use, which may include model governance; 2) review current audit and certification programs and/or frameworks that could be used to oversee insurers’ use of consumer and non-insurance data and models using AI, and, if appropriate, work to develop modifications to model laws and/or regulations; and 3) assess data needs and required tools for state insurance regulators to appropriately monitor the marketplace, including gaining a better understanding of currently available data and tools and a means to include these tools into existing or new regulatory processes. He said the Working Group has been making expected measurable progress on the charges, but the charges have not been completed.

2. **Received a Presentation on Applying Cybersecurity Lessons Learned to AI Regulation**

Jillian Froment, an independent insurance regulatory advisor, provided a presentation on the similarities of cybersecurity and AI from a regulatory viewpoint. She said the similarities between cybersecurity and AI include their consumer impact and the fact that neither is a traditional area of insurance regulation nor an area of expertise for state insurance regulators. She said both areas are constantly evolving compared to typical insurance issues and have a potential for federal overlap. She said there are also external expectations for state insurance regulators to develop an appropriate regulatory framework. She said there are five actionable areas for AI regulation similar to the areas of regulation set forth in the *Insurance Data Security Model Law* (#668). These include proactive identification and mitigation of risks, ongoing monitoring and reporting of potential risks, insurer accountability of third parties, compliance certification to state insurance regulators, and transparency to state insurance regulators. Ms. Froment said this is an ongoing process and includes a governance solution that places responsibility on insurer. She said AI has similar challenges for state insurance regulators as cybersecurity. She said the overlay of the NAIC’s AI Guiding Principles on the five actionable areas could provide a structure for the foundation of a governance model over the insurers’ use of AI.

3. **Received a Presentation on a Possible AI Regulatory Path**

Commissioner Ommen said the Working Group’s charges include researching the use of big data and AI in the business of insurance and evaluating existing regulatory frameworks for overseeing and monitoring their use, which may include model governance. He said the NAIC’s AI Guiding Principles developed expectations regarding insurers’ use of AI, which include being diligent in assessing the risks involved and mitigating those risks. He said one path forward, as explained by Ms. Froment, is to leverage the regulatory framework for cybersecurity. He said there are technical standards, audits, and certifications established for cybersecurity, and he suggested that there could be similar technical and audit standards developed for AI, which Anthony Habayeb (Monitaur) will discuss.

Mr. Habayeb said Monitaur provides a Machine Learning Assurance (MLA) software platform for model governance that helps companies monitor AI risks. He said a potential next step for regulating insurers’ AI risk could include the NAIC identifying what controls should be in place for insurers to manage AI risk based upon the expectations set forth in the NAIC AI Guiding Principles. He suggested that this is a risk-centric approach that could be immediately implemented. He reviewed the potential...
steps to implement regulatory oversight, which include defining the principles, understanding the current status, defining key risks to the principles, defining assurance statements and frequencies, providing a period of time for carriers to implement practices, and defining market conduct questions and practices.

4. **Received a Presentation on Monitoring and Mitigating AI Bias and Enabling Transparency**

Commissioner Ommen said the next presentation has aspects of governance, but it also addresses the Working Group’s charge to assess data needs and required tools for state insurance regulators to appropriately monitor the marketplace. If there is an agreed upon governance model developed, he said the next presentation will provide some thoughts on what resources or tools might be needed to verify that insurers are adhering to established expectations set forth in a governance model.

Kashyap Murali (SigmaRed) said AI is being adopted in an accelerated manner, and AI has risks related to bias, transparency, and robustness. He said there are also multiple AI regulations world-wide that require responsible AI, including the one published by the NAIC. He provided an overview of AI governance, which includes transparency and explainability, fairness and non-discrimination, accountability, safety and security, privacy, human control of technology, professional responsibility, and promotion of human values. He said prominent vendor solution archetypes include: 1) single segment solutions, which are targeted towards one component of AI governance; 2) custom, mitigative multi-segment solutions, which work on multiple components for AI governance; 3) preconfigured, non-mitigative multi-segment solutions, which work on multiple components of AI governance but do not work on custom metrics or provide solutions to mitigate risks; and 4) consulting and specific services, which provide hands-on service for customers who are just starting to implement AI and require aid for supporting technology services and non-technical services. He said SigmaRed’s platform provides companies the ability to assess AI risk on an ongoing basis, provide immediate mitigation of risk, while also making AI explainable and compliant with regulatory standards.

Birny Birnbaum (Center for Economic Justice—CEJ) said he appreciates the perspectives provided, but he said there is a distinction between cybersecurity and AI because AI is an existing regulatory concern, which requires state insurance regulators to collect market outcome data to test whether AI models are producing the expected consumer outcomes. He said unlike cybersecurity, insurers and consumers will have different opinions on what is and is not an appropriate consumer outcome, and a model governance or model audit will not resolve these differences of opinion. Commissioner Ommen said he agrees that model governance is not the only solution, but he said the ideas of governance should be discussed.

5. **Received a Presentation on PPA AI/ML Survey Results**

Commissioner Ommen said the Working Group has been researching the use of big data and AI in private passenger auto (PPA) insurance to inform the Working Group of areas related to its charges, such as evaluating the appropriateness of existing regulatory frameworks for overseeing and monitoring the use of AI, as well as informing the Working Group of the need to develop or modify model laws and regulatory guidance.

Superintendent Dwyer said the survey was conducted under the market conduct authority of the nine requesting states (Connecticut, Illinois, Iowa, Louisiana, Nevada, North Dakota, Pennsylvania, Rhode Island, and Wisconsin). She said all documents, materials, and other information requested under this authority and held by the requesting states is confidential. Superintendent Dwyer said companies that were writing PPA business in one or more of the nine requesting states and had national direct written premium of $75 million or more were requested to respond to the survey. The survey responses captured national activities, not just within nine states. Responses were not requested or provided on a state-by-state basis.

Superintendent Dwyer said a group of subject matter experts (SMEs), one from each of the nine states and several commissioners, collaborated with NAIC staff to develop the survey instrument. She said the NAIC established a weblink for the survey, which includes the survey template, filing guidance for the companies, definitions, validations, a frequently asked questions (FAQ) document, and a user guide for the tool used to submit the information. She said call letters were sent to the Government Relations, Market Conduct, and Market Conduct Annual Statement company contacts. The survey template was published on Aug. 9, and the survey submission link was released on Sept. 28. Superintendent Dwyer said the requesting states expected to receive 188 filings and received 192.

Superintendent Dwyer said the survey starts with a simple question of whether a company is using or contemplating using AI/machine learning (ML). If no, the survey asked for information regarding why not, and if yes, the survey continues with questions about what operational areas the company is using AI/ML: rating, underwriting, claims, fraud detection, marketing,
loss prevention, and “other.” The survey then requested information on specific uses within each area, including the level of deployment, level of decisions influenced, governance being applied, and types of data used.

Superintendent Dwyer said the filing deadline was Oct. 28, and the survey results are now being analyzed, but that much more needs to be completed, especially more analysis of the text information provided. She said this also needs to be completed in accordance with state confidentiality laws and agreements. She said the last response was received on Nov. 29, and out of the 192 filings received, 168 companies reported using, planning to use, or exploring the use of AI/ML. Twenty-four companies reported that they were not using AI/ML. If a company indicated that it is not planning to use AI/ML, the survey asked why to provide some insight, such as whether regulatory issues were creating obstacles. Superintendent Dwyer said just over 57% of the companies indicated that they are developing the models internally, and about 43% indicated using third parties for model development. Additional analysis will provide more detail on the development of models for each of the operational areas.

Superintendent Dwyer said the survey process has gone very well and thanked the companies for their participation in the survey. Commissioner Afable said the SMEs received a lot of input from all stakeholders, and they want to hear feedback on the survey because the Working Group will use the survey template for other lines. Superintendent Dwyer said the next steps include apprising a broader group of NAIC members and state insurance regulators about the preliminary analysis, completing more detailed analysis of the data, analyzing the open ended/free-form questions, determining what information can be made public, and analyzing strengths and weaknesses of the survey instrument for use in surveying additional lines of business.

Commissioner Ommen said the survey is focused on problem-scoping and what areas might require more attention. Mr. Haworth questioned if there is more detail on the “other” uses of AI. Superintendent Dwyer said this analysis is ongoing. Mr. Birnbaum asked how many insurer groups are represented by the company responses. Superintendent Dwyer said this would be included in the additional analysis.

6. **Discussed the Next Line of Insurance to Survey**

Commissioner Ommen said the Working Group always planned to learn how to improve the survey questions and process from the PPA survey and develop surveys for additional lines of insurance. Commissioner Afable suggested that the Working Group should continue to focus on personal lines and life or homeowners insurance. Director Wing-Heier agreed that the Working Group should focus on personal lines and homeowners as the next line of insurance. Superintendent Dwyer asked if the Working Group conducts a survey on life insurance whether the survey would be limited in scope, such as focusing on term life. Ms. Amann said it would be helpful to have the survey to be broken out by coverage types within homeowners insurance. Commissioner Ommen encouraged people with expertise in life insurance to become involved in the next survey if life is selected. He suggested that the Working Group would pursue surveys for both homeowners insurance and life insurance. Mr. Birnbaum said there will be overlap in company reporting for the PPA survey and homeowners insurance, and there is no information from life insurers.

7. **Discussed its 2022 Work Plan Development**

Denise Matthews (NAIC) said the Working Group has outlined some next steps with surveys of homeowners and life insurance. She said the new Innovation, Cybersecurity, and Technology (H) Committee, if formed by the NAIC members, will likely be looking for some more detailed plans, and she encouraged the Working Group members to think about priorities and timelines for 2022.

8. **Discussed Other Matters**

Commissioner Ommen said the American Academy of Actuaries (Academy) has authored a paper titled *Big Data and Algorithms in Actuarial Modeling and Consumer Impacts*, which is an excellent resource document. He said the paper does a good job establishing terms and definitions, which could be very helpful to the Working Group going forward. He said individuals who want more information about the paper should reach out to Dorothy L. Andrews (NAIC).

Having no further business, the Big Data and Artificial Intelligence (EX) Working Group adjourned.

_BDAI WG Minutes 12.13.21_
The Speed to Market (EX) Working Group of the Innovation and Technology (EX) Task Force met Nov. 16, 2021. The following Working Group members participated: Rebecca Nichols, Chair (VA); Maureen Motter, Vice Chair (OH); Erick Wright (AL); Jimmy Harris (AR); Shirley Taylor (CO); Susan Jennette (DE); Julie Rachford (IL); Marcia Kramer (KS); Tammy Lohmann (MN); Camille Anderson-Weddle (MO); Ted Hamby (NC); Chris Aufenthie (ND); Frank Cardamone (NH); Russell Toal (NM); Mark Worman (TX); Lichiou Lee (WA); and Barry Haney (WI).

1. **Adopted its June 30 and June 29 Minutes**

The Working Group met June 30 and June 29 and took the following action: 1) adopted its March 10 minutes; 2) heard an update from the Information Technology Group (ITG); and 3) discussed and considered the suggestions received for updates to the product coding matrices (PCMs) and uniform transmittal document (UTDs).

Mr. Toal made a motion, seconded by Ms. Jennette, to adopt the Working Group’s June 30 and June 29 minutes (see NAIC Proceedings – Summer 2021, Innovation and Technology (EX) Task Force, Attachment Two). The motion passed unanimously.


Ms. Motter stated that there are updates that need to be made to the Product Filing Review Handbook (Handbook). She stated many of the updates to be made are technical edits involving corrections, such as updating obsolete information, removing working groups that no longer exist, updating current uniform resource locators (URLs), correcting punctuation, updating the formatting, editing areas to be consistent with the currently published NAIC Style Guide, etc. Ms. Motter explained that technical types of edits like that will not need the Working Group’s review, as they do not require adoption since they are not content-related; those corrections will just be made, and the release of the updated Handbook would reflect those technical edits. She stated technical edits also include those that the System for Electronic Rates & Forms Filing (SERFF) team would be submitting, such as updating the list of current SERFF tools and updating the number of filing submissions.

Ms. Motter stated there are, however, some areas of the Handbook that may need some substantive or nontechnical content edits, and that she, Ms. Nichols, and Petra Wallace (NAIC) have started to review the Handbook to identify these types of edits. She stated this is one of the things that will be a priority in 2022 and may require Working Group involvement. Depending on the level of edits needed, a request for volunteers may be made to assist with these edits. Ms. Motter stated the main thing for the Working Group to address now is accepting the edits to Chapter 3 of the Handbook that were adopted by the Casualty Actuarial and Statistical (C) Task Force. She stated the Task Force was charged to propose modifications to reflect current best practices for the regulatory review of Generalized Linear Models (GLM) predictive analytics. Ms. Motter stated that even though these edits have already been reviewed and adopted by the Task Force, because they are considered content-related changes, the Working Group must ultimately review and accept them since revisions to the Handbook is one of this Working Group’s charges. A copy of the Regulatory Review of Predictive Models white paper was provided for review prior to the meeting, posted on the Working Group’s committee page, and shared during the meeting for review, along with a copy of the Handbook.

Ms. Motter stated many sections of Chapter 3 had no proposed changes. She stated the areas of the Handbook that were edited or added were: Interaction Between Rating Variables (Multivariate Analysis), Approval of Classification Systems, Predictive Modeling, Generalized Linear Models, What Is a Best Practice, Best Practices for the Regulatory Review of Predictive Models, Confidentiality, Questions to Ask a Company, Additional Ratemaking Information, Other Reading, and the Summary.

Mr. Toal made a motion, seconded by Ms. Lohmann, to adopt all changes proposed by the Task Force in the Regulatory Review of Predictive Models white paper for Chapter 3 of the Handbook (Attachment Two-A). The motion passed unanimously.

3. **Discussed the PRL Contacts**

Ms. Nichols stated that in the past, many states have not been utilizing the Product Requirements Locator (PRL) tool. She stated she wanted to provide information about whom states can contact for assistance with inactivating the PRL tool once a
state has made the decision to discontinue using or updating the tool, and for assistance with updating the PRL if a state is still using it.

Ms. Nichols explained that states should use their state’s assigned persons to make PRL updates if needed. The assigned individual or individuals have a username and password that allow for the adding, changing, or deleting of product content requirements at any time. She explained that if needed, the assigned information technology (IT) liaison for a state can assist with identifying who has the PRL role, or that states can reach out to the NAIC Help Desk at 816-783-8558 or help@naic.org if additional research into that role for a state is needed. The Help Desk is also whom the PRL user for a state would need to contact if a password reset is needed to access the PRL tool. The log-in ID would be the same as the person’s myNAIC login.

Ms. Nichols stated that if a state is not using or updating the PRL, the assigned persons for that state can contact Alex Rogers at arogers@naic.org, and his team can assist with inactivating that state in the PRL tool. The application removal itself will not take place until the NAIC takes it down, after the full transition into the new SERFF platform, which is still a couple of years away. She noted that this is not something states are being asked or required to address right now; this information is just being shared for any states that are looking to remove information from the PRL at this time or that might need assistance in making updates. Ms. Nichols stated there is a help document that outlines how to make PRL changes for states that are still using the tool and that it has been posted under the document tab for this Working Group’s web page.

Having no further business, the Speed to Market (EX) Working Group adjourned.

November 16 Speed to Market Minutes
The LER suggests a 29% reduction, however, with flattening for expenses, the rate credit is only 25% (1.00 - .75 deductible factor).

Calculation of Increased Limit Factors

Increased limits are typically defined as the limits of liability above the minimum required limits (e.g., the financial responsibility limits in auto insurance) established by the state. Loss ratio and pure premium methods do not work well for increased limit pricing, largely because of sparse data at the higher limits and of policy limit censorship (e.g., if a loss is $500,000 but the limit of liability is $100,000, then only the $100,000 gets coded into the data system).

Mathematical distributions are often used to derive increased limit factors. Available data is fitted to a mathematical distribution, and then that distribution is used to extrapolate anticipated expected losses at higher levels of limits.

When using loss data, consideration needs to be given to any differences in loss development or loss trends by limit. Loss development factors tend to be higher for higher limits of liability because the losses at the higher limits tend to be the ones that take a longer time to settle. Trend factors also tend to be higher for higher limits of liability because the growth of lost amounts for lower limits are capped more often by the limit of liability.

Increased limit factors often contain risk loads that increase as the limits of liability increase. Based on economic principles, it is appropriate to obtain higher rates of return when accepting higher risk. As noted in the section titled "Profit and Contingency Provisions," it is also appropriate to consider this when selecting the profit and contingency provision to apply to basic limit rates.

Credibility for Rating Factors

Just as credibility, or the level of believability of data, was considered in the overall indicated rate change, credibility is considered in the rating factor indications. While common examples of the alternative indication used when applying credibility to the overall rate change are a regional indication, countrywide indication, or inflation, credibility for rating factor indications is often weighted with the overall indication.

Interaction between Rating Variables (Multivariate Analysis)

If the pricing of rating variables is evaluated separately for each rating variable, there is potential to miss the interaction between rating variables. Care should be taken to have a multivariate analysis when possible. In some instances a multivariate analysis is not possible.

If each rating variable is evaluated separately, statistically significant interactions between rating variables may not be identified and, thus, may not be included in the rating plan. Care should be taken to have a multivariate analysis when practical. In some instances, a multivariate analysis is not possible. But, with computing power growing exponentially, insurers believe they have found many ways to improve their operations and competitiveness through use of complex predictive models in all areas of their insurance business.

Approval of Classification Systems

With rate changes, companies sometimes propose revisions to their classification system. Because the changes to classification plans can be significant and have large impacts on the consumers’ rates, regulators should focus on these changes.

Some items of proposed classification can sometimes be deemed to be against public policy, such as the use of education or occupation. You should be aware of your state’s laws and regulations regarding which rating factors are allowed.

With rate changes, companies sometimes propose revisions to their classification system. Because the changes to classification plans can be significant and have large impacts on the consumers’ rates, regulators should focus on these changes.

Some items of proposed classification can sometimes be deemed to be contrary to state laws and/or regulations, such as the use of education or occupation. You should be aware of your state’s laws and regulations regarding which rating factors are allowed, and you should require definitions of all data elements that can affect the charged premium. Finding rating or
underwriting characteristics that may violate state laws and/or regulations is becoming more difficult for regulators with the increasing and innovative ways insurers use predictive models.

Rating Tiers

Some states allow an insurer to have multiple rate levels, or rating tiers, within a single company. These rating tiers are another way of classifying risks for rating purposes. Typically, there are requirements for rating tiers: the underwriting rules for each tier should be mutually exclusive, clear, and objective; there should be a distinction between the expected losses or expenses for each tier; and the placement process should be auditable. Tiers within a company are mainly seen in personal lines products.

One particular concern with rating tiers would be the analyses of whether a plan produces unfair discrimination. Questions arise around the time-sensitive aspects of the underwriting criteria and any related re-evaluation of the tiers upon renewal. For example, consider two tiers where the insured is placed in the “high” tier because of a lapse of insurance in the prior 12 months. The question is: What happens upon renewal after there has no longer been a lapse of insurance for 12 months? Does the insured get slotted in the “low” tier as he would if he was new business? Some statutes limit the amount of time that violations, loss history, or insurance scores can be used, and some statutes might only allow credit history to be used for re-rating at the policyholder’s request. Regulators should consider the acceptability of differences in rates between existing and new policyholders when they have the same current risk profile.

Insurers also can create different rating levels by having separate companies within a group. While regulators should examine rating tiers within an insurer to a high degree of regulatory scrutiny, there tends to be less scrutiny with differences in rates that exist between affiliated companies. Workers’ compensation insurers are more likely to obtain rating tiers using separate companies.

Rate Justification: New Products

When new products are introduced, there are often new unanswered questions for a regulator, especially because new products are the most difficult to price. There may be additional judgment and use of competitor rates involved with new products. Regulators should discuss new issues with management and consider using NAIC message boards to discuss issues.

- Individual Risk Rating

The rating system established with base rates and rating factors, sometimes called “manual rates,” typically groups policyholders within classifications based on each policyholder’s individual characteristics. However, there could be some policyholders, especially in the commercial lines of business, where it is appropriate to modify the manual rate based on the policyholder’s own loss experience. The most common methods of rating based on individual actual loss experience are called experience rating, schedule rating, and retrospective rating. These plans are typically required to be filed with the state.

- Experience Rating

Experience rating uses the actual loss experience of the policyholder to calculate a rating discount or surcharge. A typical process is that actual individual losses are capped at a maximum single loss, the actual capped losses are compared to similarly limited expected losses, and credibility is considered to develop the experience rating modification factor. (There are other detailed adjustments to data in the calculations.) The states typically place limitations on the amount that experience rating can impact the overall rate.

Typically, there is a requirement of the policy being a minimum size to qualify for experience rating and a requirement that all policies meeting that size requirement be experience rated.

- Schedule Rating
Schedule rating is a method of pricing property and liability insurance. It uses charges and credits to modify a class rate based on the special characteristics of a risk. Insurers have been able to develop a schedule of rates because experience has shown a direct relationship between certain physical characteristics and the possibility of a loss. For example, implementation of an effective safety program should likely result in lower insurance rates but will not be fully reflected in loss experience for a few years. Companies who change their delivery drivers from experienced drivers to youthful drivers should likely pay more.

Some examples of schedule rating categories might include:

- Premises: Condition, Care
- Equipment: Type, Condition, Care
- Employees: Selection, Training, Supervision, Experience

Each state establishes limitations on schedule rating. Typically, there is a limitation on the overall percentage impact on the policyholder’s rates from schedule rating.

Typically, there is a requirement of the policy being a minimum size to qualify for schedule rating, which is often less than the level required for experience rating.

- Combination of Experience and Schedule Rating Factors

States typically require companies to state whether the experience rating factor and schedule rating factor are additive (where discounts/charges are added together) or multiplicative (where factors are multiplied together). If the experience rating factor is .90, or includes a 10% discount, and the schedule rating factor is 1.03, or includes a 3% charge, the additive factor would be .93 (= 1 – 10% + 3%) and the multiplicative factor would be .927 (= .90 x 1.03).

- Retrospective Rating

Retrospective rating is where a policyholder pays an initial deposit premium (likely based on manual rates) at the time the policy is issued, but the premium is adjusted over time as claims emerge and more information is known about the true costs that have arisen from the insurance policy. Retrospective rating plans differ from typical insurance pricing. Typical pricing is prospective and does not allow for recoupment of past losses.

The analysis for retrospective rating is similar to experience rating in that actual losses are used, individual claim amounts can be capped, and resulting amounts are compared to expected amounts at the same level of capping and same point in expected development. The retrospective adjustment is usually limited at minimum and maximum premium levels. There is also a limitation in how many years of adjustments are made.

- Dividend Rating Plans

Dividend rating plans, used most commonly in workers’ compensation, are sometimes allowed. The company can charge more up-front to provide more cushion when losses are worse than expected, but when loss experience is better than expected, the company can disperse extra profits out to policyholders. This plan is often used as an acceptable marketing tool.

Predictive Modeling

The ability of computers to process massive amounts of data has led to the expansion of the use of predictive modeling in insurance ratemaking. Predictive models have enabled insurers to build underwriting models with significant segmentation power and are increasingly being applied in such areas as claims modeling and used in helping insurers to price risks more effectively.

Key new rating variables that are being incorporated into insurers’ predictive models include homeowners’ rates by peril, homeowners rating by building characteristics, vehicle history, usage-based auto insurance, and credit characteristics. Data quality within and communication about models are of key importance with predictive modeling.
The ability of computers to process massive amounts of data (referred to as "big data") has led to the expansion of the use of predictive modeling in insurance ratemaking. Predictive models have enabled insurers to build rating, marketing, underwriting, and claim models with significant predictive ability.

Data quality within, and communication about, models are of key importance with predictive modeling. Depending on definitional boundaries, predictive modeling can sometimes overlap with the field of machine-learning. In the modeling space, predictive modeling is often referred to as "predictive analytics."

Insurers’ use of predictive analytics along with big data has significant potential benefit to consumers and insurers. Predictive analytics can reveal insights into the relationship between consumer behavior and the cost of insurance, lower the cost of insurance for many, and provide incentives for consumers to better control and mitigate loss. However, predictive analytic techniques are evolving rapidly and leaving many state insurance regulators without the necessary tools to effectively review insurers’ use of predictive models in insurance applications. To aid the regulator in the review of predictive models, best practices have been developed.

The term “predictive model” refers to a set of models that use statistics to predict outcomes. When applied to insurance, the model is chosen to estimate the probability or expected value of an outcome given a set amount of input data; for example, models can predict the frequency of loss, the severity of loss, or the pure premium.

To further complicate regulatory review of models in the future, modeling technology and methods are evolving rapidly. Generalized linear models (GLMs) are relatively transparent and their output and consequences are much clearer than many other complex models. But as computing power grows exponentially, it is opening the modeling world to more sophisticated forms of data acquisition and data analysis. Insurance actuaries and data scientists seek increased predictiveness by using even more complex predictive modeling methods. Examples of these methods are predicting models utilizing logistic regression, nearest neighbor classification, random forests, decision trees, neural networks, or combinations of available modeling methods (often referred to as “ensembles”). These evolving techniques will make the regulators’ understanding and oversight of filed rating plans even more challenging.

- Generalized Linear Models

The GLM is a commonly used predictive model in insurance applications, particularly in building an insurance product’s rating plan. Because of this and the fact most property/casualty regulators are most concerned about personal lines, the NAIC has developed an appendix in its white paper for guidance in reviewing GLMs for personal automobile and home insurance.

- What is a “Best Practice”?

A best practice is a form of program evaluation in public policy. At its most basic level, a practice is a “tangible and visible behavior…[based on] an idea about how the actions…will solve a problem or achieve a goal.” Therefore, a best practice represents an effective method of problem solving. The “problem” regulators want to solve is how can regulators determine whether predictive models, as used in rate filings, are compliant with state laws and/or regulations? However, best practices are not intended to create standards for filings that include predictive models.

Best practices are based on the following principles that promote a comprehensive and coordinated review of predictive models across the states:

- State insurance regulators will maintain their current rate regulatory authority and autonomy.

10 Refer to Appendix B in the NAIC white paper, Regulatory Review of Predictive Models.


State insurance regulators will be able to share information to aid companies in getting insurance products to market more quickly across the states.

State insurance regulators will share expertise and discuss technical issues regarding predictive models to make the review process in any state more effective and efficient.

State insurance regulators will maintain confidentiality, in accordance with state laws and/or regulations, regarding predictive models.


Best practices will help the regulator understand if a predictive model is cost-based, if the predictive model is compliant with state laws and/or regulations, and how the model improves the company’s rating plan. Best practices can also improve the consistency among the regulatory review processes across the states and improve the efficiency of each regulator’s review, thereby assisting companies in getting their products to market faster. With this in mind, the regulator’s review of predictive models should:

1. Ensure that the selected rating factors, based on the model or other analysis, produce rates that are not excessive, inadequate, or unfairly discriminatory.
   a. Review the overall rate level impact of the proposed revisions to rate level indications provided by the filer.
   b. Determine whether individual input characteristics to a predictive model and their resulting rating factors are related to the expected loss or expense differences in risk.
   c. Review the premium disruption for individual policyholders and how the disruptions can be explained to individual consumers.
   d. Review the individual input characteristics to, and output factors from, the predictive model (and its sub-models), as well as associated selected relativities, to ensure they are compatible with practices allowed in the state and do not reflect prohibited characteristics.

2. Obtain a clear understanding of the data used to build and validate the model, and thoroughly review all aspects of the model, including assumptions, adjustments, variables, sub-models used as input, and resulting output.
   a. Obtain a clear understanding of how the selected predictive model was built.
   b. Determine whether the data used as input to the predictive model is accurate, including a clear understanding how missing values, erroneous values, and outliers are handled.
   c. Determine whether any adjustments to the raw data are handled appropriately, including, but not limited to, trending, development, gapping, and removal of catastrophes.
   d. Obtain a clear understanding of how often each risk characteristic, used as input to the model, is updated and whether the model is periodically refreshed, so model output reflects changes to non-static risk characteristics.

3. Evaluate how the model interacts with and improves the rating plan.
   a. Obtain a clear understanding of the characteristics that are input to a predictive model (and its sub-models).
   b. Obtain a clear understanding how the insurer integrates the model into the rating plan and how it improves the rating plan.
   c. Obtain a clear understanding of how model output interacts with non-modeled characteristics/variables used to calculate a risk’s premium.
Enable competition and innovation to promote the growth, financial stability, and efficiency of the insurance marketplace.

a. Enable innovation in the pricing of insurance through acceptance of predictive models, provided such models are in compliance with state laws and/or regulations, particularly prohibitions on unfair discrimination.

b. Protect the confidentiality of filed predictive models and supporting information in accordance with state laws and/or regulations.

c. Review predictive models in a timely manner to enable reasonable speed to market.

Confidentiality

Each state determines the confidentiality of a rate filing and the supplemental material to the filing, when filing information might become public, the procedure to request that filing information be held confidentially, and the procedure by which a public records request is made. Regulatory reviewers are required to protect confidential information in accordance with applicable state laws and/or regulations. State insurance regulators should be aware of their state laws and/or regulations on confidentiality when requesting data from insurers that may be proprietary or trade secret. However, insurers should be aware that a rate filing might become part of the public record. It is incumbent on an insurer to be familiar with each state’s laws and/or regulations regarding the confidentiality of information submitted with their rate filing.

State authority, regulations and rules governing confidentiality always apply when a regulator reviews a model used in rating. When the NAIC or a third party enters the review process, the confidential, proprietary, and trade secret protections of the state on behalf of which a review is being performed will continue to apply.

Advisory Organizations

Advisory Organization Filings

Advisory organizations develop loss costs, policy forms, risk classifications, and other miscellaneous rating rules that may be used by insurer members of the organizations.

Allowable advisory organization activities are likely defined in your state rating law. The NAIC model rating laws define the advisory organizations’ permitted and prohibited activities with the intent to prohibit anticompetitive behavior and discourage concerted rate action by insurers. Generally, advisory organizations are not allowed to publish fully developed rates, including all expense and profit loadings, for the insurance companies to use. They can, however, provide advisory prospective loss costs, which would be the recommended insurance charge prior to consideration of expenses (typically, other than loss adjustment expenses) and profit.

When an advisory organization makes a loss cost or rating rule filing, the state’s resources applied to the filing are generally high given that the components of the filing will be used by many insurance companies and have a large impact on the market.

Insurance Company’s Use of Advisory Organization’s Loss Costs

Adoption of the advisory organization’s loss costs requires development of a loss cost multiplier to add in any missing expenses and profit. The NAIC developed model filing forms for loss cost multipliers (Appendices A, B, and C). A calculation of the loss cost multiplier when a company fully adopts the advisory organization’s loss costs and has no expense constants is illustrated:
If there are two indications being weighted together and one is for a rate increase and one is a rate decrease, is the weighting justified?

3. Regarding differences in assumptions from previous filings:
   a. Have methodologies changed significantly?
   b. Are assumptions for the weighting of years or credibility significantly different? Or does there appear to be some manipulation to the rate indication?

4. Is there unfair discrimination?
   a. Do classifications comply with state requirements?
   b. Are proposed rates established so that different classes will produce the same underwriting results?

5. What do you need to communicate?
   a. Can you explain why you are taking a specific action on the filing?
   b. What do you need to tell the Consumer Services Department?
   - Can you explain the impact of the rate change on current business? How big is the company and how much of the market is impacted?
   - What are the biggest changes in the filing (and the ones on which consumer calls might be expected)?
   - What is the maximum rate change impact on any one policyholder?

Questions to Ask a Company

If you remain unsatisfied that the company has satisfactorily justified the rate change, then consider asking additional questions of the company. Questions should be asked of the company when it has not satisfied statutory or regulatory requirements in the state or when any current justification is inadequate and could have an impact on the rate change approval or the amount of the approval.

If there are additional items of concern, the company can be notified so they will make appropriate modifications in future filings.

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If there are additional items of concern, the company can be notified so it can make appropriate modifications in future filings.

The NAIC white paper, Regulatory Review of Predictive Models, documents questions that a state insurance regulator may want to ask when reviewing a model. These questions are listed as “information elements” in Appendix B of the white paper. Note: Although Appendix B focuses on GLMs for personal automobile and home insurance, many of the “information elements” and concepts they represent may be transferable to other types of models, other lines of business, and other applications beyond rating.

Additional Ratemaking Information

The Casualty Actuarial Society (CAS) has an extensive examination syllabus that contains a significant amount of ratemaking information, on both the basic topics covered in this chapter and on advanced ratemaking topics. The CAS website contains links to many of the papers included in the syllabus. Recommended reading is the Foundations of Casualty Actuarial Science, which contains chapters on ratemaking, risk classification, and individual risk rating.

The Casualty Actuarial Society (CAS) and the Society of Actuaries (SOA) have extensive examination syllabi that contain a significant amount of ratemaking information, on both the basic topics covered in this chapter and on advanced ratemaking topics. The CAS and SOA websites (https://www.casact.org and https://www.soa.org, respectively) contain links to many of the papers included in the syllabus. Recommended reading is the Foundations of Casualty Actuarial Science, which contains chapters on ratemaking, risk classification, and individual risk rating.
Other Reading

Some additional background reading is recommended:


- Chapter 1: Introduction
- Chapter 3: Ratemaking
- Chapter 6: Risk Classification
- Chapter 9: Investment Issues in Property-Liability Insurance
- Chapter 10: Only the section on Regulating an Insurance Company, pp. 777–787

Casualty Actuarial Society (CAS) Statements of Principles, especially regarding property and casualty ratemaking.


Association of Insurance Compliance Professionals: “Rate Making—What the State Filer Needs to Know.”

Review of filings and approval of insurance company rates.

Additional background reading is recommended:

  - Chapter 1: Introduction
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  - Chapter 9: Investment Issues in Property-Liability Insurance
  - Chapter 10: Only the section on Regulating an Insurance Company, pp. 777–787

- CAS: Statements of Principles, especially regarding property/casualty ratemaking.
- CAS: “Basic Ratemaking.”
- Association of Insurance Compliance Professionals: “Rate Making—What the State Filer Needs to Know.”
- Review of filings and approval of insurance company rates.

NAIC: Casualty Actuarial and Statistical (C) Task Force’s white paper, *Regulatory Review of Predictive Models*

Summary

Rate regulation for property-casualty lines of business require significant knowledge of state rating laws, rating standards, actuarial science, and many data concepts.

- Rating laws vary by state, but the rating laws are usually grouped into prior approval, file and use or use and file (competitive), no file (open competition), and presumption.
Rate standards typically included in the state rating laws require that “rates shall not be inadequate, excessive, or unfairly discriminatory.”

A company will likely determine their indicated rate change by starting with historical years of underwriting data (earned premiums, incurred loss and loss adjustment expenses, general expenses) and adjusting that data to reflect the anticipated ultimate level of costs for the future time period covered by the policies. Numerous adjustments are made to the data. Common premium adjustments are on-level premium, audit, and trend. Common loss adjustments are trend, loss development, catastrophe/large loss provisions, and an adjusting and other (A&O) loss adjustment expense provision. A profit/contingency provision is also calculated to determine the indicated rate change.

Once an overall rate level is determined, the rate change gets allocated to the classifications and other rating factors.

Individual risk rating allows manual rates to be modified by an individual policyholder’s own experience.

Advisory organizations provide the underlying loss costs for companies to be able to add their own expenses and profit provisions (with loss cost multipliers) to calculate their insurance rates.

The Casualty Actuarial Society’s Statement of Principles Regarding Property and Casualty Insurance Ratemaking provides guidance and guidelines for the numerous actuarial decisions and standards employed during the development of rates.

NAIC model laws also include special provisions for workers’ compensation business, penalties for not complying with laws, and competitive market analysis to determine whether rates should be subject to prior approval provisions.

While this chapter provides an overview of the rate determination/actuarial process and regulatory review, state statutory or administrative rules may require the examiner to adopt different standards or guidelines than the ones described.

Rate regulation for property/casualty lines of business requires significant knowledge of state rating laws, rating standards, actuarial science, statistical modeling, and many data concepts.

- Rating laws vary by state, but the rating laws are usually grouped into prior approval, file and use or use and file (competitive), no file (open competition), and flex rating.

- Rate standards typically included in the state rating laws require that “rates shall not be inadequate, excessive, or unfairly discriminatory.”

- A company will likely determine its indicated rate change by starting with historical years of underwriting data (earned premiums, incurred loss and loss adjustment expenses, general expenses) and adjusting that data to reflect the anticipated ultimate level of costs for the future time period covered by the policies. Numerous adjustments are made to the data. Common premium adjustments are on-level premium, audit, and trend. Common loss adjustments are trend, loss development, catastrophe/large loss provisions, and an adjusting and other (A&O) loss adjustment expense provision. A profit/contingency provision is also calculated to determine the indicated rate change.

- Once an overall rate level is determined, the rate change gets allocated to the classifications and other rating factors.

- Individual risk rating allows manual rates to be modified by an individual policyholder’s own experience.

- Advisory organizations provide the underlying loss costs for companies to be able to add their own expenses and profit provisions (with loss cost multipliers) to calculate their insurance rates.

- The CAS’ Statement of Principles Regarding Property and Casualty Insurance Ratemaking provides guidance and guidelines for the numerous actuarial decisions and standards employed during the development of rates.

- NAIC model laws and regulations include special provisions for workers’ compensation business, penalties for not complying with laws, and competitive market analysis to determine whether rates should be subject to prior approval provisions.

- Best practices for reviewing predictive models are provided in the NAIC white paper, Regulatory Review of Predictive Models. The best practices and many of the information elements and underlying concepts may be transferable to other types of models, other lines of insurance, and applications beyond rating.
While this chapter provides an overview of the rate determination/actuarial process and regulatory review, state statutory or administrative rule may require the examiner to employ different standards or guidelines than the ones described.

Chapter Three Glossary

**Adjusting and Other Expenses:** Those expenses other than DCC. A&O includes, but is not limited to, fees and expenses of adjusters and settling agents, loss adjustment expenses for participation in voluntary and involuntary market pools if reported by calendar year, attorney fees incurred in the determination of coverage, including litigation between the reporting entity and the policyholder, and fees and salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in the capacity of an adjuster. (SSAP No. 55)

**Advisory Organizations:** As defined in the *Property and Casualty Model Rating Law (Prior Approval Version)*: “‘Advisory organization’ means any entity, including its affiliates or subsidiaries, which either has two or more member insurers or is controlled either directly or indirectly by two or more insurers, and which assists insurers in ratemaking-related activities …”

**ALAE:** Loss adjustment expenses that are assignable or allocable to specific claims. (*Foundations of CAS*)

**Base Rate:** Benchmark premium rates for each risk classification. (www.lni.wa.gov/ClaimsIns/Insurance/RatesRisk/How/RiskClass/default.asp)

**Consumer Price Index:** An index of the cost of all goods and services to a typical consumer. (http://wordnet.princeton.edu/perl/webwn)

**Defense and Cost Containment:** Includes defense litigation, and medical cost containment expenses, whether internal or external. DCC expenses include, but are not limited to: surveillance expenses; fixed amounts for medical cost containment expenses; litigation management expenses; loss adjustment expenses for participation in voluntary and involuntary market pools if reported by accident year; fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in defense of a claim, and fees or salaries for rehabilitation nurses, if such cost is not included in losses; attorney fees incurred owing to a duty to defend, even when other coverage does not exist; and the cost of engaging experts. (SSAP No. 55)

**Detrending:** The statistical or mathematical operation of removing trend from the series. Detrending is often applied to remove a feature thought to distort or obscure the relationships of interest. (www.ltrr.arizona.edu/~dmeko/notes_7.pdf)

**Experience Rating:** Statistical procedure used to calculate a premium rate based on the loss experience of an insured group. (*Dictionary of Insurance Terms*)

**Exposure Rate:** Basis to which rates are applied to determine premium. (www.irmi.com/online/insurance-glossary/terms/e/exposure-base.aspx)

**Exposures:** The basic rating unit underlying an insurance premium (*Foundations of CAS*)

**Loss Development:** Difference in the amount of losses between the beginning and end of a time period. (*Dictionary of Insurance Terms*)

**Loss Ratio Method:** Modification of premium rates by a stipulated percentage for closely related classes of property or liability insurance policies. The objective of such modification is to more directly align the combined actual loss ratio of the classes of policies under consideration with the expected loss ratio of these classes. The resultant alignment should show no significant standard deviation or variation of the actual loss ratio from the expected loss ratio

**Manual Rate:** Published cost per unit of insurance, usually the standard rate charged for a standard risk. (*Dictionary of Insurance Terms*)
The E-Commerce (EX) Working Group of the Innovation and Technology (EX) Task Force met Oct. 7, 2021. The following Working Group members participated: Kathleen A. Birrane and Robert Baron, Chair (MD); Jully Pae (CA); Heather Droge (KS); Tom Travis (LA); Cynthia Amann (MO); Chris Aufenthie (ND); Martin Swanson (NE); Lori Barron (OH); John Lacek (PA); Elizabeth Kelleher Dwyer (RI); and Bryce Carlen (WA).

1. Considered Adoption of its June 30 Minutes

Commissioner Birrane asked the Working Group whether it had an opportunity to review the June 30 minutes that were included in the meeting materials. Hearing no changes or edits to the June 30 minutes, Mr. Aufenthie made a motion, seconded by Ms. Amann, to adopt the Working Group’s June 30 minutes (see NAIC Proceedings – Summer 2021, Innovation and Technology (EX) Task Force, Attachment Three). The motion passed unanimously.

2. Discussed its Overall Status, a Potential Survey to the States, and the Timeline for its Work Plan

Commissioner Birrane reminded the Working Group of its 2021 charges, including survey states regarding federal Uniform Electronic Transactions Act (UETA) exceptions and additional questions regarding the actions taken by the states in response to the COVID-19 pandemic. She also stated the possibility of including an additional survey question to be provided to the insurance industry regarding their actions in response to the COVID-19 pandemic. She stated that the goal of the survey would be to review the responses and continue to work toward meaningful, unified recommendations with the hope being that the survey would be sent out before the end of 2021.


Gabrielle Griffith (American Council of Life Insurers—ACLI) and Angela Gleason (American Property Casualty Insurance Association—APCIA) provided a presentation entitled, “Consumer Driven, Consumer Protected – Regulatory Supported Innovation” and focused on developments in innovation in e-commerce and their continued support of consumers maintaining their ability to choose how they interact with insurers. Ms. Griffith and Ms. Gleason discussed the various requirements some states maintain requiring first-class mail delivery for certain insurance documents and notices and how many of these provisions were adopted and put in place long before the advent and development of e-commerce. This has resulted in a lack of clarity and uniformity among the states.

Ms. Griffith and Ms. Gleason continued by discussing the various regulatory accommodations that were put in place due to the COVID-19 pandemic, including the waiting for wet signatures for various filing, allowing remote notarization, allowing remote regulatory examinations, and allowing for remotely proctored producer examinations. Ms. Griffith stated that industry does not believe new laws or regulations are necessary for further innovation in the e-commerce space; instead she recommended the drafting and preparation of an innovation and technology handbook that could provide clarity and guidance for both state insurance regulators and industry. She explained that a draft handbook table of contents was prepared, and she discussed various recommended chapters to include in the handbook.

Ms. Griffith and Ms. Gleason explained that industry believes that the regulatory accommodations made during the COVID-19 pandemic worked very well, and to the extent that they were not made permanent, they should be. Ms. Griffith also stated that industry’s hope is that legislators and state insurance regulators remain open to evolving electronic transactions, and the traditional opt-in regime is no longer needed.

4. Heard a Presentation on Operational and Technology Issues Confronting the Retirement Income Industry

Sarah Wood (Insured Retirement Institute—IRI) and Bryan Harmelink (IRI) said the IRI is the leading association for the entire supply chain of insured retirement strategies and has 113 member companies. Ms. Wood and Mr. Harmelink explained that the various benefits of implementing electronic solutions include providing consumers with secure, efficient, and easy-to-use
methods to purchase insurance and service insured retirement products; providing state insurance regulators with a robust model of traceability, and providing industry a clear audit trail to prevent and detect fraud.

Ms. Wood and Mr. Harmelink explained that the IRI maintains an Operations and Technology Committee, which is a board-level working group. In early 2020, this Committee approved commitments to digital solution implementation and adoption, and as the pandemic unfolded, the Committee recognized the immediate need for remote ways of transacting business. These efforts included increasing both e-signature availability of application order entry platforms and increasing e-delivery consumer availability. Ms. Wood stated that while many of these options have been available for more than 20 years, some states still require manual steps that lead to roadblocks when adopting these types of provisions. She also said as the various temporary e-commerce accommodations expire, it will create a patchwork of requirements and inconsistencies among the states. Ms. Wood and Mr. Harmelink encouraged the NAIC to encourage permanent adoption of temporary accommodations made during the pandemic, address specific issues as they are identified through regulatory change and/or guidance, and develop model guidance or a model bulletin.

5. Heard a Presentation on State Efforts to Review E-Commerce Laws, Rules, and Regulations Prior to and As a Result of the COVID-19 Pandemic

Ms. Amann said Missouri reviewed where its regulatory processes are lacking from a technology perspective as well as its processes that were affected by the COVID-19 pandemic. Missouri began reviewing all regulatory processes across all departments in 2017 as part of a state-wide effort, which resulted in the reduction of one out of every five regulatory restrictions. When Missouri’s governor signed an executive order in 2020 declaring a state of emergency in response to the COVID-19 pandemic, it enabled the governor to waive certain state laws and regulations where necessary. This resulted in nearly 2,500 modifications to the Missouri Department of Insurance’s (DOI’s) rules and processes and identified many regulatory processes that need to be improved and streamlined.

Ms. Amman said the Missouri DOI and its system of regulation must keep pace with a rapidly evolving marketplace fueled by seismic shifts in consumer behavior, technological advances, and a dynamic policy and regulatory environment. She also said while Missouri remained open for business, any steps taken could not be at the expense of decreasing consumer protection responsibilities.

Ms. Amman said the Missouri DOI took several steps to help the insurance industry and the DOI itself to continue serving consumers during the pandemic, such as issues bulletins that provided guidance on health insurance issues and coverage for COVID-19 testing, providing temporary grace periods that allowed consumers to retain their coverage during the first few months of the pandemic, waiving license requirements, waiving onsite examination requirements for title insurers, and many others. She said the Working Group should identify concerns that must be addressed via legislative action, and the departments should identify each waiver they issue during the pandemic, while also asking whether they intend to let the waiver expire, keep the waiver in place, or propose modifications.

6. Heard a Presentation on Telematics and Privacy Issues Confronting Insurance Consumers

Lee Tien (Electronic Frontier Foundation—EFF) provided a presentation on telematics and privacy issues confronting insurance consumers.

7. Heard a Presentation on Issues Regarding Insurance Consumers and E-Commerce in the Insurance Space

Birny Birnbaum (Center for Economic Justice—CEJ) said while advances in digitalization and e-commerce hold huge potential to speed up traditional insurance processes and help insurers reach new markets, insurance is not like most consumer products. He said insurance is a complex financial protection product that promises consumers a future benefit for which there is no data about how well the product performs. He said that every digital transaction comes with terms and conditions, and that is no oversight of such e-commerce terms and conditions. He said regulatory guidance for plain language and unacceptable provisions in e-commerce terms and conditions is needed. As an example, he explained the various required consents for a hypothetical title transaction, including the requirement that a consumer provide a release allowing the company to use their name, image, likeness, etc. in various manners and mediums.

Mr. Birnbaum also explained dark patterns, which is a term used to describe digital designs created to make users do things they might not want to do that benefit the business but not the user. He said action is needed by state insurance regulators to develop the skills necessary to recognize dark patterns in insurance and stop unfair and deceptive digital interactions.
Mr. Birnbaum continued by discussing e-commerce activity analytics and how the use of e-commerce creates new personal consumer information about the consumer’s digital behavior and interactions. These new data include things such as how quickly a consumer completes an online application, and some insurance vendors are already marketing algorithms to assess consumer’s biological age and candor from video interactions with consumers. Mr. Birnbaum also said the use of e-commerce and increased digital interactions must not marginalize historically disadvantaged group or communities, and the use of e-commerce tools should explicitly consider potential bias based on race and ensure access for people with disabilities.

Having no further business, the E-Commerce (EX) Working Group adjourned.

E-Commerce WG Minutes 10.07.21.docx
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The Long-Term Care Insurance Multistate Rate Review (EX) Subgroup met in San Diego, CA, Dec. 12, 2021, immediately followed by a meeting of the Long-Term Care Insurance (EX) Task Force. The following Subgroup members participated: Michael Conway, Chair (CO); Alan McClain (AR); Andrew N. Mais represented by Paul Lombardo (CT); David Altmaier (FL); Doug Ommen represented by Andrea Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Scott Shover (IN); James J. Donelon represented by Tom Travis (LA); Anita G. Fox represented by Karen Dennis (MI); Grace Arnold and Fred Andersen (MN); Chlora Lindley-Myers (MO); Eric Dunning (NE); Russell Toal represented by Jennifer Catechis (NM); Barbara D. Richardson represented by Stephanie McGee (NV); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Raymond G. Farmer represented by Michael Wise (SC); Cassie Brown represented by Doug Slape (TX); Jonathan T. Pike (UT); Scott A. White (VA); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler and Lichiou Lee (WA); and Allan L. McVey represented by Tonya Gillespie (WV).

The following Task Force members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair (CO); Lori K. Wing-Heier represented by Anna Latham (AK); Jim L. Ridling represented by Mark Fowler (AL); Alan McClain (AR); Evan G. Daniels (AZ); Ricardo Lara represented by Susan Bernard (CA); Andrew N. Mais represented by Paul Lombardo (CT); David Altmaier (FL); Colin M. Hayashida (HI); Doug Ommen represented by Andrea Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Dana Popish Severyinghaus represented by Susan Berry (IL); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt (KS); James J. Donelon represented by Tom Travis (LA); Gary D. Anderson (MA); Eric A. Cioppa (ME); Ana G. Fox represented by Karen Dennis (MI); Grace Arnold represented and Fred Andersen (MN); Chlora Lindley-Myers (MO); Mike Chaney (MS); Troy Downing (MT); Mike Causey represented by Jackie Obusek (NC); Jon Godfrey represented by Matt Fischer (ND); Eric Dunning and Justin Schrader (NE); Russell Toal represented by Jennifer Catechis (NM); Barbara D. Richardson represented by Stephanie McGee (NV); Judith L. French (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Raymond G. Farmer represented by Michael Wise (SC); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Doug Slape (TX); Jonathan T. Pike (UT); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler and Lichiou Lee (WA); Mark Afable represented by Nathan Houdek (WI); and Allan L. McVey represented by Tonya Gillespie (WV).

1. **Long-Term Care Insurance Multistate Rate Review (EX) Subgroup**

   a. **Adopted its Nov. 15 and Sept. 28 Minutes**

   Commissioner Conway said the Subgroup met Sept. 10 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meeting. He said the Subgroup also met Nov. 15 and Sept. 28 and took the following action: 1) received and discussed interested state insurance regulator and interested party comments on the draft Long-Term Care Insurance Multi-State Rate Review Framework (MSA Framework); and 2) exposed the revised MSA Framework for a 21-day comment period ending Dec. 6.

   Commissioner Altman made a motion, seconded by Commissioner Altmaier, to adopt the Subgroup’s Nov. 15 (Attachment One) and Sept. 28 (Attachment Two) minutes. The motion passed unanimously.

   b. **Heard Comments on the Exposure Draft of the Draft MSA Framework**

   Commissioner Conway said the MSA Framework was exposed for a public comment period ending Dec. 6. Comment letters were received from: 1) the American Council of Life Insurers (ACLI) and America’s Health Insurance Plans (AHIP); and 2) Risk & Regulatory Consulting LLC (RRC) (Attachment Three).

   Jan Graeber (ACLI) thanked the Subgroup for its work on the MSA Framework. She said she recognizes that there are some issues that remain and this project will take time, and she looks forward to continuing the dialogue with the Subgroup. She said it will take the participation of both state insurance departments and insurance companies for the process to work.
Mr. Andersen summarized the drafting group’s response to comments received (Attachment Four). The drafting group agreed to make the recommended changes in items #3 and #9 from the letter. The drafting group did not recommend changes for the other items. Mr. Andersen discussed the rationale as follows:

- **Item #2:** The reasons for not utilizing the Interstate Insurance Product Regulation Commission (Compact) is because the rate proposals under the MSA Framework are outside the scope of the Compact.
- **Item #4:** The Subgroup recently decided that there is a benefit in sharing the MSA Advisory Report with the insurer. The MSA Team can answer questions from the insurer and provide clarifications rather than the insurer asking all jurisdictions.
- **Item #5:** The drafting group disagreed with the recommendation that at least one member of the MSA Team meet the qualification standards for actuaries issuing statement of opinion, as that is a high bar that is mostly for company actuaries that focus on valuation. No change was made.
- **Item #6:** As the process develops, the MSA Framework can be edited to address resources in the future.
- **Item #7:** The drafting group agreed that the MSA Team should have flexibility. The MSA Framework already includes this flexibility.
- **Item #8:** With each review, the MSA Team learns more about the time necessary for the review. Often, the timing is out of the MSA Team’s control, as it is dependent on the quality and completeness of the rate proposal.
- **Item #10:** The Texas and Minnesota methodologies eliminate the subsidization of one policyholder by another.
- **Item #11:** The MSA Framework includes an information checklist. A template may be helpful, but it will need to be developed in the future after more experience is gained from the process.
- **Item #12:** Actuarial Standards of Practice (ASOPs) are required regardless of being listed in the MSA Framework.
- **Item #13:** Assessing adequacy of reserves is outside the scope of the MSA Framework, which is focused on rate review.
- **Items #14 and #15:** The drafting group recommends no change for now, but it may make changes in the future.

2. **Adopted the MSA Framework**

Commissioner Conway said the MSA Framework will continue to undergo improvements as the MSA Team learns more about the needs of the state insurance departments and the experience of the insurers.

Mr. Lombardo made a motion, seconded by Mr. Trexler, to adopt the MSA Framework (Attachment Five). The motion passed with Louisiana abstaining.

Having no further business, the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup adjourned into the Long-Term Care Insurance (EX) Task Force meeting.

2. **Long-Term Care Insurance (EX) Task Force**

   a. **Adopted the Long-Term Care Insurance (EX) Task Force’s Oct. 29 and Summer National Meeting Minutes**

The Task Force conducted an e-vote on Oct. 29 to adopt the 2022 proposed charges for the Task Force and its subgroups.

Commissioner Altmaier made a motion, seconded by Commissioner Altman, to adopt the Task Force’s Oct. 29 (Attachment Six), and Aug. 13 (see NAIC Proceedings – Summer 2021, Long-Term Care Insurance (EX) Task Force minutes. The motion passed unanimously.

   b. **Heard an Update on Industry Trends**

Mr. Andersen said a group of state insurance regulators with long-term care insurance (LTCl) experience has reviewed insurers’ *Actuarial Guideline L1—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51) filings and coordinated and communicated with the domestic state insurance departments. This year, the group has focused on cost-of-care trends for policies with inflation protection. Often, the actual daily cost-of-care has been less than the inflation protected daily maximum benefits stated in the policy. If the cost-of-care increases, it could have a significant impact on the claims cost for inflation protected products, especially for companies with a lot of 5% inflation protected business. There has been a general trend of companies planning to increase the conservatism in the future cost-of-care assumptions. He said the group has seen some shift of care from more costly facilities to less costly home settings. This is likely temporary and an aspect that will continue. It will continue to be monitored as it affects reserves. Mr. Andersen said the group has also seen an increasing trend in the complexity of assets supporting reserves. The Life Actuarial (A) Task Force is currently asking for comments to
d. **Adopted the MSA Framework**

Commissioner White thanked the drafting group, the Subgroup, NAIC staff, state insurance regulators, and interested parties that contributed and provided feedback throughout the process. Mr. Lombardo said the MSA Framework is a work-in-progress,
and state insurance regulators will continue to work on the MSA Framework to make it better as more information is gathered. Commissioner White agreed that it is not a finished product and will be improved as the MSA Team completes its reviews. He asked everyone to remain engaged in the process going forward.

Commissioner Conway made a motion, seconded by Commissioner Pike, to adopt the MSA Framework (Attachment Five). The motion passed with Louisiana abstaining.

Commissioner Conway thanked Superintendent Cioppa for starting the process to find solutions for LTCI issues in 2019. Commissioner White thanked NAIC leadership for making LTCI a priority and giving the Task Force the necessary resources.

Commissioner White said the MSA Framework will be considered for adoption by the Executive (EX) Committee and Plenary at the 2022 Spring National Meeting. In 2022, the Subgroup will focus on implementation of the MSA Framework, which is expected to be fully operational by September 2022. Companies can continue to make rate proposals through the Pilot Project, which will inform future improvements to the MSA Framework.

e. Received the Report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup

Commissioner Altman said the Subgroup met Dec. 7 (Attachment Seven), Nov. 19 (Attachment Eight), Oct. 19 (Attachment Nine), Oct. 4 (Attachment Ten), Sept. 27 (Attachment Eleven), and Aug. 23 (Attachment Twelve). During these meetings, the Subgroup took the following action: 1) discussed comments received on a draft LTC wellness program issues document; and 2) discussed comments received on a draft reduced benefit options (RBOs) consumer notices checklist. Both documents were adopted through an open and collaborative process with state insurance regulators, industry, and consumer representatives. Both documents provide excellent guidance in two key areas aimed at protecting LTC consumers.

Commissioner Altman said on Nov. 19, the Subgroup adopted the “Checklist for Premium Increase Communications” document. This checklist is intended to establish a consistent approach to drafting and reviewing LTCI RBO policyholder communications. The checklist can be used by states for guidance, and it is not required to be used for the review of insurer communications with policyholders. It is a tool to try to gain more consistency across the states. This tool will be available to state insurance regulators to use; as reviews of consumer notices are performed, state insurance departments will need to consider states’ requirements.

Commissioner Altman said on Dec. 7, the Subgroup adopted a document titled “Issues Related to LTC Wellness Benefits Document.” She said the Subgroup first heard from industry about the types of benefits they were introducing and testing. This is an area of LTCI that is new, and there are a lot of innovative ideas out there. Therefore, it also requires state insurance regulators to consider the issues that may arise from these types of new benefits. The document outlines issues, observations, and next steps that the Subgroup identified for various topics, including:

- The effectiveness of LTC wellness programs.
- Preventions of unfair discrimination related to extra-contractual benefits and costs.
- Consumer confusion over wellness programs.
- Rebating; i.e., whether some LTC wellness benefits run afoul of anti-rebating laws.
- Tax considerations for policyholders.
- The regulatory role in approving or evaluating LTC wellness approaches.
- Actuarial considerations of the impact of LTC wellness benefits.
- Data privacy.

Commissioner Altman said the document is intended to provide guidance to state insurance regulators. The area of wellness benefits is expected to evolve over time; therefore, this document may be revised and enhanced in the future as these benefits evolve and these conversations mature. She encouraged every state to review and utilize these documents.

Bonnie Burns (California Health Advocates) said RBOs are a serious decision for consumers when faced with the trade-offs they make to maintain some of their coverage. She related a story of an 88-year-old woman that had reduced benefits over the years instead of rate increases and was left with a policy with only two years of coverage and no inflation protection. That said, the RBOs given to consumers is decreasing the promise that the company made to the consumer when the policy was purchased. State insurance regulators need to understand how the RBOs work over time and how many decisions policyholders are being asked to make to keep some of their coverage. RBOs have serious consequences for consumers. Commissioner White said the work on RBOs is important. If policyholders are given options, they need to understand the consequences for accepting those RBOs. The checklist goes a long way in ensuring consumers have good options and understand those options.
Commissioner Conway made a motion, seconded by Commissioner Altmaier, to receive the report of the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup. The motion passed unanimously.

f. Adopted the “Issues Related to LTC Wellness Benefits” Document

Commissioner Altman made a motion, seconded by Mr. Gaffney, to adopt the “Issues Related to LTC Wellness Benefits” document (Attachment Thirteen). The motion passed unanimously.

Ms. Burns said wellness benefits are new and are operating in an unregulated and unstructured environment. It is important for the NAIC to have some oversight over these benefits. Ms. Burns asked that state insurance regulators monitor these products as they emerge.

g. Adopted the “Checklist for Premium Increase Communications” Document

Commissioner Altman made a motion, seconded by Commissioner Altmaier, to adopt the “Checklist for Premium Increase Communications” document (Attachment Fourteen). The motion passed unanimously.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned.
The Long-Term Care Insurance Multistate Rate Review (EX) Subgroup met Nov. 15, 2021. The following Subgroup members participated: Michael Conway, Chair (CO); Jimmy Harris (AR); Paul Lombardo (CT); Philip Barlow (DC); Benjamin Ben (FL); Klete Geren (IA); Dean L. Cameron (ID); Alex Peck (IN); Rod Friedy (LA); Fred Andersen (MN); William Leung (MO); Michael Muldoon (NE); Russel Toal (NM); Jessica K. Altman (PA); Matt Gendron (RI); Michael Wise (SC); Doug Slape (TX); Tomasz Serbinowski (UT); Bob Grissom (VA); Anna Van Fleet (VT); Michael Walker (WA); and Joylynn Fix (WV).

1. Discussed and Exposed Comments on an MSA Framework Draft

Mr. Conway said the purpose of today’s meeting is to: 1) review the latest changes that have been made to the draft combined Long-Term Care Insurance (LTCI) Multistate Rate Review Framework (MSA Framework); 2) address the comments received on the second exposure of the MSA Framework; and 3) expose the draft for a final public comment period in advance of the Fall National Meeting.

Mr. Andersen presented a recommendation (Attachment One-A) from the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup. He said the recommendation was in response to a referral from the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup for guidance concerning suggested edits to the Reduced Benefit Options appendix of the draft MSA Framework. He said it is recommended that no changes be made at this time.

Mr. Andersen gave a summary of the changes made to the draft MSA Framework in response to comments received from the Arizona Department of Insurance (DOI) and Financial Institutions (Attachment One-B), the North Carolina DOI (Attachment One-C), the American Academy of Actuaries (Academy) (Attachment One-D), and the American Council of Life Insurers (ACLI) and America’s Health Insurance Plans (AHIP) (Attachments One-E and One-F) during the second exposure, using a marked-up version of the draft (Attachment One-G).

Mr. Conway said the combined draft of the MSA Framework discussed during the meeting will be exposed for a third public comment period ending Dec. 6. He said the Subgroup plans to discuss any comments received and consider adoption of the MSA Framework during its Dec. 12 meeting, and then forward it to the Long-Term Care Insurance (EX) Task Force for its consideration.

Having no further business, the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup adjourned.
The Vermont Department of Financial Regulation submitted the following comment to the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup (MSRRSG) in response to the Subgroup’s exposure of operational sections of the Long-Term Care Insurance (LTCI) Multistate Rate Review Framework (MSA Framework) for public comment:

On p. 14, in appendix D, Principles for Reduced Benefit Options (RBO) Associated with LTCI Rate Increases, it reads:

- Regulators and interested parties should continue to study the idea of offerings being made by insurers including potentially being tied to rate increases, e.g., providing hand railings for fall prevention in high-risk homes, and identifying the pros and cons of such an approach.

Vermont suggests keeping the bullet above as is, and adding another bullet:

- In the case that an offering is tied to a rate increase, and involves the collection of consumer data, regulators should ensure that data collection and use is clearly disclosed and easily understood, that the consumer is made aware of any other available options, that the offer is not discriminatory, and that the rate impact is correlated to the offering. Consumer data should not be collected to be monetized for profit or for advertising.

The MSRRSG referred the comment to the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup (RBOSG) during its Sept. 28, 2021 meeting for evaluation.

The RBOSG discussed the referral during its Oct. 4, 2021 meeting. It recommends the following:

The RBOSG recommends that the proposed language not be added to the MSA Framework at this time. However, if the Multistate Actuarial LTCI Rate Review Team (MSA Team) is presented with a rate increase filing that includes the issue addressed in the comment, the RBOSG requests that the MSRRSG make a referral that includes details of the offering’s connection to the rate increase request.

Cc: Commissioner Scott A. White, Shannen Logue, Anna Van Fleet, Jeff Johnston, Jane Koenigsman
Arizona Comments
Greetings,

The following comments are submitted from the Arizona Department of Insurance and Financial Institutions on the LTC Multistate Rate Review Framework (MSA). Thank you for accepting our late submission.

We appreciate the potential benefit of the uniformity of the MSA LTC rate review and standardized format of the corresponding reports, particularly if the MSA process becomes used by many state insurance departments. We also appreciate that there are multiple points in the process where participating/impacted states will be able to ask questions about and comment on the MSA review. However, we may not always be able to participate in, or become aware of, an MSA review until an insurer references an MSA report in its subsequent AZ rate filing. Thus, in order for Arizona to be able to maximize its use of the MSA reports to augment, or even potentially replace, some of its review of a LTC rate filing, we believe the MSA report should contain a certain level of detail about the actuarial rate review analysis. Currently, the framework document indicates the report will contain a “summary” of the analysis, rather than the actual analysis. Here are our suggestions for actuarial review details that we believe should be made available to participating/impacted states:

- A more detailed description about how the MSA reached its conclusions regarding the application of the different methodologies it used (Texas method, Minnesota method, other), including the calculated values (at a high level). Given that the methodologies used by the MSA to analyze the filing might differ from state-specific statutory or regulatory requirements, this analysis could be important for subsequent state reviewers to understand.

- A clear indication of whether the recommended increase in the report is based on:
  - a total allowed increase in the pending request, or
  - a recommended cumulative inception-to-date increase?

- A clear indication about whether the rate increase submitted for review to the MSA involved:
  - different increases for different coverages based on lifetime vs limited coverages,
  - different increase with or without inflation coverage
  - different increases based on issue age groupings

- In order to determine when we can and cannot use the MSA analysis, we must be able to discern whether the filing contains Pre Stabilization and/or Post Stabilization business in accordance with when our Rate Stabilization rules became effective. Currently, it appears that the MSA combines its results into a single Recommended rate increase, with no distinction between the policy issuance periods. Because states may have different standards for Pre Stabilization business than for Post Stabilization business, and because states adopted the Pre and Post rules at different times, there is a potential for the resulting recommended rate increase found in the MSA report to be either higher or lower than a rate more accurately based only on whether policies were issued in a Pre or Post period.

- A clear indication about whether the MSA independently projects lifetime premiums and claims and a comparison of the MSA projections to the filer's projections.
Arizona Comments

- A clear indication about any analysis the MSA made regarding the "fairness" or equity of landing spots or benefit reduction options.

- A clear indication about any analysis the MSA made regarding the filer's actuarial assumptions and margins, discount interest rate, and other pertinent factors.

Regards,

Erin H. Klug
Assistant Director, Product Filing & Compliance Division
Arizona Department of Insurance and Financial Institutions
100 N. 15th Ave, Suite 261, Phoenix AZ 85007
erin.klug@difi.az.gov / 602.364.3762
North Carolina Comments on Operational Section of the MSA Framework – 9/14/21

I had a few insignificant observations on the Long-Term Care Insurance Multi-State Rate Review Framework.

1. The Table of Contents needs to be updated with the addition of Section II. D.
2. In section VI. B. Appendix, I think the first sentence should read: “... LTCI rate increase review inquiries from all of states”
3. Section VI. A. 2. Disclaimers does not seem to be in the Section VII. A. Exhibit – Sample MSA Advisory Report.

Some additional questions:

1. How will Reduced Benefit Options like “landing spots” or new endorsements for reduced inflation benefits be handled? Especially when the MSA Team is recommending different rate increases for different states due to historical approvals.
2. Section II. F. states “the MSA Team ... may communicate with the insurer outside of SERFF.” Will this be documented?
3. Section IV. B. – Will the insurer get a chance to respond to the MSA Team’s recommendation before the Advisory Report is released to the states?

Thank you for the opportunity to comment.

David Yetter
NCDOI
October 8, 2021

Commissioner Scott A. White, Chair
Commissioner Michael Conway, Vice Chair
Long-Term Care Insurance (EX) Task Force
National Association of Insurance Commissioners (NAIC)

Attn: Jane Koenigsman, Senior Manager, Life and Health Financial Analysis

Re: Long-term Care Insurance (LTCI) Multistate Rate Review Framework Operational and Actuarial Sections, September 2021 Exposures

Dear Commissioners White and Conway:

On behalf of the American Academy of Actuaries LTC Reform Subcommittee, I appreciate the opportunity to offer comments on the exposure drafts of the operational and actuarial sections of the Long-Term Care Insurance Multi-State Rate Review Framework (“Framework”) released September 10, 2021, and September 15, 2021, respectively. This letter provides our comments on both the operational and actuarial aspects of the exposed Framework.

We previously provided comments on the operational aspects of the prior version of the Framework in our letter dated May 24, 2021, and comments on the actuarial aspects in our letter dated July 26, 2021. We appreciate the NAIC Long-Term Care Insurance (EX) Task Force’s consideration of our previous comments and the opportunity to discuss them with the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup.

Actuarial Qualifications and Professional Judgment

We appreciate the revisions and additions to the Framework reflecting our previous comments on actuarial qualifications and professional judgment.

Future Updates

Section IV.E. of the Framework calls for regulatory feedback on the Multi-State Actuarial (MSA) Review process. We recommend that interested parties continue to be invited to review and comment on future changes to the Framework. In particular, if any formalized actuarial and/or policy approaches beyond the Minnesota and Texas approaches are considered for...
frequent use by the MSA Team in evaluating rate proposals (as contemplated in Section V.A.), we suggest that those new approaches should be similarly vetted through the NAIC’s Multistate Rate Review (EX) Subgroup or the Long-Term Care Pricing (B) Subgroup, with opportunity for feedback from the Academy and others.

Future Non-Actuarial Considerations

Section V.F.2. of the Framework discusses the potential for additional non-actuarial considerations to be incorporated into the MSA Review process. This introduces—or continues—a potentially open-ended and inconsistent decision-making process with respect to future rate increase proposals. Insurers and their pricing actuaries should be able to anticipate a stable regulatory framework when introducing new long-term care (LTC) policies into the market. We recognize that individual states’ use of non-actuarial considerations may be outside the scope of the MSA Framework.

Loss Ratio Approach

Section V.A. of the Framework specifies that the MSA Team will “apply both the Minnesota and Texas approaches for each rate proposal submitted.” This implies that the rate stabilization methodology is not sufficient. The rate stabilization approach is used by many state insurance departments. To not include this baseline approach would be contrary to the intent of the MSA Team proposal, which seeks uniformity across states and reduces the implied subsidization that currently exists. The MSA Team should also apply the appropriate loss ratio approach and provide an opinion on the assumptions underlying the calculation if it seeks to have greater state participation.

Section V.B.4. states that

“The loss ratio approach, one of the minimum standards in many states’ statutes, is evaluated by the MSA Team. However, there is general recognition that this approach produces rate increases that are too high and do not recognize other typical statutory standards such as fair and reasonable rates.”

We suggest that the opinion in the preceding sentence be properly attributed to either the members of the MSA Team and/or a decision of an appropriate committee.

Section V.B.5. discusses an application of the 58% / 85% standard to rate-stabilized business. Not all states have adopted rate stability regulations, and effective dates vary across states that have adopted regulations based on policy issue date. Therefore, it is not entirely clear when a rate proposal will be considered to cover a “relevant block” of rate-stabilized business. Given that this test would impose, by regulation, a restriction on rate increases for policies initially issued under rate stability regulation, the MSA Framework’s statement that “if this standard produced lower increases than the Minnesota and Texas approaches, it would produce the recommended rate increase,” may not be justified in all jurisdictions. If the 58% / 85% standard is analyzed by the MSA team, we suggest that the resulting rate increase be reported in comparison with the Minnesota and Texas results. This will allow individual Participating States to consider whether the 58/85 limit applies under their own regulations. Otherwise, the MSA Team’s use of the 58/85
standard may have the effect of layering on a limit that was never applicable to some of the policies in a nationwide block.

**Minnesota and Texas Approaches**

In sections V.D. and VII.A, the Minnesota and Texas approaches are described as actuarially justified approaches. As mentioned in our July 26 letter, these approaches include decisions based on non-actuarial considerations. Two examples of non-actuarial considerations in these approaches are cost-sharing provisions and disallowing interest rate deviations as a reason for a rate increase. We suggest recognizing that these approaches include both actuarial and non-actuarial considerations.

We believe that the Minnesota approach embeds implied policy decisions that are not actuarial in nature. While the calculations themselves may require actuarial methods, as stated in Section V.C., the approach embeds non-actuarial considerations that seek a “fair and reasonableness consideration,” the level of which is not clearly defined. Also, as the approaches labeled “if-knew / makeup approach” and “cost-sharing formula” are public policy decisions that are not specified in adopted model law, defining them as “actuarially justified” seems inappropriate.

Appendix 3 of the sample MSA Advisory Report in Section VII.A. includes a reference to cost sharing and the Texas approach. This reference should be clarified or corrected, as cost sharing does not appear throughout the rest of the Framework in the description of the Texas approach. To our knowledge, cost sharing has never been included in prior documentation of the Texas approach.

**Goals of MSA Review Process**

The sample MSA Advisory Report in Section VII.A. mentions a goal of the MSA Team to attain the same resulting rate tables in each state for a given product. When products have had varied historical rate increase approvals, both in magnitude and timing across states, this goal conflicts, at least in part, with another stated goal of the MSA Review of eliminating cross-state subsidization. A goal of having the same resulting rate tables in each state has a potential adverse impact of creating less incentive for more appropriate rate increase approvals in states that were slow to approve (or did not approve at all) prior rate increase requests, before participating in an MSA review. Said another way, this could have the unintended effect of encouraging states to delay approving rate increases.

**Additional Items**

Insurers may want to file rate increase requests in non-participating states concurrently with the MSA Review filing so that the insurer does not needlessly delay the filing and review process in non-participating states. It is unclear if and how insurers will know which states are Participating States in the MSA Review, and whether states will decide on participation in the MSA review each time any rate increase request is submitted.
Average premiums may vary significantly based on policy characteristics and issue age distribution differences across jurisdictions, in addition to past rate increase approvals. Also, Section V.A. acknowledges that premium rates may be lower in lower-cost states based on coverage differences elected by insureds. In the sample MSA Advisory Report in Section VII.A., the reference to average annual premium rate variation by state should be clarified. We suggest that any comparison of average premium rates be carefully considered as it may be misleading.

*****

Thank you for the opportunity to provide input on the development of the operational and actuarial aspects of the Long-Term Care Insurance Multi-State Rate Review Framework. We welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments or on other topics. If you do have any questions or would like to discuss further, please contact Matthew Williams, the Academy’s senior health policy analyst, at williams@actuary.org.

Sincerely,

Andrew H. Dalton, MAAA, FSA
Vice Chairperson, LTC Reform Subcommittee
American Academy of Actuaries

CC: Eric King, Health Actuary, NAIC
October 11, 2021

Commissioner Michael Conway  
Chairman, NAIC LTCI Multi-State Rate Review (EX) Subgroup  
Colorado Insurance Department

Dear Commissioner Conway and Subgroup Members,

The American Council of Life Insurers (ACLI)\(^i\) and the American Association of Health Insurance Plans (AHIP)\(^ii\) appreciate the opportunity to comment on the second draft of the Operational Section of the Long-Term Care Insurance (LTC) Multi-State Rate Review Framework, exposed by the NAIC LTC (EX) Task Force on September 13, 2021. Our members recognize the hard work that has gone into developing the Framework thus far and hope that our input can further the progress already made.

GENERAL

The purpose of the Framework is to develop a consistent national approach for reviewing current LTC rates that results in actuarially appropriate increases being granted by the states in a timely manner that eliminates cross-state rate subsidization. We provide our comments in full support of this charge from the NAIC to the LTCI Multi-State Rate Review (EX) Subgroup.

Consistent, actuarially appropriate, timely rate increases that eliminate cross-state rate subsidization are achieved when the governance, policies, procedures, and actuarial methodologies utilized by the MSA Review Team are openly communicated and reliably followed. We are encouraged by the Subgroup’s edits to the first draft of the Operational Section to give insurers access to the MSA Advisory Report. Access to the final Report will help insurers to understand the thought process the MSA Team worked through to make their recommendation, thereby giving insurers greater predictability in how their business will be regulated.

This letter’s headings correspond with the various sections and subsections of the Framework for which we have comments. In addition to these comments, we respectfully submit our suggested edits (highlighted in yellow) to the Operational Section in the attached redlined document.

I. INTRODUCTION

PURPOSE

We urge the Subgroup to incorporate its entire charge into the Framework. Currently, the portion of the charge directing the Subgroup to develop an approach to the MSA Review that eliminates cross-state rate subsidization is not included. Eliminating cross-state rate subsidization should be a key component of, and explicitly stated in, the Framework. The original charge of the LTC (EX) Task Force emphasized the importance of addressing cross-state inequities. It recognized, “... the gravity of the threat posed by the current long-term care...”
insurance environment both to consumers and our state-based system of insurance regulation” and the need to take action to address the threat.

Many of the recommendations that ACLI/AHIP made in our comments on the first draft of the Operational Section, and are making again in this comment letter, would mitigate cross-state rate inequities. If adopted, these recommendations will help to keep rate increase decisions on blocks of business both consistent and actuarially sound.

STATE PARTICIPATION IN THE MSA REVIEW
ACLI/AHIP acknowledges the careful balance the Framework must achieve “to create a voluntary and efficient MSA Review that produces reliable and nationally consistent rate recommendations that state insurance regulators and insurers can depend upon.” A voluntary, yet dependable, MSA Review requires an expectation that Participating States will rely on the MSA Advisory Report in their rate approval decisions. If this expectation is not communicated to, and followed by, the states, rate recommendations will not be consistent, nor will regulators or insurers depend on them in their decision-making. We recommend that the Framework emphasize the expectation that participating in the MSA Review means a commitment to the results of the Review, barring any contradictory state law requirements.

Understanding that the Review process will be refined over time, we suggest that wording in the Operational Section be changed to say, “state participation is expected to increase (as opposed to evolve) in the future.” Emphasizing state reliance on the MSA Review will help to promote the consistency and efficiency the review process is meant to achieve.

In order for “[i]nsurance companies . . . to understand how . . . the MSA Advisory Report may impact the insurer’s in-force LTCI premium rate increase filing decisions and interactions with individual state insurance regulators” the MSA Review process must be transparent about how it applies the actuarial methodologies. ACLI/AHIP will address this matter in more detail in our comments on the second draft of the Actuarial Section of the Framework.

GENERAL DESCRIPTION OF THE MSA REVIEW
In our redline document, we suggest amendments to the language in this section to clarify that the MSA Team will keep insurers updated throughout the Review process and inform the insurer if the recommendation differs from the proposal. We also recommend language that strongly encourages states to rely on the MSA Advisory Report to achieve the charge and purpose of the MSA Review process.

BENEFITS OF PARTICIPATING IN THE MSA REVIEW
This Section lists the benefits state regulators will attain if they participate in the MSA process. However, unless the MSA Team, does, in fact, use the same dedicated approach to evaluate in force LTCl rate increase reviews, the states will not obtain the stated “benefit of using the same consistent methodology that is relied upon by other state insurance departments when reviewing in force LTCI rate increase filings in their state.” The MSA process will also not realize the “increased efficiency and reduced timelines for nationwide premium rate increase
requests” listed as a benefit for insurers. For these reasons, and as asserted in other sections of this letter, the Operational Section should encourage the states to not only accept the Advisory Report, but to also accept the rate filing submitted to the MSA Team, without additional state-specific filing requirements, unless mandated by state law.

DISCLAIMERS AND LIMITATIONS
While we appreciate the additional clarification that Participating States will provide MSA Advisory Reports the same protection from disclosure as provided by the confidentiality provisions contained within their state’s laws and regulations for rate filings, we remain concerned that insurers’ proprietary information could be revealed in the MSA Review process. Section I. E. 2. refers to the Master Information Sharing and Confidentiality Agreement between states that governs the sharing of information among state insurance regulators. We respectfully request that this document be shared with insurers so that we may understand the privacy protocols in place throughout the MSA review process. We recommend that the Subgroup clarify which privacy rules govern each part of the MSA Review process in the Framework. The safeguards used to keep insurers’ information confidential will influence whether an insurer decides to participate in the MSA Review process. Development of the MSA recommendation, including the Advisory Report, should be held confidential, subject to the Master agreement. Once the insurer filed the Advisory Report with the state it should be provided the confidentiality protections afforded by the state’s law.

II. MULTI-STATE ACTUARIAL LTCI RATE REVIEW TEAM (MSA TEAM)
MSA ASSOCIATE PROGRAM
We applaud the addition of the MSA Associate Program to the Framework to develop and expand LTCI actuarial expertise amongst state insurance department regulators. ACLI/AHIP members offer their support of the program and their help answering questions, if desired.

III. REQUESTING AN MSA REVIEW
PROCESS FOR REQUESTING AN MSA REVIEW
ACLI/AHIP requests clarification on the confidentiality of information in SERFF. The draft Framework states that “Participating States will have access to view the insurer’s rate proposal and review correspondence in SERFF.” Is the request for a rate proposal in SERFF, as well as accompanying information and correspondence, protected by Compact confidentiality procedures, state law, the Master Agreement, or something else?

CERTIFICATION
The certification provision references Participating States that “affirmatively relied on the MSA Review and/or the MSA Advisory Report in making its determination; or . . . consents in writing to use the MSA Review and/or the MSA Advisory Report.” Under what circumstances does the Subgroup believe that a state would do either? We suggest that all Participating States disclose whether they affirmatively relied on the MSA Review/Advisory Report in making their rate recommendations.

IV. REVIEW OF THE RATE PROPOSAL
RECEIPT OF A RATE PROPOSAL
In the referenced SERFF or email notifications, how much of the rate proposal submission, correspondence between the MSA Team and insurers, and other activities be visible to Participating States? Will Participating States be able to read all submitted information in its entirety? How will this information be kept confidential among the MSA Team and Participating States?

COMPLETION OF THE MSA REVIEW
We would appreciate clarity regarding the timeline once the MSA Team completes its review. The Framework states that the insurer will receive sufficient information regarding the MSA Team’s recommendation to allow “the insurer an opportunity to review the recommendation and in the event that the MSA Team recommendation differs from the proposal submitted by the insurer, the insurer will be given the opportunity to interact with MSA Team in order to ask questions, understand the MSA Team’s reasoning, and provide additional information in support of its proposal [sic] will address questions from the insurer about the result of the review.” Does this mean an insurer will see the recommendation before it is communicated to state insurance departments? If so, ACLI/AHIP are in support.

At what point will the MSA Team decide to abort the insurer’s efforts to refute a MSA recommendation differing from its proposal? We suggest that the Framework clearly state that an insurer can see and appeal the MSA recommendation prior to its communication to Participating States. A minimum two-week appeal period would give the insurer time to compile and submit additional information in support of its proposal.

PREPARATION AND DISTRIBUTION OF THE MSA ADVISORY REPORT
Furthermore, whether the recommendation differs from the proposal or not, our members would like to participate in MSA Team presentations of the draft MSA Advisory Report with regulators from Participating States. We believe an insurer’s ability to answer questions and respond to concerns from Participating States, if needed, would be helpful to all involved and increase MSA review efficiency.

TIMELINE OF REVIEW AND DISTRIBUTION OF THE MSA ADVISORY REPORT
Please see our suggested changes to the timeline in the redline document.

FEEDBACK TO THE MSA TEAM
The MSA Review process will be refined over time. With this in mind, we strongly recommend that the draft Framework be edited to specify a formal, annual assessment of the MSA Review process. Further, in addition to a survey gathering feedback from Participating States, insurers should also be surveyed for feedback on the process. Obtaining a clear and complete picture of the process from all participants will give NAIC leadership a more accurate picture of how well the process is working and what areas need improvement. Moreover, the anonymous results of the annual assessment should be shared with both Participating States and insurers to aid both groups in their business-planning and decision-making.
VII. EXHIBITS

EXHIBIT A. SAMPLE MSA ADVISORY REPORT

In Appendix 1, the note regarding the Minnesota approach refers to downward adjustments to morbidity assumptions. We suggest the Advisory Report include more explicit information about the adjustments made so that they may be re-evaluated, if appropriate.

The cost-sharing formula included in Appendix 3 of Exhibit A. assumes a company should have had more information about the possibility of rate increases than the consumer had. Whether or not this is true in any given circumstance, inclusion of the cost-sharing formula here is inappropriate. The assumption is a policy consideration that should not be incorporated into the actuarial approach. Further, Appendix 3 appears to apply the prospective cost-sharing formula within the Texas methodology, which differs from the provided Texas methodology explanation. See our red-lined document for additional suggested edits to this portion of the draft Framework.

CONCLUSION

ACLI/AHIP remains committed to working with the Subgroup to address the challenges in developing an MSA Review Framework. We look forward to addressing questions on our comments at our next LTCI Multi-State Rate Review (EX) Subgroup meeting.

Sincerely,

Jan M. Graeber Ray Nelson
ACLI Senior Actuary AHIP Consulting Actuary

1 The American Council of Life Insurers advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care (LTC) insurance, disability income insurance, reinsurance, dental, vision, and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States.

2 AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.
LONG-TERM CARE INSURANCE
MULTI-STATE
RATE REVIEW FRAMEWORK

Drafted by the
Ad Hoc Drafting Group\(^1\) of the
NAIC Long-Term Care Insurance (EX) Task Force

\(^1\) The Ad Hoc Drafting Group consists of representatives from state insurance departments in Minnesota, Nebraska, Texas, Virginia, and Washington
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I. INTRODUCTION

A. Purpose

The National Association of Insurance Commissioners ("NAIC") charged the Long-Term Care Insurance (EX) Task Force ("LTCI (EX) Task Force") with developing a consistent national approach for reviewing current long-term care insurance ("LTCI") rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. Considering that charge and the threat posed by the current LTCI environment both to consumers and the state-based system of insurance regulation, the LTCI (EX) Task Force developed this framework for a multi-state actuarial ("MSA") LTCI rate review process ("MSA Review").

This framework is based upon the extensive efforts of the LTCI Multi-State Review (EX) Subgroup, including its experience with a pilot program conducted by the pilot program’s rate review team ("Pilot Team"). As part of that pilot program, the Pilot Team reviewed LTCI premium rate increase proposals and issued MSA Advisory Reports recommending actuarially justified state-by-state rate increases. This framework aims to institutionalize a refined version of the Pilot Team’s approach to create a voluntary and efficient MSA Review that produces reliable and nationally consistent rate recommendations that state insurance regulators and insurers can depend upon. The MSA Review has been designed to leverage the limited LTCI actuarial expertise among state insurance departments by combining that expertise into a single review process analyzing in force LTCI premium rate increase proposals ("rate proposal(s)") and producing an MSA Advisory Report for the benefit and use of all state insurance departments. 

Note that rate decreases can be contemplated within the MSA Review process. The same concepts of this MSA Framework would be applied, if such a decrease request is received for MSA Review. The goal of this framework is to create a process that will not only encourage insurers to submit their LTCI products for multi-state review, but also provide insurance departments the requisite confidence in the MSA Review so that they will voluntarily rely upon its recommendations when conducting their own state level reviews of in force LTCI rate increase filings.

Ultimately, the MSA Review is designed to foster as much consistency as possible between states in their respective approaches to rate increases.

The purpose of this document is to function as a user's manual framework for the MSA Review that communicates to NAIC members, state insurance department staff, and external stakeholders how the MSA Review works to the benefit of state insurance departments and how insurers might engage in the MSA Review. This user's manual framework is intended to communicate the governance, policies,
procedures, and actuarial methodologies supporting the MSA Review. State insurance regulators can utilize the information and guidance contained herein to understand the basis of the multi-state actuarial LTCI rate review team’s (“MSA Team”) MSA Advisory Reports. Insurance companies can access the information and guidance contained herein to understand how to engage in the MSA Review, and how the MSA Advisory Report may impact the insurer’s in force LTCI premium rate increase filing decisions and interactions with individual state insurance regulators.

This document will be maintained by NAIC staff under the oversight of the LTCI (EX) Task Force and be revised as directed by the Task Force or an appointed Subgroup. This document will be part of the NAIC library of official publications and copyrighted.

B. State Participation in the MSA Review

The MSA Review of an insurer’s rate proposal will be available to state insurance departments who are both an Impacted State and a Participating State. These are defined as follows.

- "Impacted State" is defined as the domestic state, or any state for which the product associated with the insurer’s in force LTCI premium rate increase proposal is or has been issued.
- "Participating State" is defined as any impacted state insurance department that agrees to participate in the MSA Review. Participation is voluntary as described in Section I.E.1 below. Participation may include activities such as, but not limited to, receiving notifications of rate proposals in SERFF, participation in communication/Webinars with the MSA Team, and access to the MSA Advisory Report.

Note that state participation is expected to evolve/increase in the future as the MSA Review process continues to be developed and refined.

C. General Description of the MSA Review

The MSA Review provides for a consistent actuarial review process that will result in an MSA Advisory Report which state insurance departments may choose to rely on when deciding to make decisions on an insurer’s rate increase filing or to supplement the state’s own review process.

The MSA Review is conducted by a team of state’s regulatory actuaries with expertise in LTCI rate review. Each review will be led by a designated member of the MSA Team. The review process is supported by NAIC staff, the Interstate Insurance Product Regulation Commission ("Compact") staff, who will administratively assist insurers in making requests to utilize the MSA process and facilitate communication between the insurer, the MSA Team and [Participating/Impacted TBD] States. The NAIC’s electronic infrastructure, the System for Electronic Rates and Forms ("SERFF") will be used to streamline the rate proposal and review process. Although the administrative services of the Compact staff and SERFF’s Compact filing platform are utilized in the MSA Review, MSA rate proposals are reviewed, and MSA

4 Certain processes for Impacted vs. Participating States are yet to be determined (TBD).
Advisory Reports are prepared by the MSA Team. MSA rate proposals are not Compact filings and Compact staff will not have any role in determining the substantive content of the MSA Advisory Reports.

The MSA Review process begins when an insurer expresses interest in an MSA Review being performed for an in force LTCI rate proposal to the MSA Team through SERFF, or to supporting NAIC or Compact staff. The eligibility of the rate proposal will be reviewed and determined by the MSA Team and, as needed, from supporting staff.

The MSA Review of eligible rate proposals will resemble a state-specific rate review process utilizing consistent actuarial standards and methodologies. The MSA Team will apply the Minnesota and Texas approaches to calculate recommended, approvable rate increases. While aspects of the Minnesota and Texas approaches may result in lower rate increases than resulting from loss ratio-based approaches and are outside the pure loss ratio requirements contained in many states’ laws and rules, the approaches fall in line with legal provisions that rates shall be fair, reasonable, and not misleading. The MSA Team will review support for the assumptions, experience, and projections provided by the insurer and perform validation steps to review the insurer-provided information for reasonableness. The MSA Team will document how the proposal complies with the regulatory approach utilized by the MSA Team for Participating States. See Section V for more details on the actuarial review.

Throughout the MSA Review process the MSA Team will provide updates to the insurer. The MSA Team will deliver the final MSA Advisory Report to the insurer and address any questions the insurer has about the results of the Review. Through the MSA Review, the MSA Team will communicate MSA information to the insurer, including the final MSA Advisory Report, and the MSA Team will address any questions from the insurer about the results of the review.

Additionally, the review will consider reduced benefit options that are offered in lieu of the requested rate increases and factor in non-actuarial considerations.

At the completion of the review, the MSA Team will draft an MSA Advisory Report for Participating States that provides both summary and detail information about the rate proposal, the review methodologies, the analysis and other considerations of the team, and the recommendation for rate increases as outlined in Appendix A. Participating States are encouraged to utilize the information filed with the MSA Team in addition to the advisory report recommendation unless required by state law. Participating States are encouraged to utilize the information filed with the MSA Team in addition to the advisory report recommendation unless required by state law. Participating States are encouraged to utilize the information filed with the MSA Team in addition to the advisory report recommendation unless required by state law. Participating States are encouraged to utilize the information filed with the MSA Team in addition to the advisory report recommendation unless required by state law. Participating States are encouraged to utilize the information filed with the MSA Team in addition to the advisory report recommendation unless required by state law. Participating States are encouraged to utilize the information filed with the MSA Team in addition to the advisory report recommendation unless required by state law.

The rate proposal, review process, actuarial methodologies and other review considerations are detailed within this framework document and accompanying appendices.

D. Benefits of Participating in the MSA Review

Both state insurance regulators and insurers will benefit by participating in the MSA Review in multiple ways.
For state insurance regulators:

- First, they will be able to leverage the demonstrated expertise of the MSA Team in reviewing in force LTCI rate increases filed to their state. It is recognized that multiple states may not have significant actuarial expertise with LTCI, so participation in the MSA Review will allow those states to build on the specific, dedicated LTCI actuarial expertise of the MSA Team.
- Second, state insurance regulators will be able to utilize the MSA Team to promote consistency of actuarial reviews among filings submitted by all insurers to states, and among actuarial reviews across all states. Because the MSA Team is using the same dedicated approach to in force LTCI rate increase reviews, states who utilize the MSA Team will have the benefit of using the same consistent methodology that is relied upon by other state insurance departments when reviewing in force LTCI rate increase filings in their state.
- Third, the MSA Review allows for more state regulatory actuaries to work with or under the supervision of qualified actuaries which affords them an opportunity to establish LTCI-specific qualifications in making actuarial opinions. This is particularly important when we consider that requirements to be a “Qualified Actuary” include years of experience under the supervision of another already qualified actuary in that subject matter.
- Finally, participating in the MSA Review will allow all state insurance regulators to share questions and information regarding a particular rate proposal or review methodologies; thus, increasing each state’s knowledge base in this area and promoting a more consistent national approach to in force LTCI rate review.

Note that states’ use of and reliance on the MSA Advisory Report is expected to increase in the future as the MSA Review process continues to be developed and refined and the benefits of the MSA Review described above become more evident.

Long-Term Care (LTCI) insurers will likewise see multiple benefits in participating the MSA Review.

- First, by utilizing the MSA Review and through the receipt of MSA information and the MSA Advisory Report from the MSA Team, insurers should see increased efficiency and reduced timelines for nationwide premium rate increase requests. As the MSA Team delivers the MSA Advisory Report for a rate proposal to Participating States, they have functionally reduced the review time for each state, meaning that LTC insurers should see more efficient and timely reviews from these states.
- Second, participating in the MSA Review will provide LTC insurers with one consistent recommendation to be used when making rate increase filings to all states, thus reducing the carrier’s workload in developing often widely differing filings for states’ review.
- Finally, the consistency of one uniform national system for reviewing rate proposals should lead to more accurate reviews, theoretically reducing some of the need for ongoing rate increase filings.

E. Disclaimers and Limitations

1. State Authority over Rate Increase Approvals
The MSA Advisory Report is a recommendation to Participating States based upon the methodologies adopted by the MSA Review. The recommendations are not specific to, and do not account for, the requirements of any specific state’s laws or regulations. The MSA Review is not intended, nor should it be considered, to supplant or otherwise replace any state’s regulatory authority, responsibility and/or decision-making. Each state remains ultimately responsible for approving, partially approving or disapproving any rate increase in accordance with applicable state law. To satisfy the LTC EX Task Force charge to “develop a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization,” it is expected that states will generally follow the MSA Advisory Report’s recommendations and not impose state-specific caps on actuarially appropriate increases unless specifically mandated by state law.

A Participating State’s non-adoption of the MSA Advisory Report’s recommendations with respect to one filing does not require that state to consider or use adopt any MSA Advisory Report recommendations with respect to any other filing. The MSA Review in no way (a) eliminates the insurer’s obligation to file for a rate increase in each Participating State or (b) modifies the substantive or procedural requirements for making such a filing. While expected to adopt the recommendations of the MSA Review in each of their state filings, insurers are not obligated to align their individual state rate filings with the recommendations contained within the MSA Advisory Report.

The MSA Advisory Reports, including the recommendations contained therein, are only for use by Participating States in considering and evaluating rate filings. The MSA Advisory Reports or their conclusions shall not be utilized by any insurer in a rate filing submitted to a non-participating state, nor shall the MSA Advisory Reports be used outside of each regulator’s own review process, or to challenge the results of any individual state’s determination of whether to grant, partially grant or deny a rate increase.

2. Information Sharing Between State Insurance Departments

The MSA Review, including, but not limited to, meetings, calls, and correspondence with insurers on insurer-specific matters are held in regulator-to-regulator sessions and are confidential. In addition, if certain information and documents related to specific companies that are confidential under the state law of a MSA Team member or a Participating State need to be shared with other regulators, such sharing will occur as authorized by state law, and pursuant to the Master Information Sharing and Confidentiality Agreement ("Master Agreement") between states that governs the sharing of information among state insurance regulators. Through the Master Agreement, state insurance regulators affirm that any confidential information received from another state insurance regulator will be maintained as confidential and represent that they have the authority to protect such information from disclosure.

3. Confidentiality of the Rate Proposal
Members of the MSA Team affirm and represent that they will provide any in-force LTCI rate proposal as discussed herein with the same protection from disclosure, if any, as provided is protected from disclosure by the confidentiality provisions contained within their state’s laws and regulations.

4. Confidentiality of the MSA Reports

Likewise, members of the MSA Team and Participating States affirm and represent that they will provide any MSA Advisory Report(s) and MSA information provided to insurers as discussed herein with the same protection from disclosure, if any, as provided is protected from disclosure by the confidentiality provisions contained within their state’s laws and regulations for rate filings.

F. Governing Body and Role of the NAIC Long-Term Care Insurance (EX) Task Force

The NAIC LTCI (EX) Task Force is expected to remain in place for the foreseeable future to oversee the implementation of the MSA Review, and related MSA Advisory Reports, and to provide a discussion forum for MSA-related activities. The Task Force or any successor will continuously evaluate the effectiveness and efficiency of the MSA Review for the benefit of state insurance regulators and provide direction, as needed.

The LTCI (EX) Task Force may create one or more subgroups to carry out its oversight responsibilities.

Membership and leadership of the Task Force will be selected by the NAIC President and President-elect as part of the annual committee assignment meeting held in January. Selection of the membership and leadership may consider a variety of criteria, including commissioner participation, insurance department staff competencies, market size, domestic LTC insurers, and other criteria considered appropriate for an effective governance system.

II. Multi-State Actuarial LTCI Rate Review Team (MSA Team)

The MSA Team comprises state insurance department actuarial staff. MSA Team members are chosen by their skill set and LTCI actuarial experience. The LTCI (EX) Task Force, or its appointed Subgroup, will determine the appropriate experience and skill set for qualifying members for the MSA Team. It is expected that state participants will provide expertise and technical knowledge specifically regarding the array of LTCI products and solvency considerations. The desired MSA Team membership composition should include a minimum of five and up to seven members.

Membership must follow the requirements below and be approved by the Chair of the LTCI (EX) Task Force or the Chair of an appointed Subgroup. The following outlines the qualifications, duties, participation expectations and resources required for MSA Team members.

A. Qualifications of an MSA Team Member
To be eligible to participate as a member of the MSA Team, a state insurance regulator is required to:

- Hold a senior actuarial position in a state insurance department in life insurance, health insurance, or long-term care insurance
- Be recommended by the Insurance Commissioner of the state in which the actuary serves
- Have over five years of relevant LTCI insurance experience
- Hold an Associate of the Society of Actuaries (ASA) designation
- Currently participates as a member of the LTCI Multistate Rate Review (EX) Subgroup (or equivalent Subgroup appointed by the LTCI (EX) Task Force) and the LTC Pricing (B) Subgroup
- At least one member of the MSA Team must be a member of the American Academy of Actuaries

Additionally, the following qualifications are preferred:

- Hold a Fellow of the Society of Actuaries (FSA) designation
- Have spent at least one year engaged in discussions of either the LTCI (EX) Task Force or its appointed Subgroup

As both state insurance regulators and the MSA Review process may benefit by developing and expanding specific LTCI actuarial expertise through participation in this process, having one or more suitably experienced and qualified actuaries participate in and supervise the work of the MSA Team is critical to the viability of the MSA process. Participation also provides opportunities for additional actuaries to meet the requirements of the U.S. Qualification Standards applicable to members of the American Academy of Actuaries and other U.S. actuarial organizations as they relate to LTCI.

Consultants engaged by the state insurance department would not be considered for MSA Team membership.

B. Duties of an MSA Team Member

- Active involvement with the MSA Team, with an expected average commitment of 20 hours per month (See Section IV for details of the MSA Review and activities of a team member)
- Participate in all MSA Team calls and meetings (unless an extraordinary situation occurs)
- Review and analyze materials related to MSA rate proposals
- Provide input on the MSA Advisory Reports, including regarding the recommended rate increase approval amounts
- Maintain confidentiality of MSA Team meetings, calls, correspondence, and the matters discussed therein to the extent permitted by state law and protect from disclosure any confidential information received pursuant to the Master Information Sharing and
Confidentiality Agreement. MSA Team Members should communicate any request for public disclosure of MSA information or any obligation to disclose.

- Active involvement within NAIC LTCI actuarial groups
- Willingness to provide expertise to assist other states

C. Participation of an MSA Team Member

Except for webinars and other general communications with state insurance departments, participation in the MSA Review conference calls and meetings related to the review of a specific rate proposal will be limited to named MSA Team members, supporting NAIC or Compact staff members who will be assisting the MSA Team, and the Chair and Vice Chair of the LTC (EX) Task Force, or its appointed Subgroup. Other interested regulators, e.g., domiciliary state insurance regulator, may be invited to participate on a call at the discretion of the MSA Team, or Chair or Vice Chair of the Task Force or its appointed Subgroup.

D. MSA Associate Program

The MSA Associate Program within the MSA Framework is intended to encourage and engage state insurance department regulators to become actively involved in the MSA process. Additionally, a benefit of the program is to provide an educational opportunity for state insurance department regulatory actuaries that wish to gain expertise in LTCI. Regulatory actuaries can participate with varying levels of involvement or for different purposes as described. Regulatory actuaries may participate:

- As a mentee. The mentee would participate in aspects of the MSA Review process. An MSA Team member will serve as a mentor to another state regulatory actuary and provide one-on-one guidance.
- To gain more knowledge and understanding of the Minnesota and Texas actuarial approaches.
- To share their own expertise through feedback to the MSA Team on MSA Advisory Reports, to better enhance the overall MSA process.
- To participate on an ad hoc limited basis, i.e., where a regulatory actuary would like to participate but is unable to make the required time commitment.
- To meet the U.S. Qualification Standards applicable to members of the American Academy of Actuaries and other U.S. actuarial organizations as they relate to LTCI by serving under the supervision of a qualified actuary on the MSA Team.
- To serve as a peer reviewer of the MSA Advisory Reports.

D.E. Conflicts, Confidentiality and Authority of the MSA Team

1. Authority of the MSA Team

Members of the MSA Team serve in a purely voluntary basis, and any member’s participation shall not be viewed or construed to be any official act, determination or finding on behalf of their respective jurisdictions.
2. **Disclosures and Confidentiality Obligations, as Applicable**

All members of the MSA Team acknowledge and understand that the MSA Review, including, but not limited to, meetings, calls, and correspondence are confidential and may not be shared, transmitted, or otherwise reproduced in any manner. Additionally, all members of the MSA Team affirm and represent that they will (a) provide any in force LTCI rate proposal with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state’s laws and regulations; and (b) provide any MSA Advisory Report with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state’s laws and regulations for rate filings. Any resulting advisory report, as well as all meetings, calls, correspondence, and all other materials produced in connection herewith are confidential and may not be shared, transmitted, or otherwise reproduced in any manner.

3. **Conflict of Interest Avoidance Procedures and Certifications**

No member of the MSA Team may own, maintain, or otherwise direct any financial interest in any company or its affiliates subject to the regulation of any individual State, nor may any member serve or otherwise be affiliated with the management or board of directors in any company or its affiliates subject to the regulation of any individual State. All conflicts of interest, whether real or perceived, are prohibited and no member of the MSA Team shall engage in any behaviors that would result in or create the appearance of impropriety.

E.F. **Required NAIC and Compact Resources**

The MSA Team will require administrative and technical support from the NAIC. As the MSA Review develops, it is expected NAIC support resources will play an integral role in managing the overall program. Administrative staff support will be needed to support MSA Team communications and manage record keeping for underlying workpapers and final MSA Advisory Reports associated with each rate proposal, etc. Additionally, it is possible that limited actuarial support will be needed for the analysis of rate proposals, including preparing data files, gathering information, performing limited actuarial analysis procedures, drafting MSA Advisory Reports, and monitoring interactions among the state insurance departments and the MSA Team. Dedicated staff support for the ongoing work of the LTCI (EX) Task Force will be needed as well. As more experience with rate proposal volumes and average analysis time is gained, the full complement of human resources required will be better understood.

The MSA Team and supporting NAIC and Compact staff will use the NAIC SERFF electronic infrastructure to receive insurer rate proposals and correspond with insurers. As needed, the MSA Team or supporting NAIC and Compact staff may communicate with the insurer outside of SERFF. NAIC and Compact staff will communicate with insurers only at the direction of the MSA Team. Compact staff will perform administrative work related to MSA Filings at the direction of the MSA Team and as described in this Framework.
III. REQUESTING AN MSA REVIEW

A. Scope and Eligibility of a Rate Proposals for MSA Review

The following are the preferred eligibility criteria for requesting an MSA Review of a rate proposal:

- Must be an in force long-term care insurance product [individual or group]
- Must be seeking a rate increase in at least 20 states and must affect at least 5,000 policyholders nationwide
- Includes any stand-alone LTCI product approved by states, not by the Interstate Insurance Product Regulation Commission (Compact)
- For Compact-approved products meeting certain criteria, the Compact Office will provide the first-level advisory review subject to the input and quality review of the MSA

It is recognized that rate proposals vary from insurer to insurer. The above criteria and the timelines provided below are general guidelines. The MSA Team has the authority to weigh the benefits of the MSA Review for state insurance departments and the insurer against available MSA Team resources when considering the eligibility of rate proposals and the timeline for completion. Based on these considerations, the MSA Team, at its discretion, may elect to perform an MSA Review on a rate proposal that does not satisfy the above eligibility criteria.

The MSA Team reserves the right to deny a request that does not meet eligibility criteria. An insurer will be notified if the request for an MSA Review is denied.

An insurer may ask questions for more information about a potential rate proposal though communication to supporting NAIC and Compact staff and the MSA Team. This will be accomplished through a Communication Form that will be available on the Compact webpage. Supporting NAIC and Compact staff will work with the insurer to complete the necessary steps to assess eligibility, discuss any technical or other issues and answer questions.

The insurer will have access to primary and supplementary checklists in Appendix B that provide guidance to the insurer for information that should be included in a complete MSA rate proposal requested through the NAIC’s SERFF application.

B. Process for Requesting an MSA Review

As noted in Section I.C. above, the MSA Review will utilize the Compact’s multi-state review platform within the NAIC’s SERFF application and its format for in-force LTCI rate increase requests. Therefore, a state may participate in the MSA Review without being a member of the Compact. The following describes a few key elements of the process for insurers and state insurance department regulators.

- The insurer will work with NAIC and Compact support staff and the MSA Team to make a seamless request.
• Instructions containing a checklist for information required to be included in the rate proposal, as reflected in Appendix B, will be available to insurers through the Compact’s webpage or within SERFF.
• The insurer shall include in the rate proposal a list of all states for which the product associated with the rate increase request is or has been issued. Participating states will have access to view the insurer’s rate proposal and review correspondence in SERFF.
• Fee schedule for using the MSA Review [To Be Determined].
• Rate proposals for MSA Review within SERFF will be clearly identified as separate from Compact filings.
• The supporting NAIC and Compact staff through SERFF will notify the impacted states upon receipt of the request with the SERFF Tracking No.
• The MSA Team may utilize a “queue” process for managing workload and resources for incoming requests through SERFF.
• The MSA Team may utilize Listserv or other communication means for inter-team communications.
• The MSA Team’s review of objections and insurer responses are completed through SERFF.

C. Certification

The insurer shall provide certifications signed by an Officer of the insurer that it acknowledges and understands the non-binding effect of the MSA Review and MSA Advisory Report. The certification shall also provide, and the insurer shall agree, that it will not utilize or otherwise use the MSA Review and/or the resulting MSA Review and/or the resulting MSA Advisory Report to challenge, either through litigation or any applicable administrative procedure(s), any state’s decision to approve, partially approve or disapprove a rate increase filing except when: 1) the individual state is a [Participating/Impacted TBD] State that affirmatively relied on the MSA Review and/or the MSA Advisory Report in making its determination; or 2) the individual state consents in writing to use of the MSA Review and/or the MSA Advisory Report.

Failure to abide by the terms of the insurer’s certification will result in the insurer and its affiliates being excluded from any future MSA Reviews, and it will permit the MSA Team to terminate, at its sole discretion, any other ongoing review(s) related to the insurer and its affiliates.

Should the MSA Team exclude any insurer and its affiliates for failure to adhere to its certification, the MSA Team, at its sole discretion, may permit the insurer and its affiliates to resume submitting rate proposals for review upon written request of the insurer.

IV. REVIEW OF THE RATE PROPOSAL

A. Receipt of a Rate Proposal

The MSA rate review process begins when an insurer expresses interest in an MSA Review being performed for a rate proposal. This interest can be expressed through completion of a Communication
Form, which will be available through the Compact webpage. The initial request will be reviewed by the MSA Team lead reviewer and/or supporting NAIC and Compact staff. Once an insurer has completed this initial communication and meets the criteria for requesting an MSA Review, the insurer will work with supporting NAIC and Compact staff and the MSA Team to complete the rate proposal in SERFF. The MSA Team will be notified, via SERFF, when the proposal is available for review.

The supporting NAIC and Compact staff via SERFF or e-mail will notify (Participating/Impacted states TBD) when rate proposals are submitted, correspondence between the MSA Team and insurer is sent or received in SERFF, the MSA Advisory Report is available and other pertinent activities occur during the review.

B. Completion of the MSA Review

The MSA Team shall designate a lead reviewer to perform the initial review of each rate proposal. Once the rate proposal is made through SERFF, the MSA Review will resemble a state-specific review process.

The MSA Team will meet periodically to discuss the review and determine any needed correspondence with the insurer. Objections and communications with filers will be conducted through SERFF, similar to any state-specific filing or Compact filing, to maintain a record of the key review items. Other supplemental communication between the insurer and the MSA Team or supporting NAIC and Compact staff, may occur, such as conference calls or emails, as appropriate.

The timeframe for completion of the MSA Team’s review and drafting the MSA Advisory Report will be dependent upon the completeness of the rate proposal and the size and complexity of the block of policies for which the rate increase applies. The MSA Team may utilize a “queue” process for managing workload and resources for incoming requests through SERFF. The timeliness of any necessary communication between the MSA Team and the insurer to resolve questions or request/receive additional information about the rate proposal will impact the completion of the review.

As the MSA Team completes its review: 1) the insurer will receive initial communication of a completed review and that a final MSA Advisory Report with recommendations will be distributed and communicated to state insurance departments within the next month which may serve as a signal for a potential ideal time for the insurer to prepare to submit the state-specific filings to each state; and, 2) the insurer will receive sufficient MSA Review information regarding the MSA Team’s recommendation to allow for the insurer an opportunity to review the recommendation; and in the event that the MSA Team recommendation differs from the proposal submitted by the insurer, the insurer will be given the opportunity to interact with MSA Team in order to ask questions, understand the MSA Team’s reasoning, and provide additional information in support of its proposal. The MSA Team will address questions from the insurer about the result of the review.

C. Preparation and Distribution of the MSA Advisory Report
Upon completion of the actuarial review, the MSA Team will prepare a draft MSA Advisory Report for the rate proposal. The reports will be made available within SERFF “reviewer notes” for Participating States. Supporting NAIC and Compact staff will maintain a distribution list and send notifications of the availability of reports to Participating States. Consultants engaged by a state insurance department staff to perform rate reviews would be given access to the MSA Advisory Report, subject to the terms of the agreement between the consultant and the Participating State insurance department.

Consultants who are bound by the actuarial Code of Professional Conduct, adopted by the Academy of Actuaries, Society of Actuaries and Conference of Consulting Actuaries, should consider whether receipt of the MSA Advisory Report is acceptable under Precept 7 regarding Conflicts of Interest. For other professions, similar consideration should be made if bound by similar professionalism standards.

Prior to finalizing the MSA Advisory Report, the MSA Team will present the draft MSA Advisory Report to Participating States on a regulatory-only WebEx call, as deemed necessary, to provide an overview of the recommendations and respond to questions from Participating States. Insurers may participate in the call at a time of day to directly address state regulator questions.

The MSA Team will issue the final MSA Advisory Report to the Participating States and the insurer after consideration of any comments and questions from Participating States.

The MSA Advisory Report will include standardized content as reflected in Appendix A, with modifications as necessary for any unique factors specific to the rate proposal. The content and format are based on feedback received from state insurance departments and the LTCI (EX) Task Force during the pilot project.

The content and format of the MSA Advisory Report may be modified in the future under the direction of the LTCI (EX) Task Force, or appointed Subgroup, as the MSA Team gains more experience in generating the reports and receives more feedback through this process. A formal, annual review will ensure Participating States and insurers have a forum to provide feedback.

D. Timeline for Review and Distribution of the MSA Report

The draft MSA Advisory Report will be made available to Participating States for a two-week comment period prior to being finalized. The following timeline for this comment period and distribution of the final MSA Advisory Report will be adhered to as close as possible, barring timing delays due to, e.g., holidays or other unexpected events. Note that the MSA Review is intended to occur before filings are made to the state insurance departments, therefore not impacting state insurance departments’ required timelines for review. However, use of the MSA Advisory Report by the state insurers may result in a reduction in the amount of time required for the state to complete its review.

- Share the draft Report with the insurer. If the recommendation in the Report differs from the insurer’s proposal, allow the insurer a two-week comment period to ask questions and provide additional information.
- Day 1 – Distribution of a draft MSA Advisory Report to all Participating States
E. Feedback to the MSA Team

At the direction of the LTCI (EX) Task Force, or appointed Subgroup, state insurance departments will be requested to periodically annually provide data and feedback on their state rate increase approval amounts and feedback on their state’s use of and reliance on the MSA Advisory Reports. Among other things, the annual review will collect and share information about:

1. The number of filings made with the MSA Review Team
2. The number of rate requests approved by the MSA Review Team
3. The number of states that approved MSA recommendations
4. The number of states that required additional information from the insurer before making an approval or disapproval decision
5. Feedback regarding how the Review process and methodology could be improved

State responses will be confidential pursuant to the Master Agreement and aggregated results of feedback surveys will not specifically identify state responses. This collective feedback will aid the Task Force in understanding the practical effects of the MSA Review process in achieving the goal of developing a more consistent state-based approach for reviewing LTCI rate proposals that result in actuarily appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. The feedback will also help refine the review process, improve future reports to better meet participants’ needs and make updates to this MSA Framework. Finally, the feedback will assist NAIC leadership in making decisions regarding the technology and staff resources needed for the continued success of the project. Aggregated survey results will be shared with Participating States and Insurers.

VII.A. APPENDIX A—MSA ADVISORY REPORT FORMAT FOR REGULATORS

The MSA Advisory Report that is distributed to Participating State insurance departments and the insurer will generally follow a template that includes the following information. Note that degree of rigor in the review and the details and content of the MSA Advisory Report will depend on the magnitude of rate increases.
increase and complexity of the rate proposal and the insurer’s financial condition. See also the sample MSA Advisory Report in Exhibit A.

1. Executive Summary
   a. Overall recommended rate increase, before consideration of different states’ history of approvals
   b. Explanation of whether or not the recommended rate approval is in line with the insurer’s proposal

2. Disclaimers
   a. Purpose and intent of how states should use the MSA Advisory Report
   b. Disclaimer that the MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer
   c. Statement that the in-force rate increase request filed with the respective states shall be subject to the approval of each state, and each state’s applicable state laws and regulations shall apply to the entire rate schedule increase filing
   d. Statement that states are encouraged to work directly with insurers to address lifetime rate equity

3. Background on the MSA Rate Review process

4. Explanation of the Insurer’s Request

5. Summary of the MSA Team’s rate review analysis, including these aspects:
   a. Actuarial review
   b. Summary of consideration of differences in the history of state’s rate increase approvals
   c. Non-actuarial considerations and findings
   d. Financial solvency-related aspects and adjustments
   e. Review for reasonableness and clarity of reduced-benefit options
   f. Summary information about the mix of business

6. Appendices
   a. Summary of the drivers of the rate increase request
   b. Details regarding the Minnesota and Texas approaches as applied to the rate proposal
   c. Summary of rate proposal correspondence
   d. Tables of recommended rate increases by state, after consideration of different state’s history of approvals
   e. Frequently Asked Questions (FAQ)

VI. B. APPENDIX B — INFORMATION CHECKLIST

At the request of the former Long-Term Care Insurance (B/E) Task Force, the LTC Pricing (B) Subgroup developed a single checklist that reflects significant aspects of LTCI rate increase review inquiries from all
of states. In this context, “checklist” means the list or template of inquiries, that states typically send at the beginning of reviews of state-specific rate increase filings.

This document contains aspects of the NAIC Guidance Manual for Rating Aspect of the Long–Term Care Insurance Model Regulation and checklists developed by several other states. This consolidated checklist is not intended to prevent a state from asking for additional information. The intent is to take a step toward moving away from 50 states having 50 different checklists to have a more efficient process nationally to provide the most important information needed to determine an approvable rate increase. To keep the template at a manageable length, it is anticipated that this template will result in states attaining 90 to 100 percent of the information necessary to decide on approvable rate increases. State and block specifics will generate the other zero to ten percent of requests. As states apply this checklist, it or an improved version may be considered for future addition to the Guidance Manual for Rating Aspect of the Long–Term Care Insurance Model Regulation.

A. Information Required for an MSA Review of a Rate Proposal

The following provides a checklist of information necessary for a complete rate proposal to the MSA Review. This checklist is consistent with the “Consolidated, Most Commonly Asked Questions – States’ LTC Rate Increase Reviews” as adopted by the Health Actuarial (B) Task Force on March 23, 2018.

1. Identify all states for which the product associated with the rate increase request is or has been issued.

2. New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
   a. Provide rate increase percentages by policy form number and clear mapping of these numbers to any alternative terminology describing policies stated in the actuarial memorandum and other supporting documents.
   b. Provide the cumulative rate change since inception, after the requested rate increase, for each of the rating scenarios.

3. Rate increase history that reflects the filed increase.
   a. Provide the month, year, and percentage amount of all previous rate revisions.
   b. Provide the SERFF MSA numbers associated with all previous rate revisions.

4. Actuarial Memorandum justifying the new rate schedule, which includes:
   a. Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
      i. The projection should be by year.
      ii. Provide the count of covered lives and count of claims incurred by year.

---

6 https://content.naic.org/sites/default/files/inline-files/cmte_b_ltc_price_sg_180323_ltc_increase_reviews%20%289%29.docx
iii. Provide separate experience summaries and projections for significant subsets of policies with substantially different benefit and premium features. Separate projections of costs for significant blocks of paid-up and premium-paying policies should be provided.

iv. Provide a comparison of state versus national mix of business. In addition, a state may request separate state and national data and projections. The insurer should accompany any state-specific information with commentary on credibility, materiality, and impact on requested rate increase.

5. Reasons for the rate increase, including which pricing assumptions were not realized and why.
   a. Attribution analysis - present the portion of the rate increase allocated to and impact on the lifetime loss ratio from each change in assumption.
   b. Related to the issue of past losses, explain how the requested rate increase covers a policyholder’s own past premium deficiencies and/or subsidizes other policyholders’ past claims.
   c. Provide the original loss ratio target to allow for comparison of initially assumed premiums and claims and actual and projected premiums and claims.
   d. Provide commentary and analysis on how credibility of experience contributed to the development of the rate increase request.

6. Statement that policy design, underwriting, and claims handling practices were considered.
   a. Show how benefit features, e.g., inflation and length of benefit period, and premium features, e.g., limited pay and lifetime pay, impact requested increases.
   b. Specify whether waived premiums are included in earned premiums and incurred claims, including in the loss ratio target calculation; provide the waived premium amounts and impact on requested increase.
   c. Describe current practices with dates and quantification of the effect of any underwriting changes. Describe how adjustments to experience from policies with less restrictive underwriting are applied to claims expectations associated with policies with more restrictive underwriting.

7. A demonstration that actual and projected costs exceed anticipated costs and the margin.

8. The method and assumptions used in determining projected values should be reviewed considering reported experience and compared to the original pricing assumptions and current assumptions.
   a. Provide applicable actual-to-expected ratios regarding key assumptions.
   b. Provide justification for any change in assumptions.
9. Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
   a. Explain the relevance of any data sources and resulting adjustments made relevant to the current rate proposal, particularly regarding the morbidity assumption.
   b. A comparison of the population or industry study to the in-force related to the rate proposal should be performed, if applicable.
   c. Explain how claims cost expectations at older ages and later durations are developed if data is not fully credible at those ages and durations.
   d. Provide the year of the most recent morbidity experience study.

   a. Comparison with asset adequacy testing reserve assumptions.
      i. Explain the consistency regarding actuarial assumptions between the rate proposal and the most recent asset adequacy (reserve) testing.
      ii. Additional reserves that the insurer is holding above NAIC Model Regulation 10 formula reserves should be provided, (such as premium deficiency reserves and Actuarial Guideline 51 reserves).
   c. Provide actuarial assumptions from original pricing and most recent rate increase proposal and have the original actuarial memorandum available upon request.

11. Provide the following calendar year projections, including totals, for current premium paying nationwide policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate*:
   a. Present value of future benefits (PVFB) under current assumptions
   b. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
   c. Present value of future premiums (PVFP) under current assumptions.
   d. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).

*To emphasize, these projections should include only active nationwide policyholders currently paying premium, and should not include any policyholders not paying premium, regardless of the reason. Projections under current actuarial assumptions must not include policyholder behavior as a result of the proposed premium rate increase, such as a shock lapse assumption or benefit reduction assumption.

b. Also, please identify the maximum valuation interest rate and ensure that it is the same for all four projections.
12. **NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation** checklist items: summaries (including past rate adjustments); average premium; distribution of business, including rate increases by state; underwriting; policy design and margins; actuarial assumptions; experience data; loss ratios; rationale for increase; reserve description.

13. Assert that analysis complies with actuarial standards of practice, including 18 & 41.

14. Numerical exhibits should be provided in Excel spreadsheets with active formulas maintained, where possible.

15. Rate Comparison Statement of renewal premiums with new business premiums, if applicable.

16. Policyholder notification letter – should be clear and accurate.
   a. Provide a description of options for policyholders in lieu of or to reduce the increase.
   b. If inflation protection is removed or reduced, is accumulated inflation protection vested?
   c. Explain the comparison of value between the rate increase and policyholder options.
   d. Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
   e. How are partnership policies addressed?

17. Actuarial certification and rate stabilization information, as described in the Guidance Manual, and contingent benefit upon lapse information, including reserve treatment.

**B. Supplemental Information**

As part of the LTCI (EX) Task Force’s pilot project in 2020-2021, the following supplemental information was identified by the MSA Team as beneficial and therefore, may be requested to assist in the MSA Review.

1. Benefit utilization:
   a. Provide current, prior rate increase, and original assumptions, including first-projection year through ultimate utilization percentages for 5% compound inflation, lesser inflation, and zero inflation cells.
   b. Explain how benefit utilization assumptions vary by maximum daily benefit.
   c. Provide the cost of care inflation assumption implied in the benefit utilization assumption.

2. Attribution of rate increase
a. Provide the attribution of rate increase by factor: morbidity, mortality, lapse, investment, other.

b. For the morbidity factor, break down the attribution by incidence, claim length, benefit utilization, and other.

c. Provide information on the assumptions that are especially sensitive to small changes in assumptions.

3. Reduced benefit options (RBOs)
   a. Provide the history of RBOs offered and accepted for the block.
   b. Provide a reasonability analysis of the value of each significant type of offered RBO.

4. Investment returns:
   a. Provide original and updated / average investment return assumptions underlying the pricing.
   b. Explain how the updated assumption reflects experience.

5. Expected loss ratio:
   a. With respect to the initial rate filing and each subsequent rate increase filing, provide the target loss ratio.
   b. Provide separate ratios for lifetime premium periods and non-lifetime premium periods and for inflation-protected and non-inflation-protected blocks.

6. Shock lapse history: Provide shock lapse data related to prior rate increases on this block.

7. Waiver of premium handling:
   a. Explain how policies with premiums waived are handled in the exhibits of premiums and incurred claims.
   b. Explain how counting is appropriate (as opposed to double counting or undercounting).

8. Actual-to-expected differences: Explain how differences between actual and expected counts or percentages (in the provided exhibits) are reflected or not reflected in assumptions.

9. Assumption consistency with the most recent asset adequacy testing: Explain the consistency or any significant differences between assumptions underlying the rate increase request and those included in Actuarial Guideline 51 testing.
VII. EXHIBIT – SAMPLE MSA ADVISORY REPORT

FROM: Long-Term Care Insurance (LTCI) Multistate Actuarial Rate Review Team
DATE: [Date]
RE: ABC Insurance Company – Block LTC1 – Draft of Initial MSA Advisory Report

Executive Summary
The LTCI Multistate Actuarial Rate Review Team (MSA Team) recommends a rate increase of 35% to be approved for inflation-protected products and 20% to be approved for products with no inflation, related to ABC Company’s block.

Higher rate increases are recommended for states where past cumulative rate increases below 55% have been approved. Reduced benefit options may be selected to help manage the impact of the rate increase.

Analysis by the MSA Team resulted in the recommended rate increase being consistent with that resulting from the actuarially justified Texas and Minnesota approaches. The recommended rate increases are below the increases that would have resulted from the lifetime loss ratio approach and the rate stability rules.

Background
The MSA Team was formed to assist the Task Force in developing a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.

The members are: [List names and state of members]. Starting in the first half of 2020, the MSA Team accepted rate increase filings as part of a pilot program. The MSA Review process became operational on [insert date].

This MSA Advisory Report is related to the rate increase request filed by ABC Company for its LTC 1 block sold between 2003 and 2006. The MSA Team’s actuarial analysis is provided below. The intention is that states can utilize this analysis and feel comfortable accepting the MSA Advisory Report recommendation when taking action on the upcoming ABC filings that will be made to the states.

7 Information contained in this sample report is an example only and is not derived from any actual rate filing.
As this is a state-approved product, each state will ultimately be responsible for approving, partially approving, or disapproving the rate increase. A goal of the Task Force is for as much consistency as possible to occur between states in the rate increase approvals.

Insurer’s Request
ABC Company requests a rate increase of 60% to be approved for inflation-protected products and 40% to be approved for products with no inflation.

In addition, ABC is requesting higher rate increases for states that did not grant full approval of prior rate increase requests, consistent with the MSA Team’s goal of attaining the same resulting rate tables in each state for a given product.

Workstream-related Review Aspects

Actuarial Review

At the direction of the LTCI Multistate Rate Review (EX) Subgroup, the MSA Team applied the Minnesota and Texas approaches to calculate the recommended, approvable rate increases. Aspects of the Minnesota approach that result in lower rate increases than those resulting from loss ratio-based approaches contained in many states’ laws and rules include:

- Reduction in rate increases at later policy durations to address shrinking block issues;
- Elimination of rate increases related to inappropriate recovery of past losses;

Minnesota also has additional unique aspects: consideration of adverse investment expectations related to decline in market interest rates, adjustments to projected claim costs to ensure impact of uncertainty is adequately borne by the insurer, and a cost-sharing formula applied in typical circumstances.

Even though these additional aspects are outside the pure loss-ratio requirements, they fall in line with legal provisions that rates shall be fair, reasonable, and not misleading.

The Minnesota approach, including application of the typical-circumstance cost-sharing formula, results in an approvable rate increase of 35% for inflation-protected products and 20% for products with no inflation protection.

The Texas approach results in an approvable rate increase of 29% in aggregate.
The MSA Team’s recommendation, in consideration of the Minnesota and Texas approaches, is to approve a rate increase of 35% for inflation-protected products and 20% for products with no inflation protection.

Higher rate increases are recommended for states where past cumulative rate increases below 55% have been approved.

The MSA Team reviewed support for the assumptions, experience, and projections provided by the insurer and performed validation steps to review the insurer-provided information for reasonableness. Details regarding the actuarial review are provided in Appendix 1. Also, the initial submission and subsequent correspondence between the insurer and MSA Team are available on SERFF. The SERFF tracking number is ABCC-123456789.

Consideration of Differences in Histories of States’ Rate Increase Approvals

According to the Historical Rate Level Summary, Appendix D in the insurer filing, past rate increase approvals by state have varied and can be categorized as follows:

- 25 states have granted full or near-full approval of ABC’s past requests (at or near 55%, cumulative).
- 18 states have granted cumulative approvals averaging 45%.
- 5 states have granted cumulative approvals averaging 27%.
- 2 states have granted cumulative approvals averaging 15%.

The insurer’s stated goal is to bring rates in all states up to an equivalent rate level. Currently, the average annual premium rates for a policyholder range from below $1,700 in some states (with the lowest past approvals) to over $2,200 in other states (with the highest past approvals).

The MSA Team’s recommendation is based on a goal of rates per benefit unit being uniform between states going forward.

A table of examples of recommended rate increases, based on past cumulative approval history is provided in Appendix 2.

Non-actuarial & Valuation/Solvency Considerations

Non-actuarial considerations, including, flexibility regarding phase-in of rate increases, waiting periods between rate increases should be coordinated with phase-in periods, and other issues are being discussed at the LTCI (EX) Task Force and LTCI Multistate Rate Review (EX) Subgroup.
Even with future claims potentially being reduced due to COVID-19-related behavioral impact, ABC will continue to experience substantial losses on this block.

Regarding coordination of rate and reserving reviews, the insurer states that assumptions underlying the rate increase request are consistent with assumptions underlying the reserve adequacy testing.

**Reduced Benefit Options – Review for Reasonableness**

Unless a rider was purchased, ABC policyholders facing a rate increase will be offered the following applicable options in lieu of a rate increase:

1. extending the elimination period;
2. decrease the benefit period;
3. Reduce future inflation accumulation.

The insurer produced rate tables which demonstrate the RBOs provide reasonable value in relation to a case of a policyholder retaining full benefits and paying the full rate increase.

**Financial Impact for Insurer**

The requested rate increase associated with recent adverse development would result in around $50 million of reduced losses for this block, according to information contained in the actuarial memorandum.

**Mix of Business**

From the insurer’s actuarial memorandum:

- Total enrollees as of date of filing: 15,000
- Inflation protection: 9,000 (inflation protection), 6,000 (no inflation)
- Benefit period: 8,500 (lifetime benefits), 6,500 (limited benefits)

- Product type: Expense reimbursement
- Average issue age: 58
- Average attained age: 75
- Annualized premium: $30 million; $2,000 average per policyholder

**Appendix 1**

Drivers of Rate Increase Request - Summary
The primary drivers, summarized in the insurer actuarial memorandum, were lower lapses and longer average claim length. The insurer assumptions were based on actual-to-expected adjustments, based in part by insurer experience that has become more credible in recent years. The assumptions were determined to be reasonable and in line with industry and actuarial averages.

Details Regarding Minnesota Approach

For an average (in terms of benefit period and issue age) 5% compound inflation-protected cell:

- Makeup cumulative rate increase: 177% (the increase from original rates needed going forward to get the block to the financial position contemplated at original pricing)
  - This increase is equal to the increase that would result from a pure loss ratio approach.
- If-knew cumulative rate increase: 36% (the increase from original rates needed if the insurer could go back to the past and reprice the product given information it knows now)
- Proportion of original policyholders remaining in force, based on insurer original and updated assumptions: 62%
- Blended if-knew / makeup rate cumulative rate increase since issue: 123%
  - $0.62 \times 177\% + (1 - 0.62) \times 36\%$, adjusted for rounding
- Insurer cost share based on Minnesota formula (see Appendix 3): 12%
- Recommended cumulative rate increase since issue: 109%
  - $(1 - 0.12) \times 1.23$, adjusted for rounding
- Past cumulative rate increases: 55%
- Actuarial recommended rate increase from current rates: 35%
  - $(1 + 1.09) / (1 + 0.55) - 1$, adjusted for rounding
- Final actuarial recommended rate increase from current rates (for the inflation-protected cell): 35%
  - Minimum of: calculated approval rate of 35% and insurer request of 60%
- Using the same methodology, the final actuarial recommended rate increase from current rates (for the non-inflation-protected cell): 20%

Note that the Minnesota approach includes reflection of declining interest rates which tends to lead to adverse investment returns compared to expectations in original pricing. Where applicable, insurer morbidity assumptions are adjusted downward due to lack of credible support at extremely high ages.

Commented [CB1]: See ACLI/AHIP comment letter
and general lack of complete support for aspects of morbidity assumptions, including uncertainty regarding future benefit utilization.

Details regarding Texas approach

- Insurer Calculation (aggregate): 52%

PPV calculations

- Texas Life & Health Actuarial Office (LHAO) PPV Calculation (aggregate): 29%

LHAO Comments

- For purposes of the MSA report, and as a component of the calculation of the approvable rate increase, Texas recommends an actuarially justified PPV calculated amount of 29%.

Texas rate stabilized PPV Formula:

\[
\text{rate increase } \% = \frac{\Delta PV(\text{future incurred claims}) - \left( \frac{(5S + 5.5C)}{1 + C} \right) \Delta PV(\text{future earned premiums})}{\Delta PV(\text{future earned premiums})}
\]

Reconciliation of Minnesota and Texas approaches

The Texas PPV calculated amount of 29% aligns well with the Minnesota approach’s recommended rate increase of 35% for inflation-protected policies and 20% for non-inflation-protected policies when the distribution of inflation-protected vs non-inflation-protected cells is applied. The MSA Team’s recommended rate increase is 35% for inflation-protected policies and 20% for non-inflation-protected policies.

Recommended rate increases by state, in consideration of various histories of rate increase approvals, are listed in Appendix 2.

Filing Correspondence Summary

- Template information request for multi-state rate increase filings, based on the list adopted by the NAIC Health Actuarial Task Force on March 23, 2018.
- New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
- Rate increase history that reflects the filed increase.
- Actuarial Memorandum justifying the new rate schedule, which includes:
• Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the
maximum valuation interest rate.
• Reasons for the rate increase, including which pricing assumptions were not realized & why.
• Statement that policy design, underwriting, and claims handling practices were considered.
• A demonstration that actual and projected costs exceed anticipated costs and the margin.
• The method and assumptions used in determining projected values should be reviewed in
light of reported experience and compared to the original pricing assumptions and current
assumptions.
• Combined morbidity experience from different forms with similar benefits, whether from
inside or outside the insurer, where appropriate to result in more credible historical claims
as the basis for future claim costs.
• Information (from NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance
★ Comparison with asset adequacy testing reserve assumptions
★ Provide actuarial assumptions from original pricing and most recent rate increase
filing, and have the original actuarial memorandum available upon request.
• Guidance Manual Checklist items: summaries (including past rate adjustments); average
premium; distribution of business, including rate increases by state; underwriting; policy
design and margins; actuarial assumptions; experience data; loss ratios; rationale for
increase; reserve description
• Assert that analysis complies with Actuarial Standards of Practice, including No. 18 & No. 41.
• Numerical exhibits should be provided in Excel spreadsheets with active formulas
maintained, where possible.

• Rate Comparison Statement of renewal premiums with new business premiums, if applicable.

• Policyholder notification letter – should be clear and accurate.
★ Provide a description of options for policyholders in lieu of or to reduce the increase.
★ If inflation protection is removed or reduced, is accumulated inflation protection vested?
★ Explain the comparison of value between the rate increase and policyholder options.
★ Are future rate increases expected if the rate increase is approved in full? If so, how is this
communicated to policyholders?
★ How are partnership policies addressed?

• Supplementary information, based on a list developed by the MSA Team following review of initial
pilot program filings:
★ Information on benefit utilization
★ Attribution of rate increase by factor
Following initial review of the filing, additional information was requested by the MSA Team related to:

- Original pricing assumptions.
- Lapse assumption by duration.
- Premiums & incurred claims by calendar year based on original assumptions.
- Distribution of inforce by inflation protection.
- Loss ratios by lifetime/non-lifetime benefit period and with/without inflation protection.
- Description of waiver of premium handling in premium & claim projections.
- Commentary on COVID-19 short-term and long-term LTC impact

Appendix 2

Examples of Rate Increases if a Reduced Benefit Option is not Selected

<table>
<thead>
<tr>
<th>ABC Company</th>
<th>Past Cumulative Approved Increases</th>
<th>Increase to catch up</th>
<th>Recommended New</th>
<th>2021 Recommended Rate Incr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: state with average past approvals</td>
<td>55%</td>
<td>0%</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Example: state with lower than average past approvals</td>
<td>27%</td>
<td>22%</td>
<td>35%</td>
<td>65%</td>
</tr>
</tbody>
</table>

*The recommendation for each state is based on the actual past cumulative approved increases in that state.

Commented [CB2]: Change to “state with full past approvals”
Re “state with average past approvals”—is this the average or is this the maximum rate approved by a state?
Potential Cost-Sharing Formula for Typical Circumstance

Cumulative rate increase since issue date is haircut by:

- No haircut for the first 15%
- 10% for the portion of cumulative rate increase between 15% and 50%
- 25% for the portion of cumulative rate increase between 50% and 100%
- 35% for the portion of cumulative rate increase between 100% and 150%
- 50% for the portion of cumulative rate increase in excess of 150%

Example: if the Texas approach or pre-cost sharing Minnesota approach results in a cumulative 210% rate increase since issue:

- Break 210% into the following components: 15%, 35%, 50%, 50%, 60%
- Post haircut approval is 100% of 15% + 90% of 35% + 75% of 50% + 50% of 50% + 50% of 60%
- = 15% + 32% + 38% + 33% + 30%
- = 147%

Legal justification for the cost-sharing formula is that the insurer should have had more information about the possibility of triple-digit rate increases than the consumer had.

Adjustments to the formula may be desired when an insurer’s solvency position is dependent on a certain level of rate increase approval. That is not the case with this insurer or filing.

Commented [CB3]: See ACLI/AHIP comment letter

Commented [CB4]: Is there a legal ruling regarding this justification?
October 28, 2021

Commissioner Michael Conway
Chairman, NAIC LTCI Multi-State Rate Review (EX) Subgroup

Dear Commissioner Conway and Subgroup Members,

The American Council of Life Insurers (ACLI)\(^1\) and the American Association of Health Insurance Plans (AHIP)\(^2\) appreciate the opportunity to comment on the second draft of the Actuarial Section of the Long-Term Care Insurance (LTC) Multi-State Rate Review Framework, exposed by the NAIC LTC (EX) Task Force on September 15, 2021. Our members recognize the hard work that has gone into developing the Framework and hope that our input can further the progress already made.

PRIMARY COMMENT

The purpose of the Framework is to develop a consistent national approach for reviewing current LTC rates that results in actuarially appropriate increases being granted by the states in a timely manner that eliminates cross-state rate inequities. We provide our comments in full support of this charge from the NAIC to the LTCI Multi-State Rate Review (EX) Subgroup.

As we mentioned in our July 26, 2021 comment letter, insurers best protect their policyholders when they can fulfill the obligations they made to these policyholders. This is accomplished when insurers have some level of predictability in their ability to effectively manage their LTC business over time. At its core, this level of predictability can only be achieved through transparency and consistency within the MSA Review Process, specifically with respect to the methodology used to calculate the increase recommended by the MSA Team.

While some fundamental questions outlined in our prior comment letter remain, we recognize that for a new process of this magnitude, many questions will need to be addressed over time as both regulatory and industry experience evolves. Our hope is that regulators will continue to have an open dialogue with industry to address outstanding issues.

As mentioned in Section V. A of the Framework document, the "**MSA Team will apply a balanced approach and professional judgement for each rate proposal based on the characteristics of the block reviewed to determine the method most appropriate.**"

Our primary request at this time is that the Framework document include a commitment that after review of a certain number of filings, the MSA Team will provide insight into the general rationale or criteria utilized when determining which method applied to each filing. We understand that this is a dynamic review and that flexibility is key. We acknowledge that different characteristics of the block might influence the method used in the future. For example, general category trends, such as those in the chart below, would be helpful to
industry in managing their blocks of business going forward as well as in understanding how business being sold today will be regulated.

We suggest that the following language be added to Section V. A - MSA Team’s Actuarial Review Considerations

After review of “X” filings, the MSA Team will provide the method generally applied to the filings based on the following general characteristics:

<table>
<thead>
<tr>
<th>Primary Characteristic of the Block</th>
<th>Method Used (Texas, Minnesota, Loss Ratio)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Remaining Block (i.e. percentage of policyholders remaining is less than X percent)</td>
<td></td>
</tr>
<tr>
<td>Older Legacy Block or Newer Block (i.e. blocks with policies first issued before or after MM/DD/YYYY)</td>
<td></td>
</tr>
<tr>
<td>Cumulative Past Rate Increase Percentage Greater Than “X” Percent</td>
<td></td>
</tr>
</tbody>
</table>

The above characteristic are examples and may differ from those the MSA Team identified as the primary characteristics of the blocks actually.

ADDITIONAL COMMENT

We appreciate the subgroup’s change to heading of Section V. C. 5. with respect to the term “bait and switch” under the Minnesota method. We believe the name itself draws a legal conclusion and believe that all references to this type of adjustment should be categorized as an “original assumption adjustment”. The term “bait and switch” remains in Sections V.C.5.a.iii and VI.A.3.a.i.3.c. We believe this is an oversight and respectfully request that the term “bait and switch” be removed from these sections.
CONCLUSION
ACLI/AHIP remains committed to working with the Subgroup to address the challenges in developing an MSA Review Framework. We look forward to addressing questions on our comments at our next LTCI Multi-State Rate Review (EX) Subgroup meeting.
Sincerely,

Jan M. Graeber  Ray Nelson
ACLI Senior Actuary  AHIP Consulting Actuary

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1 The American Council of Life Insurers advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care (LTC) insurance, disability income insurance, reinsurance, dental, vision, and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States.

2 AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.
LONG-TERM CARE INSURANCE
MULTI-STATE
RATE REVIEW FRAMEWORK

Drafted by the
Ad Hoc Drafting Group\(^1\) of the
NAIC Long-Term Care Insurance (EX) Task Force

\(^1\) The Ad Hoc Drafting Group consists of representatives from state insurance departments in Connecticut, Minnesota, Nebraska, Texas, Virginia, and Washington.
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I. INTRODUCTION

A. Purpose

The National Association of Insurance Commissioners (“NAIC”) charged the Long-Term Care Insurance (EX) Task Force (“LTCI (EX) Task Force”), with developing a consistent national approach for reviewing current long-term care insurance (“LTCI”) rates that result in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.

Considering that charge and the threat posed by the current LTCI environment both to consumers and the state-based system (SBS) of insurance regulation, the LTCI (EX) Task Force developed this framework for a multi-state actuarial (“MSA”) LTCI rate review process (“MSA Review”).

This framework is based upon the extensive efforts of the Long-Term Care Insurance Multi-State Rate Review (EX) Subgroup, including its experience with a pilot program conducted by the pilot program’s rate review team (“Pilot Team”). As part of that pilot program, the Pilot Team reviewed seven LTCI premium rate increase proposals and issued MSA Advisory Reports recommending actuarially justified state-by-state rate increases. This framework aims to institutionalize a refined version of the Pilot Team’s approach to create a voluntary and efficient MSA Review that produces reliable and nationally consistent rate recommendations that state insurance regulators and insurers can depend upon. The MSA Review has been designed to leverage the limited LTCI actuarial expertise among state insurance departments by combining that expertise into a single review process analyzing in force LTCI premium rate increase proposals or “rate increases” (2) and producing an MSA Advisory Report for the benefit and use of all state insurance departments. Note that rate decrease proposals can be contemplated within the MSA Review. The same concepts of this MSA Framework would be applied, if such a rate decrease proposal request is received for MSA Review. The goal of this framework is to create a process that will not only encourage insurers to submit their LTCI products for multi-state review, but also provide insurance departments the requisite confidence in the MSA Review so that they will voluntarily rely upon the processes the Multistate Actuarial LTCI Rate Review Team’s (MSA Team’s) recommendations when conducting their own state level reviews of in force LTCI rate increase filings. Ultimately, the MSA Review is designed to foster as much consistency as possible between states in their respective approaches to rate increases.

The purpose of this document is to function as a user’s manual framework for the MSA Review that communicates to NAIC members, state insurance department staff, and external stakeholders how the MSA Review works to the benefit of state insurance departments and how insurers might engage in the MSA Review. This user’s manual framework is intended to communicate the governance, policies, procedures, and actuarial methodologies supporting the MSA Review. State insurance regulators can utilize the information and guidance contained herein to understand the basis of the multi-state actuarial LTCI rate review team’s (“MSA Team’s”) MSA Advisory Reports. Insurance companies can access the information and guidance contained herein to understand how to engage in the MSA Review, and how

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2 “Premium rate increase proposal(s)” or “rate proposal(s)” in this document refers only to an insurer’s request for review of a proposed in force LTCI premium rate increase or decrease under the MSA Review process.

3 The term “rate increase filing” or “rate filing(s)” in this document refers only to the in force LTCI premium rate request(s) that is submitted to individual state departments of insurance (DOI) for a regulatory decision. Filings refer to both rate increase filings and rate decrease filings.
the MSA Advisory Report may affect the insurer’s in force LTCI premium rate increase filing decisions and interactions with individual state insurance regulators.

This document will be maintained by NAIC staff under the oversight of the LTCI (EX) Task Force and be revised as directed by the Task Force or an appointed subgroup. This document will be part of the NAIC library of official publications and copyrighted.

B. State Participation in the MSA Review

The MSA Review of an insurer’s rate proposal will be available to state insurance departments who are both an Impacted State and a Participating State. These are defined as follows.

- “Impacted State” is defined as the domestic state, or any state for which the product associated with the insurer’s in force LTCI premium rate increase proposal is or has been issued.
- “Participating State” is defined as any impacted state insurance department that agrees to participate in the MSA Review. Participation is voluntary as described in Section 1E.1 below. Participation may include activities such as, but not limited to, receiving notifications of rate increase proposals in System for Electronic Rate and Form Filing (SERFF), participation in communication/aweblinars with the MSA Team, and access to the MSA Advisory Report.

Note that state participation is expected to evolve in the future as the MSA Review process continues to be developed and refined.

C. General Description of the MSA Review

The MSA Review provides for a consistent actuarial review process that will result in an MSA Advisory Report, which state insurance departments may consider when deciding how to review and make decisions on an insurer’s rate increase filing or to supplement the state’s own review process.

The MSA Review is conducted by a team of state’s regulatory actuaries with expertise in LTCI rate review. Each review will be led by a designated member of the MSA Team. The review process is supported by NAIC staff and the Interstate Insurance Product Regulation Commission (Compact) staff, who will administratively assist insurers in making requests to utilize the MSA process and facilitate communication between the insurer, the MSA Team and [Participating/Impacted TBD] States. The NAIC’s electronic infrastructure, the System for Electronic Rates and Forms (SERFF) will be used to streamline the rate proposal and review process. Although the administrative services of the Compact staff and SERFF’s Compact filing platform are utilized in the MSA Review, MSA rate proposals are reviewed, and MSA Advisory Reports are prepared by the MSA Team. MSA rate proposals are not Compact filings, and Compact staff will not have any role in determining the substantive content of the MSA Advisory Reports.

The MSA Review process begins when an insurer expresses interest in an MSA Review being performed for an in force LTCI rate proposal to the MSA Team through SERFF or supporting NAIC or Compact staff. The eligibility of the rate proposal will be reviewed and determined by the MSA Team and with assistance, as needed, from supporting staff.

4 Certain processes for Impacted vs. Participating States are yet to be determined (TBD).
The MSA Review of eligible rate proposals will resemble a state-specific rate review process utilizing consistent actuarial standards and methodologies. The MSA Team will apply the Minnesota and Texas approaches to calculate recommended, approvable rate increases. While aspects of the Minnesota and Texas approaches may result in lower rate increases than those resulting from loss ratio-based approaches and are outside the pure loss/ratio requirements contained in many states' laws and rules, the approaches fall in line with legal provisions that rates shall be fair, reasonable, and not misleading. The MSA Team will review support for the assumptions, experience, and projections provided by the insurer and perform validation steps to review the insurer-provided information for reasonableness. The MSA Team will document how the proposal complies with the regulatory approach utilized by the MSA Team for Participating States. See Section V for more details on the actuarial review.

Throughout the MSA Review, the MSA team will provide updates to the insurer. The MSA team will deliver the final MSA advisory Report to the insurer and address any questions the insurer has about the results of the Review. Through the MSA Review, the MSA Team will communicate MSA information to the insurer, including the final MSA Advisory Report, and the MSA Team will address any questions from the insurer about the results of the review[Staff9][DG10].

Additionally, the review will consider reduced benefit options (RBOs) that are offered in lieu of the requested rate increases and factor in non-actuarial considerations.

At the completion of the review, the MSA Team will draft an MSA Advisory Report for Participating States that provides both summary and detail information about the rate proposal, the review methodologies, the analysis and other considerations of the team, and the recommendation for rate increases as outlined in Appendix A. The MSA Advisory Report will also indicate whether the recommendation differs from the insurer's proposal. Participating States can utilize either rely on the MSA Advisory Report or supplement their own state's rate review with it as described in the following Subsection[Staff11][DG12] I-D. Participating States may also utilize the information filed with the MSA Team in addition to the Advisory Report as appropriate.

The rate proposal, review process, actuarial methodologies, and other review considerations are detailed within this framework document and accompanying appendices.

D. Benefits of Participating in the MSA Review

Both state insurance regulators and insurers will benefit by participating in the MSA Review in multiple ways.

For state insurance regulators:
- First, they will be able to leverage the demonstrated expertise of the MSA Team in reviewing in force LTCI rate increases filing to in their state. It is recognized that multiple states may not have significant actuarial expertise with LTCI, so participation in the MSA Review will allow states to build on the specific, dedicated LTCI actuarial expertise of the MSA Team.
- Second, state insurance regulators will be able to utilize the MSA Team to promote consistency of actuarial reviews among filings submitted by all insurers to states, and among actuarial reviews across all states. Because the MSA Team is using the same dedicated approach to in force LTCI rate increase reviews, states who utilize the MSA Team will have the benefit
of using the same consistent methodology that is relied upon by other state insurance departments when reviewing in force LTCI rate increase filings in their state.

- Third, the MSA Review allows for more state regulatory actuaries to work with or under the supervision of qualified actuaries which affords them an opportunity to establish LTCI-specific qualifications in making actuarial opinions. This is particularly important when we consider that requirements to be a qualified actuary include years of experience under the supervision of another already qualified actuary in that subject matter.

- Finally, participating in the MSA Review will allow all state insurance regulators to share questions and information regarding a particular rate proposal or review methodologies; thus, increasing each state’s knowledge base in this area and promoting a more consistent national approach to in force LTCI rate review.

**Note that states’ use of and reliance on the MSA Advisory Report is expected to evolve increase in the future as the MSA Review continues to be developed and refined and the benefits of the MSA Review described above become more evident.**

Long-Term Care (LTC) insurers will likewise see multiple benefits in participating in the MSA Review:

- First, by utilizing the MSA Review and through the receipt of MSA information and the MSA Advisory Report from the MSA Team, insurers should see increased efficiency and reduced timelines for nationwide premium rate increases. As the MSA Team delivers the MSA Advisory Report for a rate proposal to Participating States, it has functionally reduced the review time for each state, meaning that LTC insurers should see more efficient and timely reviews from these states.

- Second, participating in the MSA Review will provide LTC insurers with one consistent recommendation to be used when making rate increase filings to all states, thus reducing the carrier’s workload in developing often widely differing filings for states’ review.

- Finally, the consistency of one uniform national system for reviewing rate increase proposals should lead to more accurate reviews, theoretically reducing some of the need for ongoing rate increase filings.

**E. Disclaimers and Limitations**

State Authority Over Rate Increase Approvals

The MSA Advisory Report is only a recommendation to Participating States based upon the methodologies adopted by the MSA Review. The recommendations are not specific to, and do not account for, the requirements of any specific state’s laws or regulations. The MSA Review is not intended, nor should it be considered, to supplant or otherwise replace any state’s regulatory authority, responsibility, and/or decision-making. Each state remains ultimately responsible for approving, partially approving, or disapproving any rate increase in accordance with applicable state law. To satisfy the Task Force charge to “develop a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization,” a Participating State’s use of the MSA Advisory Report’s recommendations with respect to one filing does not require that state to consider or adopt any MSA Advisory Report recommendations.
with respect to any other filing. The MSA Review in no way: ːeliminates the insurer’s obligation to file
for a rate increase in each Participating State; or, ːmodifies the substantive or procedural
requirements for making such a filing. While ːencouraged[Staff17][DG18] to adopt the recommendations of
the MSA Review in each of their state filings, insurers are not obligated to align their individual state rate
filings with the recommendations contained within the MSA Advisory Report.

The MSA Advisory Reports, including the recommendations contained therein, are only for use by
Participating States in considering and evaluating rate filings. The MSA Advisory Reports or their
conclusions shall not be utilized by any insurer in a rate filing submitted to a non-Participating State,
nor shall the MSA Advisory Reports be used outside of each state’s regulator’s own review process, or to challenge the results of any individual state’s determination of whether to grant, partially grant, or deny a rate increase.

Information Sharing Between State Insurance Departments

The MSA Review, including, but not limited to, meetings, calls, and correspondence with insurers on
insurer-specific matters are held in regulator-to-regulator sessions and are confidential. In addition, if
certain information and documents related to specific companies ːthat are confidential under the state
law of an MSA Team member or a Participating State need to be shared with other state insurance regulators, such sharing will occur as authorized by state law, and pursuant to the Master Information Sharing and Confidentiality Agreement (“Master Agreement”[Staff19][DG20:]) between states that govern the sharing of information among state insurance regulators. Through the Master Agreement, state insurance regulators affirm that any confidential information received from another state insurance regulator will be maintained as confidential and represent that they have the authority to protect such information from disclosure.

Confidentiality of the Rate Proposal

Members of the MSA Team and Participating States[Staff21][DG22] affirm and represent that they will provide
any in-force LTCI rate proposal, as discussed herein, with the same protection from disclosure, if any, as
provided is protected from disclosure by the confidentiality provisions contained within their state’s laws
and regulations.

Confidentiality of the MSA Reports

Likewise, members of the MSA Team and Participating States affirm and represent that they will provide
any MSA Advisory Report(s), and MSA information provided to insurers as discussed herein with the same
protection from disclosure, if any, as provided is protected from disclosure by the confidentiality
provisions contained within their state’s laws and regulations for rate filings.

F. Governing Body and Role of the NAIC Long-Term Care Insurance (EX) Task Force

The NAIC Long Term Care Insurance (EX) Task Force is expected to remain in place for the foreseeable
future to oversee the implementation of the MSA Review, and related MSA Advisory Reports, and to
provide a discussion forum for MSA-related activities. The Task Force or any successor will continuously
evaluate the effectiveness and efficiency of the MSA Review for the benefit of state insurance regulators and provide direction, as needed.

The LTCI (EX) Task Force may create one or more subgroups to carry out its oversight responsibilities.

Membership and leadership of the Task Force will be selected by the NAIC President and President-elect as part of the annual committee assignment meeting held in January. Selection of the membership and leadership may consider a variety of criteria, including commissioner participation, insurance department staff competencies, market size, domestic LTC insurers, and other criteria considered appropriate for an effective governance system.

II. Multi-State Actuarial LTCI Rate Review Team (MSA Team)

The MSA Team comprises state insurance department actuarial staff. MSA Team members are chosen by their skill set and LTCI actuarial experience. The Long-Term Care Insurance (EX) Task Force, or its appointed subgroup, will determine the appropriate experience and skill set for qualifying members for the MSA Team. It is expected that state participants will provide expertise and technical knowledge specifically regarding the array of LTCI products and solvency considerations. The desired MSA Team membership composition should include a minimum of five and up to seven members.

Membership must follow the requirements below and be approved by the Chair of the LTCI (EX) Task Force or the Chair of an appointed subgroup. The following outlines the qualifications, duties, participation expectations and resources required for MSA Team members.

A. Qualifications of an MSA Team Member

To be eligible to participate as a member of the MSA Team, a state insurance regulator is required to:

- Hold a senior actuarial position in a state insurance department in life insurance, health insurance, or long-term care insurance.
- Be recommended by the Insurance Commissioner of the state in which the actuary serves.
- Have over five years of relevant LTCI insurance experience.
- Hold an Associate of the Society of Actuaries (ASA) designation.
- Currently participates as a member of the Long-Term Care Insurance (EX) Multistate Rate Review (EX) Subgroup (or an equivalent Subgroup appointed by the Long-Term Care Insurance LTCI (EX) Task Force) and the LTC Pricing (B) Subgroup.
- At least one member of the MSA Team must be a member of the American Academy of Actuaries (Academy) (at least one member).

Additionally, the following qualifications are preferred:

- Hold a Fellow of the Society of Actuaries (FSA) designation
- Have spent at least one year engaged in discussions of either the LTCI (EX) Task Force or its appointed Subgroup
As both state insurance regulators and the MSA Review may benefit by developing and expanding specific LTCI actuarial expertise through participation in this process, having one or more suitably experienced and qualified actuaries participate in and supervise the work of the MSA Team is critical to the viability of the MSA process. Participation also provides opportunities for additional actuaries to meet the requirements of the U.S. Qualification Standards applicable to members of the Academy and other U.S. actuarial organizations as they relate to LTCI.

Consideration will be given to joint membership where two actuaries within a state combine to meet the criteria stated above.

Consultants engaged by the state insurance department would not be considered for MSA Team membership.

B. Duties of an MSA Team Member

- Active involvement with the MSA Team, with an expected average commitment of 20 hours per month (see Section IV for details of the MSA Review and activities of a team member).
- Participate in all MSA Team calls and meetings (unless an extraordinary situation occurs).
- Review and analyze materials related to MSA rate proposals.
- Provide input on the MSA Advisory Reports, including regarding the recommended rate increase approval amounts.
- Maintain confidentiality of MSA Team meetings, calls, correspondence, and the matters discussed therein to the extent permitted by state law and protect from disclosure any confidential information received pursuant to the Master Information Sharing and Confidentiality Agreement. MSA Team Members should communicate any request for public disclosure of MSA information or any obligation to disclose.
- Active involvement within NAIC LTCI actuarial groups.
- Willingness to provide expertise to assist other states.

C. Participation of an MSA Team Member

Except for webinars and other general communications with state insurance departments, participation in the MSA Review conference calls and meetings related to the review of a specific rate proposal will be limited to named MSA Team members, supporting NAIC or Compact staff members who will be assisting the MSA Team, and the Chair and Vice Chair of the Long-Term Care Insurance (EX) Task Force, or its appointed subgroup. Other interested state insurance regulators, e.g., domiciliary state insurance regulators, may be invited to participate on a call at the discretion of the MSA Team, or the Chair or Vice Chair of the Task Force or its appointed subgroup.

D. MSA Associate Program

The MSA Associate Program within the MSA Framework is intended to encourage and engage state insurance regulators to become actively involved in the MSA process. Additionally, a benefit of the program is to provide an educational opportunity for state insurance department regulatory actuaries.
that wish to gain expertise in LTCI. Regulatory actuaries can participate with varying levels of involvement or for different purposes as described. Regulatory actuaries may participate:

- As a mentee. The mentee would participate in aspects of the MSA Review. An MSA Team member will serve as a mentor to another state regulatory actuary and provide one-on-one guidance.
- To gain more knowledge and understanding of the Minnesota and Texas actuarial approaches.
- To share their own expertise through feedback to the MSA Team on MSA Advisory Reports to better enhance the overall MSA process.
- To participate on an ad hoc limited basis, i.e., where a regulatory actuary would like to participate but is unable to make the required time commitment.
- To meet the U.S. Qualification Standards applicable to members of the Academy and other U.S. actuarial organizations as they relate to LTCI by serving under the supervision of a qualified actuary on the MSA Team.
- To serve as a peer reviewer of the MSA Advisory Reports.

**D.E. Conflicts, Confidentiality, and Authority of the MSA Team**

**Authority of the MSA Team**

Members of the MSA Team serve on a purely voluntary basis, and any member’s participation shall not be viewed or construed to be any official act, determination, or finding on behalf of their respective jurisdictions.

**Disclosures and Confidentiality Obligations, as Applicable**

All members of the MSA Team acknowledge and understand that the MSA Review, including, but not limited to, meetings, calls, and correspondence are confidential and may not be shared, transmitted, or otherwise reproduced in any manner. Additionally, all members of the MSA Team affirm and represent that they will: (a) provide any in force LTCI rate proposal with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state’s laws and regulations; and, (b) provide any MSA Advisory Report with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state’s laws and regulations for rate filings, any resulting advisory report, as well as all meetings, calls, correspondence, and all other materials produced in connection herewith are confidential and may not be shared, transmitted, or otherwise reproduced in any manner.

**Conflict of Interest Avoidance Procedures and Certifications**

No member of the MSA Team may own, maintain, or otherwise direct any financial interest in any company or its affiliates subject to the regulation of any individual state, nor may any member serve or otherwise be affiliated with the management or board of directors in any company or its affiliates subject to the regulation of any individual state. All conflicts of interest, whether real or perceived, are prohibited and no member of the MSA Team shall engage in any behaviors that would result in or create the appearance of impropriety.
E.F. Required NAIC and Compact Resources

The MSA Team will require administrative and technical support from the NAIC. As the MSA Review develops, it is expected that NAIC support resources will play an integral role in managing the overall program. Administrative staff support will be needed to support MSA Team communications and manage record keeping for underlying workpapers and final MSA Advisory Reports associated with each rate proposal, etc. Additionally, it is possible that limited actuarial support will be needed for the analysis of rate proposals, including preparing data files, gathering information, performing limited actuarial analysis procedures, drafting MSA Advisory Reports, and monitoring interactions among the state insurance departments and the MSA Team. Dedicated staff support for the ongoing work of the Long-Term Care Insurance (EX) Task Force will be needed as well. As more experience with rate proposal volumes and average analysis time is gained, the full complement of human resources required will be better understood.

The MSA Team and supporting NAIC and Compact staff will use the NAIC SERFF electronic infrastructure to receive insurer rate increase proposals and correspond with insurers. As needed, the MSA Team or supporting NAIC and Compact staff may communicate with the insurer outside of SERFF. [S25][DG26]. The material substance of such communication can be documented within SERFF. [NAIC and Compact staff will communicate with insurers only at the direction of the MSA Team. Compact staff will perform administrative work related to MSA rate increase proposals] at the direction of the MSA Team and as described in this Framework.

III. REQUESTING AN MSA REVIEW

A. Scope and Eligibility of a Rate Proposals for MSA Review

The following are the preferred eligibility criteria for requesting an MSA Review of a rate proposal.

- Must be an in force long-term care insurance LTCI product (individual or group).
- Must be seeking a rate increase in at least 20 states and must affect at least 5,000 policyholders nationwide.
- Includes any stand-alone LTCI product approved by states, not by the Interstate Insurance Product Regulation Commission (Compact).
- For Compact-approved products meeting certain criteria, the Compact Office will provide the first-level advisory review subject to the input and quality review of the MSA.

It is recognized that rate proposals vary from insurer to insurer. The above criteria and the timelines provided below are general guidelines. The MSA Team has the authority to weigh the benefits of the MSA Review for state insurance departments and the insurer against available MSA Team resources when considering the eligibility of rate proposals and the timeline for completion. Based on these considerations, the MSA Team, at its discretion, may elect to perform an MSA Review on a rate proposal that does not satisfy the above eligibility criteria.

The MSA Team reserves the right to deny a proposal that does not meet eligibility criteria. An insurer will be notified if the proposal for an MSA Review is denied.
An insurer may ask questions for more information about a potential rate proposal through communication to supporting NAIC and Compact staff and the MSA Team. This will be accomplished through a Communication Form that will be available on the Compact webpage. Supporting NAIC and Compact staff will work with the insurer to complete the necessary steps to assess eligibility, discuss any technical or other issues, and answer questions.

The insurer will have access to primary and supplementary checklists in Appendix B that provide guidance to the insurer for information that should be included in a complete MSA rate proposal requested through the NAIC’s SERFF application.

B. Process for Requesting an MSA Review

As noted in Section I.C. above, the MSA Review will utilize the Compact’s multi-state review platform within the NAIC’s SERFF application and its format for in-force LTCI rate increases. Therefore, a state may participate in the MSA Review without being a member of the Compact. The following describes a few key elements of the process for insurers and state insurance department regulators:

- The insurer will work with NAIC and Compact support staff and the MSA Team to make a seamless rate increase proposal request.
- Instructions containing a checklist for information required to be included in the rate increase proposal, as reflected in Appendix B, will be available to insurers through the Compact’s webpage or within SERFF.
- The insurer shall include in the rate proposal a list of all states for which the product associated with the rate increase request proposal is or has been issued. Participating states will have access to view the insurer’s rate proposal and review correspondence in SERFF.
- Fee schedule for using the MSA Review [To Be Determined].
- Rate increase proposals for MSA Review within SERFF will be clearly identified as separate from Compact filings.
- The supporting NAIC and Compact staff through SERFF will notify the impacted states upon receipt of the rate increase proposal with the SERFF Tracking Number.
- The MSA Team may utilize a “queue” process for managing workload and resources for incoming rate increase proposals, requests through SERFF.
- The MSA Team may utilize Listserv or other communication means for inter-team communications.
- The MSA Team’s review of objections and insurer responses are completed through SERFF.

C. Certification

The insurer shall provide certifications signed by an officer of the insurer that it acknowledges and understands the non-binding effect of the MSA Review and MSA Advisory Report. The certification shall also provide, and the insurer shall agree, that it will not utilize or otherwise use the MSA Review and/or the resulting MSA Advisory Report to challenge, either through litigation or any applicable administrative procedure(s), any state’s decision to approve, partially approve, or disapprove a rate increase filing except when: [(Participating/Impacted State [TBD])]

—END—
State that affirmatively relied on the MSA Review and/or the MSA Advisory Report in making its determination; or 2) the individual state consents in writing to use of the MSA Review and/or the MSA Advisory Report.

Failure to abide by the terms of the insurer’s certification will result in the insurer and its affiliates being excluded from any future MSA Reviews, and it will permit the MSA Team to terminate, at its sole discretion, any other ongoing review(s) related to the insurer and its affiliates.

Should the MSA Team exclude any insurer and its affiliates for failure to adhere to its certification, the MSA Team, at its sole discretion, may permit the insurer and its affiliates to resume submitting rate proposals for review upon written request of the insurer.

**IV. REVIEW OF THE RATE PROPOSAL**

**A. Receipt of a Rate Proposal**

The MSA rate review process begins when an insurer expresses interest in an MSA Review being performed for a rate proposal. This interest can be expressed through completion of a Communication Form, which will be available through the Compact web page. The initial request will be reviewed by the MSA Team lead reviewer and/or supporting NAIC and Compact staff. Once an insurer has completed this initial communication and meets the criteria for requesting an MSA Review, the insurer will work with supporting NAIC and Compact staff and the MSA Team to complete the rate increase proposal in SERFF. The MSA Team will be notified, via SERFF, when the rate increase proposal is available for review.

The supporting NAIC and Compact staff will, via SERFF or e-mail, notify participating/impacted States [TBD] when rate increase proposals are submitted, correspondence between the MSA Team and insurer is sent or received in SERFF, the MSA Advisory Report is available, and other pertinent activities occur during the review.

**B. Completion of the MSA Review**

The MSA Team shall designate a lead reviewer to perform the initial review of each rate proposal. Once the rate increase proposal is made through SERFF, the MSA Review will resemble a state-specific review process.

The MSA Team will meet periodically to discuss the review and determine any needed correspondence with the insurer. Objections and communications with filers will be conducted through SERFF, similar to like any state-specific filing or Compact filing, to maintain a record of the key review items. Other supplemental communication between the insurer and the MSA Team or supporting NAIC and Compact staff, may occur, such as conference calls or emails, as appropriate.

The timeframe for completing the MSA Team’s review and drafting the MSA Advisory Report will be dependent upon the completeness of the rate proposal and the size and complexity of the block of policies for which the rate increase applies. The MSA Team may utilize a “queue” process for managing workload and resources for incoming rate increase proposals through SERFF. The timeliness of any
necessary communication between the MSA Team and the insurer to resolve questions or request/receive additional information about the rate proposal will impact the completion of the review.

As the MSA Team completes its review: 1) the insurer will receive initial communication of a completed review, and that a final MSA Advisory Report with recommendations will be drafted and communicated to state insurance departments within the next month, which may serve as a signal for a potential ideal time for the insurer to prepare to submit the state-specific filings to each state; and; 2) the insurer will receive MSA Review information for the insurer and the MSA Team will address questions from the insurer about the result of the review. 2) the insurer will receive sufficient information regarding the MSA Team’s recommendation to allow the insurer an opportunity to review the recommendation and in the event that the MSA Team recommendation differs from the proposal submitted by the insurer, the insurer will be given the opportunity to interact with the MSA Team in order to ask questions, and understand the MSA Team’s reasoning.

### C. Preparation and Distribution of the MSA Advisory Report

Upon completion of the actuarial review, the MSA Team will prepare a draft MSA Advisory Report for the rate proposal. The reports will be made available within SERFF “reviewer notes” for Participating States. Supporting NAIC and Compact staff will maintain a distribution list and send notifications of the availability of reports to Participating States. Consultants engaged by state insurance department staff to perform rate reviews would be given access to the MSA Advisory Report, subject to the terms of the agreement between the consultant and the Participating State insurance department.

Consultants who are bound by the actuarial Code of Professional Conduct, adopted by the Academy of Actuaries, the Society of Actuaries (SOA) and the Conference of Consulting Actuaries (CCA), should consider whether receipt of the MSA Advisory Report is acceptable under Precept 7 regarding Conflicts of Interest. For other professions, similar consideration should be made if bound by similar professionalism standards.

Prior to finalizing the MSA Advisory Report, the MSA Team will present the draft MSA Advisory Report to Participating States on a regulatory-only WebEx call, as deemed necessary, to provide an overview of the recommendations and respond to questions from Participating States.

The MSA Team will issue the final MSA Advisory Report to the Participating States and the insurer after consideration of any comments and questions from Participating States.

The MSA Advisory Report will include standardized content, as reflected in Appendix A, with modifications, as necessary, for any unique factors specific to the rate proposal. The content and format are based on feedback received from state insurance departments and the Long-Term Care Insurance (EX) Task Force during the pilot project.

The content and format of the MSA Advisory Report may be modified in the future under the direction of the LTCI (Ex)-Task Force, or an appointed Subgroup, as the MSA Team gains more experience in generating the reports and receives more feedback from Participating states and the insurer, through this process.
D. **Timeline for Review and Distribution of the MSA Advisory Report**

The draft MSA Advisory Report will be made available to Participating States for a two-week comment period prior to being finalized. The following timeline for this comment period and distribution of the final MSA Advisory Report will be adhered to as close as possible, barring timing delays due to, e.g., holidays or other unexpected events. Note that the MSA Review is intended to occur before filings are made to the state insurance departments, therefore not affecting state insurance departments’ required timelines for review. However, use of the MSA Advisory Report by the state review [Staff39][DG40] may result in a reduced amount of time required for the state to complete its review.

- **Pre-Distribution**: Share the draft MSA Advisory Report with the insurer. The insurer will be given the opportunity to interact with the MSA Team to ask questions and understand the MSA Team’s reasoning.
- **Day 1**: Distribution of a draft MSA Advisory Report to all Participating States.
- **Day 5-7**: Regulator-to-regulator WebEx conference call of all Participating States [DG44] during which the MSA Team will present the recommendations in the MSA Advisory Report and seek comments from states.
- **Day 21**: Deadline for comments on the Draft Initial MSA Advisory Report.
- **Day 35**: Distribution of the final MSA Advisory Report, with consideration of comments, to Participating States and the insurer.
- **Date to be determined TBD**: By the Insurer – Individual rate increase filings submitted to each state insurance department.
- **Date to be determined TBD**: By each state’s department of insurance [DOI] – approval or disapproval of the rate increase filing submitted to in each state.

E. **Feedback to the MSA Team**

At the [Staff47][DG48] direction of the Long-Term Care Insurance (EX) Task Force, or an appointed Subgroup, state insurance departments will be requested to periodically provide data and feedback on their state rate increase approval amounts and on their state’s use of and reliance on the MSA Advisory Reports. The following items may be considered in a feedback survey:

1. The number of filings for proposals made with the MSA Review Team;
2. The number of rate request proposals approved by the MSA Review Team;
3. Information regarding states approval of MSA recommendations;
4. Feedback on additional information states requested;
5. Feedback regarding how the review process and methodology could be improved.

State responses will be confidential pursuant to the Master Agreement, and aggregated results of feedback surveys will not specifically identify state responses. The MSA Team and state insurance regulators welcome feedback from insurers on their experience using the MSA Review Process. This collective feedback will aid the Task Force in understanding the practical effects of the MSA Review process in achieving the goal of developing a more consistent state-based approach for reviewing LTCI rate proposals that result in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. The feedback will also help refine the review process.
process, improve future reports to better meet participants’ needs, and make updates to this MSA Framework. Finally, the feedback will assist NAIC leadership in making decisions regarding the technology and staff resources needed for the continued success of the project. Aggregated feedback results will be shared with Participating States and Insurers as determined appropriate.

V. ACTUARIAL REVIEW

A. MSA Team’s Actuarial Review Considerations

In conducting its actuarial review of a rate proposal, the MSA Team will consider assumptions, projections, and other information provided by the insurer as outlined in Appendix B. The MSA actuarial review process will be evaluated and evolve over time as more rate proposals are reviewed.

The Minnesota and Texas approaches ensure remaining policyholders do not make up for losses associated with past policyholders. Professional judgment is used to address agreed upon policy issues, including the handling of incomplete or non-fully credible data. The Minnesota approach also considers adverse investment expectations related to the decline in market interest rates, and a cost-sharing formula is applied. The Texas approach ensures rate changes reflect prospective changes in expectations. More detail of each approach is provided in the following sections.

The MSA Team will consider the following in performing their review, applying their expertise and professional judgement to the review, and as well as reviewing the actuarial formulas and results:

- Review company insurer experience, company insurer narrative explanation, and relevant industry studies.
- Assess reasonability of assumptions for lapse, mortality, morbidity, and interest rates.
- Validate and adjust or request new projections of claim costs and premiums by year.
  - Validate that the patterns of claims and premium projections over time match reasonably align those reflected in the assumptions.
  - Adjust or request new projections of claims and premium to the extent that any underlying assumptions are deemed unreasonable or unsupported by the MSA Team. Any differences will initially result in correspondence between the MSA Team and the insurer via SERFF.
  - After verifying loss ratio compliance, apply both the Minnesota and Texas approaches for each rate proposal submitted.

which ensure remaining policyholders do not make up for losses associated with past policyholders.

In developing a recommendation, the MSA Team will apply a balanced approach and professional judgement for each rate proposal based on the characteristics of the block reviewed to determine the most appropriate method. The MSA Team’s recommendation will not be the lowest or the highest percentage method just because it is the lowest or the highest. Rather, the recommendation may be the result of either the Texas or Minnesota approach, a blend of the two approaches; or using professional judgement, the MSA Team may recommend a rate increase outside of these two approaches. Other methods may evolve over time that may be incorporated into the future process that generate similar or unique results. In developing a recommendation, the MSA Team will in applying regulatory actuarial
professional judgement, for instance [e.g., when considering the extent to which less-than-fully credible older-age morbidity should be projected to cause adverse experience], a balanced approach is applied as opposed to denying a rate increase, which could lead to a spike in the future, or approving the rate increase if there was full credibility, which could lead to rates that could be too high. As [Staff] [pos] the MSA Team reviews more rate proposals, it will consider and evaluate the characteristics of the rate proposals as it refines the blending of the two methods.

The MSA Team will consider how to reflect the differences in the histories of states’ rate approvals. Current approach includes:

- The MSA Team’s recommendation results in the same rate per unit in each state following the current rate increase round, leading to higher percentage rate increases in states that approved lower rate increases in the past.
- Analysis will continue on state cost differences impacting justifiable rate increases. As of May 2021, there does not appear to be substantial evidence that policyholders who purchased policies in lower-cost states [source] should receive lower percentage rate increases. Part of the reason is that there was a tendency for people in lower-cost areas to purchase less coverage. Their premium rates will continue to be lower than rates for policyholders with more coverage, even if percentage rate increases are the same.
- Any recommendation from the MSA Team for a catch-up increase aims to achieve only current rate equity between states and not lifetime rate equity between states.

Consideration of Solvency Concerns

If concerns exist regarding an insurer’s financial solvency and the impact of rate increases on future solvency, each state DOI, by their authority over rate approval, has the flexibility to consider solvency adjustments in these rare instances. In rare, non-typical circumstances, adjustments could be considered within the MSA Review, including consultation with states as part of the MSA Advisory Report comment period.

Follow-Up Proposals Filings on the Same Block

Any subsequent rate increase proposal to the MSA Team on a block of business previously reviewed by the MSA Team needs to involve the development of adverse experience and/or expectations. In the absence of adverse experience or expectation development, the MSA Team will consider a reasonable explanation from an insurer for an increase in credibility of morbidity data of being the reason for a rate increase. Prior rate increases would need to be implemented before the implementation of a subsequent rate increase. The MSA Team will not consider a new rate increase request proposal on a block that did not receive the full percentage rate increase requested without the experience, expectation, or credibility criteria noted above. If an insurer did not receive the full percentage rate increase and has no adverse changes in experience or expectations, the insurer should work directly with the applicable state DOI.

B. Loss Ratio Approach

Key aspects of the loss ratio approach to the actuarial review of rate changes include:
1. At policy issuance, pricing based on a lifetime loss-ratio target is typically established. A common target is 60%, which means the present value of claims is targeted to equal 60% of the present value of premiums. In some instances, products may be priced with a projected lifetime loss ratio in excess of 60%. The remainder goes towards sales-related costs, administrative expenses, expenses related to claims, and profit. Note that 60% is a required minimum loss ratio under the pre-rate stability rules; newer policies may be priced with lower expected loss ratios. Refer to state law or regulation modeled from the Long-Term Care Insurance Model Regulation (#641), Section 19 for more details on compliance with loss ratio standards.

2. As lapses and mortality have generally been lower than expected, more people have reached ages where claims tend to occur than originally expected. In some cases, this has resulted in a substantial increase in the present value of claims; thus, resulting in substantially higher expected lifetime loss ratios than originally targeted. For companies where morbidity expectations have increased over original assumptions, lifetime loss ratios would be even higher.

3. The loss ratio approach increases future premiums to a level referred to as make-up premium, such that the original loss ratio target is once again attained.

4. The loss ratio approach, one of the minimum standards in many states’ statutes, is evaluated by the MSA Team. However, there is general recognition that this approach produces rate increases that are too high and do not recognize other typical statutory standards such as fair and reasonable rates.
   a. The loss ratio approach also does not recognize actuarial considerations such as the shrinking block issue, where past losses being absorbed by a shrinking number of remaining policyholders would lead to unreasonably high-rate increases. This concern was the main driver of the Minnesota, Texas, and other approaches.
   b. The loss ratio approach shifts all the risk to the policyholders. If the company is allowed to always return to the 60% loss ratio, there may be a lower incentive for more reasonable appropriate initial pricing.

5. For rate-stabilized business, lifetime loss ratios are broken out, such as in a 58%/85% pattern, where the 58% reflects the portion of initial premiums and the 85% reflects the portion of the increased premium available to pay the claims. For relevant blocks, this standard is analyzed by the MSA Team. If this standard produced lower increases than the Minnesota and Texas approaches, it would produce the recommended rate increase.

C. **Minnesota Approach**

Key aspects of the Minnesota approach to the actuarial review of rate changes include:

1. Blended if-knew / makeup approach to address the shrinking block issue.
   a. The if-knew concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
b. The makeup concept is for a premium to be charged going forward to return the block to its original lifetime loss ratio.

c. The blending method helps ensure concepts discussed in public NAIC Long-Term Care rate

(Professional) Subgroup calls from 2015 to 2019[4] are incorporated, including the concept that rates will not substantially rise as the block shrinks, (as policyholder persistency falls over time).

2. Cost-sharing formula that increases the company insurer’s burden as cumulative rate increases rise.

a. This addition to company insurer’s burden moves rates away from a direction that could potentially be seen as misleading. The company insurer likely had or should have had more information on the likelihood of large rate increases than the consumer had at the time the policy was issued.

3. Assumption review.

a. Verification that the company insurer’s original and current assumptions are indeed drivers of the magnitude increase in lifetime loss ratio presented by the company insurer.

b. Verification of appropriateness of current assumptions.

i. A combination of credible company insurer experience, relevant industry experience, and regulatory professional judgement is applied.

ii. For areas of uncertainty, such as older-age morbidity, conservatism may be added to the company insurer-provided assumptions. This conservatism can be released as credible experience develops.

4. Interest rate / investment return component.

a. The Minnesota approach considers changes in expectations regarding interest rates and related investment returns in a manner consistent with how other key assumptions are considered. Reasons include:

i. Changes in market interest rates are among the key factors driving profits and losses associated with blocks of LTC business.

ii. In the Minnesota approach, all factors impacting the business are considered.

1. If interest rates rise, this would tend to lead to lower rate increase approvals. Note, in this scenario, if interest rate changes were not considered, it is possible an company insurer would get approval for rate increases even when profits on the block were higher than expected.

2. If interest rates fall, this would tend to lead to higher rate increase approvals.

iii. To prevent shifting of “good assets” and “bad assets” to supporting LTC rates, and to prevent an company insurer from increasing rates based on risky investments that turned into losses, an index of average corporate bond yields (e.g., Moody’s) is relied on to reflect experience and current expectations.

iv. Original pricing typically includes an assumption on investment returns, (for which premiums and other positive cash flows are assumed to accumulate). This forms the interest component of the original assumption.

v. The original pricing investment return in Section VC(4)iv is compared to the average corporate bond yields in Section VC(4)iii to determine the adversity associated with the interest rate factor.

5. Anti-bait and switch adjustment

   Original Assumption Adjustment

   a. If original mortality, lapse, or investment return assumptions were out of line with industry-average assumptions at the time of original pricing, the original premium is replaced by a “benchmark premium.”
      i. This results in a lower rate increase.
      ii. This adjustment wears off over 20 years from policy issue.
         1. The rationale for the wearing off of this adjustment is the assumption that no company insurer would intentionally underprice a product, knowing it would suffer losses for 20 years and then hope to offset a portion of that loss with a rate increase.
      iii. This adjustment is intended to prevent bait & switch, where, e.g., an company insurer would underpricing a product, gaining market share, and then immediately requesting a rate increase.

D. Texas Approach

The Texas approach to the actuarial review of rate changes was developed in response to the NAIC Long-Term Care Pricing (B) Subgroup’s discussions regarding the recoupment of past losses in LTCI rate increases. The Texas approach relies upon a formula intended to prevent the recoupment of past losses by calculating the actuarially justified rate increase for premium-paying policyholders based solely on projected future (prospective) claims and premiums.

Key aspects of the Texas approach to the actuarial review of rate changes include:

1. Past losses are assumed by the company insurer, and not by existing policyholders. An approach that considers past claims in the calculation of the rate increase, such as a lifetime loss ratio approach, permits to some extent, the recoupment of past losses to some extent.

2. Calculates the rate increase needed to fund the prospective premium deficiency for active, premium-paying policyholders based on an actuarily supported change in assumption(s). This ensures that active policyholders do not pay for the past claims of policyholders who no longer pay premium.

3. Data Requirements for Calculation:
   a. The following calendar year projections, including totals, for current premium-paying policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate:
      i. Present Value of Future Benefits (PVFB) under current assumptions.
      ii. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
      iii. Present Value of Future Premiums (PVFP) under current assumptions.
      iv. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
1. {Note that for all 4 projections above, the projection period is typically 40–50 years; although, some companies project for 60 or more years.}

To emphasize, these projections should only include active policyholders currently paying premium and should not include any policyholders not paying premium (e.g., policies on waiver, on claim, or paid up); regardless of the reason. -Projections under current actuarial assumptions must not include policyholder behavior as a result of the proposed premium rate increase, such as a shock lapse assumption.

Also, the company, insurer should identify and explain any estimates or adjustments to the data, as applicable.

4. Assumptions
   a. Rate increases are commonly driven by a change to the persistency, morbidity, or mortality assumption, or a combination of the three.
   b. Verification that assumption change(s) are supported by credible data.
   c. The interest rate is the same for all four projections. This ensures that interest rate risk is assumed by the company, insurer, not the policyholder.

The formula used in the TexasX approach is provided in Appendix C.

E. Reduced Benefit Options (RBOs)

In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup (“LTCI RBO (EX) Subgroup”) of the Long-Term Care Insurance (EX) Task Force, developed a list of RBO principles to provide guidance for evaluating RBO offerings in Appendix D.

RBOs in the MSA Advisory Report

As part of the MSA Review, the MSA Team will perform a limited review of the reasonableness of RBOs included in the rate proposal that are extracontractual. The MSA Advisory Report will highlight how the company, insurer demonstrates the proposed RBOs’ reasonableness. Note that the MSA Team will not perform an assessment of RBOs in relation to individual state specific requirements for RBOs. The purpose of the guidance in the MSA Advisory Report is to provide initial information about the RBOs with which the state insurance regulators can then utilize to perform a more detailed assessment specific to their state’s requirements. As the MSA Review process develops and as the LTCI RBO (EX) Subgroup continues its work, this area of review may evolve.

Future RBOs

As the industry continues to innovate new RBOs for consumers, the MSA Review process will likewise develop and evolve to consider the reasonableness of RBOs. Additionally, as the MSA Review process evolves, additional regulatory expertise with RBOs may be added to the MSA Team in the future. To achieve more consistency across states in their understanding and consideration of RBOs, the LTCI (EX) Task Force will encourage its appointed Subgroup and/or an appropriate NAIC actuarial committee or group, to collectively consider new RBOs, as they arise. This process will provide for input and technical...
F. Non-Actuarial Considerations

The Long-Term Care Insurance (EX) Task Force continues to review and consider non-actuarial considerations impacting states’ approval or disapproval of LTCI rate changes to develop consensus among jurisdictions and develop recommendations for application of these considerations. These considerations include such topics as:

1. Caps or limits on approved rate changes.
2. Phase-in of approved rate changes over a period of years.
3. Waiting periods between rate change requests.
4. Considerations of prior rate change approvals and disapprovals.
5. Limits or disapproval on rate changes based solely or predominately on the number of policyholders in a particular state.
6. Limits or disapproval on rate changes based on attained age of the policyholder.
7. Fair and reasonableness considerations for policyholders.
8. The impact of the rate change on the financial solvency of the insurer.

Considerations in the MSA Advisory Report

As part of the MSA Review, the MSA Team will identify relevant aspects of the insurer’s rate proposal, based on the information provided by the insurer, that may be impacted by the state’s non-actuarial considerations. Note that the MSA Team will not perform a state-by-state review of each state’s non-actuarial considerations, statutes, or practices. Instead, the MSA Team will highlight in the MSA Advisory Report those aspects of the rate proposal that relate to or that may be impacted by non-actuarial considerations. The purpose of this guidance in the MSA Advisory Report is to prompt state insurance regulators to contemplate those impacted aspects of the rate proposal when completing their individual state’s rate review. For example, the MSA Advisory Report may highlight:

- If cumulative rate increases are high, as this may impact the cost-sharing formula.
- If a rate proposal is for a block of business where the average policyholder age is predominately 85 or above, as this may impact states that consider age caps.
- If it is determined that the block of business will likely continue to incur substantial financial losses and impose a potential solvency concern, as this may impact the potential need for adjustments to the cost-sharing formula.
- Aspects of the coordination of rate and reserving review, as this may signify adjustments to the methodology assumptions used by the MSA Team in their review.

Future Non-Actuarial Considerations[Staff67][DG68]

The MSA Review process will continue to develop and evolve as it is implemented. To achieve more consistency and minimize the number of differences across states in their application of other non-actuarial considerations in rate review criteria for LTCI rate filings, the LTExTask Force will encourage

advice from actuaries and non-actuarial experts to the state insurance departments as they exercise their authority in considering RBOs as part of rate filings. States and insurers are therefore encouraged to discuss new and developing RBOs through this process.
its appointed Subgroup, or an appropriate NAIC actuarial committee or group, to collectively consider new future non-actuarial considerations, as they arise. This process will provide for input and technical advice from actuaries to states as they exercise their authority in considering non-actuarial factors. States are therefore encouraged to discuss new and developing practices and/or recommendations in this area.

VI. APPENDICES—MSA ADVISORY REPORT FORMAT FOR REGULATORS

A. Appendix A—MSA Advisory Report Format

The MSA Advisory Report that is distributed to Participating State insurance departments and the insurer will generally follow a template that includes the following information. Note that degree of rigor in the review and the details and content of the MSA Advisory Report will depend on the magnitude of rate increase and the complexity of the rate proposal and the insurer’s financial condition. See also the sample MSA Advisory Report in Exhibit A.

1. Executive Summary,
   a. Overall recommended rate increase, before consideration of different states’ history of approvals.

2. Disclaimers,
   a. Purpose and intent of how states should use the MSA Advisory Report.
   b. Disclaimer that the MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer.
   c. Statement that the in-force rate increase request filing submitted to the respective states shall be subject to the approval of each state, and each state’s applicable state laws and regulations shall apply to the entire rate schedule increase filing.

3. Background on the MSA Rate Review process.

4. Explanation of the insurer’s Proposal Request,
   a. The explanation will be based on the aspects of the insurer’s rate proposal, which may include details as to whether the rate increase submitted for review involved different types of coverages or groupings.

5. Summary of the MSA Team’s rate review analysis, including these aspects:
   a. Actuarial review,
      i. The summary of the review and the MSA Team’s recommendation will be based on the aspects of the insurer’s rate proposal, and may include specific details of the review, for example analysis of projections, assumptions, margins or other aspects.
   b. Summary of consideration of differences in the history of state’s rate increase approvals.
   c. Non-actuarial considerations and findings.
   d. Financial solvency-related aspects and adjustments.
   e. Review for reasonableness and clarity of reduced benefit option.
   f. Summary information about the mix of business.

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6. Appendices
   a. Summary of the drivers of the rate proposal increase request.
   b. Details regarding the Minnesota and Texas approaches as applied to the rate proposal.
   c. Summary of rate proposal correspondence.
   d. Examples of rate increases if an RBO is not selected.
   e. Potential cost-sharing formula for typical circumstances.
      
      e. – Tables of recommended rate increases by state, after consideration of different state’s history of approvals.
      d. – Frequently Asked Questions (FAQ)

**A-B. Appendix B – Information eChecklist**

At the request of the former Long-Term Care Insurance (B/E) Task Force, the Long-Term Care Pricing (B) Subgroup developed a single checklist that reflects significant aspects of LTCI rate increase review inquiries from all states. In this context, “checklist” means the list or template of inquiries; states typically send at the beginning of reviews of state-specific rate increase filings.

This document contains aspects of the NAIC Guidance Manual for Rating Aspect of the Long–Term Care Insurance Model Regulation⁶ (Guidance Manual) and checklists developed by several other states. This consolidated checklist is not intended to prevent a state from asking for additional information. The intent is to take a step toward moving away from 50 states having 50 different checklists to have a more efficient process nationally to provide the most important information needed to determine an approvable rate increase. To keep the template at a manageable length, it is anticipated that this template will result in states attaining 90–100% percent of the information necessary to decide on approvable rate increases. State and block specifics will generate the other 0-10% zero to ten percent of requests. As states apply this checklist, it or an improved version may be considered for a future addition to the Guidance Manual for Rating Aspect of the Long–Term Care Insurance Model Regulation.

**A. Information Required for an MSA Review of a Rate Proposal**

The following provides a checklist of information necessary for a complete rate proposal to the MSA Review. This checklist is consistent with the “Consolidated, Most Commonly Asked Questions – States’ LTC Rate Increase Reviews”⁷ as adopted by the Health Actuarial (B) Task Force on March 23, 2018.

1. Identify all states for which the product associated with the rate increase request proposal is or has been issued.

2. New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.

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⁷ https://content.naic.org/sites/default/files/inline-files/cmte_b_ltc_price_sq_180323_ltc_increase_reviews%20%289%29.docx
a. Provide rate increase percentages by policy form number and clear mapping of these numbers to any alternative terminology describing policies stated in the actuarial memorandum and other supporting documents.
b. Provide the cumulative rate change since inception, after the requested rate increase, for each of the rating scenarios.

3. Rate increase history that reflects the filed increase.
a. Provide the month, year, and percentage amount of all previous rate revisions.
b. Provide the SERFF MSA numbers associated with all previous rate revisions.

4. Actuarial memorandum justifying the new rate schedule, which includes:
a. Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
   i. The projection should be by year.
   ii. Provide the count of covered lives and count of claims incurred by year.
   iii. Provide separate experience summaries and projections for significant subsets of policies with substantially different benefit and premium features. Separate projections of costs for significant blocks of paid-up and premium-paying policies that should be provided.
   iv. Provide a comparison of state versus national mix of business. In addition, a state may request separate state and national data and projections. The insurer should accompany any state-specific information with commentary on credibility, materiality, and the impact on requested rate increase.

5. Reasons for the rate increase, including which pricing assumptions were not realized and why.
a. Attribution analysis - presents the portion of the rate increase allocated to and the impact on the lifetime loss ratio from each change in assumption.
b. Related to the issue of past losses, explain how the requested rate increase covers a policyholder’s own past premium deficiencies and/or subsidizes other policyholders’ past claims.
c. Provide the original loss ratio target to allow for comparison of initially assumed premiums and claims and actual and projected premiums and claims.
d. Provide commentary and analysis on how credibility of experience contributed to the development of the rate increase.

6. Statement that policy design, underwriting, and claims handling practices were considered.
a. Show how benefit features, [e.g., inflation and length of benefit period], and premium features, [e.g., limited pay and lifetime pay] impact requested increases.
b. Specify whether waived premiums are included in earned premiums and incurred claims, including in the loss ratio target calculation; provide the waived premium amounts and impact on requested increase.
c. Describe current practices with dates and quantification of the effect of any underwriting changes. Describe how adjustments to experience from policies with less restrictive underwriting are applied to claims expectations associated with policies with more restrictive underwriting.

7. A demonstration that actual and projected costs exceed anticipated costs and the margin.
8. The method and assumptions used in determining projected values should be reviewed considering reported experience and compared to the original pricing assumptions and current assumptions.
   a. Provide applicable actual-to-expected ratios regarding key assumptions.
   b. Provide justification for any change in assumptions.

9. Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
   a. Explain the relevance of any data sources and resulting adjustments made relevant to the current rate proposal, particularly regarding the morbidity assumption.
   b. A comparison of the population or industry study to the in-force related to the rate proposal should be performed, if applicable.
   c. Explain how claims cost expectations at older ages and later durations are developed if data is not fully credible at those ages and durations.
   d. Provide the year of the most recent morbidity experience study.

    a. Comparison with asset adequacy testing reserve assumptions.
       i. Explain the consistency regarding actuarial assumptions between the rate proposal and the most recent asset adequacy (reserve) testing.
       ii. Additional reserves that the insurer is holding above Health Insurance ReservesNAIC Model Regulation [#10] formula reserves should be provided, (such as premium deficiency reserves and Li—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) Actuarial Guideline 51 reserves).
    c. Provide actuarial assumptions from original pricing and most recent rate increase proposal and have the original actuarial memorandum available upon request.

11. Provide the following calendar year projections, including totals, for current premium paying nationwide policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate*:
    a. Present value of future benefits (PVFB) under current assumptions
    b. PVFB under prior assumptions [(from prior rate increase filing, or if no prior increase, from original pricing)]
    c. Present value of future premiums (PVFP) under current assumptions
    d. PVFP under prior assumptions [(from prior rate increase filing, or if no prior increase, from original pricing)]

*To emphasize, these projections should include only active nationwide policyholders currently paying premium, and they should not include any policyholders not paying premium, regardless of the reason. Projections under current actuarial assumptions must not include policyholder behavior as a result of the proposed premium rate increase, such as a shock lapse assumption or benefit reduction assumption.
b. Also, please identify the maximum valuation interest rate and ensure that it is the same for all four projections.

12. **NAIC** Guidance Manual *for Rating Aspect of the Long-Term Care Insurance Model Regulation* checklist items: 
   a) summaries (including past rate adjustments); 
   b) average premium; 
   c) distribution of business, including rate increases by state; 
   d) underwriting; 
   e) policy design and margins; 
   f) actuarial assumptions; 
   g) experience data; 
   h) loss ratios; 
   i) rationale for increase; and 
   j) reserve description.

13. Assert that analysis complies with *Actuarial Standards of Practice (ASOPs)*, including 18 & 41.

14. Numerical exhibits should be provided in Microsoft Excel spreadsheets with active formulas maintained, where possible.

15. Rate Comparison Statement of renewal premiums with new business premiums, if applicable.

16. Policyholder notification letter— should be clear and accurate.
   a. Provide a description of options for policyholders in lieu of or to reduce the increase.
   b. If inflation protection is removed or reduced, is accumulated inflation protection vested?
   c. Explain the comparison of value between the rate increase and policyholder options.
   d. Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
   e. How are partnership policies addressed?

17. Actuarial certification and rate stabilization information, as described in the Guidance Manual, and contingent benefit upon lapse information, including reserve treatment.

**Supplemental Information**

As part of the Long-Term Care Insurance (EX) Task Force’s pilot project in 2020–2021, the following supplemental information was identified by the MSA Team as beneficial; and, therefore, the Task Force may be requested to assist in the MSA Review.

1. Benefit utilization:
   a. Provide current, prior rate increase, and original assumptions, including first-projection year through ultimate utilization percentages for 5% compound inflation, lesser inflation, and zero inflation cells.
   b. Explain how benefit utilization assumptions vary by maximum daily benefit.
   c. Provide the cost of care inflation assumption implied in the benefit utilization assumption.

2. Attribution of rate increase
   a. Provide the attribution of rate increase by factor: morbidity, mortality, lapse, investment, and other.
   b. For the morbidity factor, break down the attribution by incidence, claim length, benefit utilization, and other.
c. Provide information on the assumptions that are especially sensitive to small changes in assumptions.

3. **Reduced benefit options (RBOs)**
   a. Provide the history of RBOs offered and accepted for the block.
   b. Provide a reasonableness analysis of the value of each significant type of offered RBO.

4. Investment returns:
   a. Provide original and updated/average investment return assumptions underlying the pricing.
   b. Explain how the updated assumption reflects experience.

5. Expected loss ratio:
   a. With respect to the initial rate filing and each subsequent rate increase filing, provide the target loss ratio.
   b. Provide separate ratios for lifetime premium periods and non-lifetime premium periods and for inflation-protected and non-inflation-protected blocks.

6. **Shock lapse history:**
   a. Provide shock lapse data related to prior rate increases on this block.

7. Waiver of premium handling:
   a. Explain how policies with premiums waived are handled in the exhibits of premiums and incurred claims.
   b. Explain how counting is appropriate (as opposed to double counting or undercounting).

8. **Actual-to-expected differences:**
   a. Explain how differences between actual and expected counts or percentages (in the provided exhibits) are reflected or not reflected in assumptions.

9. **Assumption consistency with the most recent asset adequacy testing:**
   a. Explain the consistency or any significant differences between assumptions underlying the rate increase request/proposal and those included in Actuarial Guideline 51 testing.

**B.C. Appendix C—Actuarial Approach Detail**

**A. Minnesota Approach**

Details on the key aspects of the Minnesota approach to the actuarial review of rate changes include:

1. Review of current assumptions for appropriateness, reasonableness, justification, and support.
   a. A combination of credible company, insurer experience, relevant industry experience, and regulatory professional judgment is applied.

2. If-knew premium and makeup premium aspects — aggregate application.
   a. Makeup percentage:
      i. \[ \frac{[\text{PV (claims)} - \text{PV (past premium)}]}{\text{PV (future premium)}} - 1 \]
ii. Premiums in the formula reflect the actual rate level.

b. If-knew percentage:
   i. \[ \frac{\text{PV (claims)}}{\text{PV (premiums)}} \] / original LLR – 1
   ii. Premiums in the formula are at the original rate level.
   iii. The concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.

c. Definitions and explanations:
   i. PV means present value.
   ii. LLR means lifetime loss ratio.
   iii. Interest rates underlying PVs and LLRs are based on:
      1. For original PVs and LLRs, the interest rate is the investment return assumed in original pricing. Note that this rate is typically different than the statutory LLR discount rate.
      2. For current PVs, the interest rates are the average corporate bond yields over time for each year minus 0.25% (to account for expected defaults). For projections beyond the current year, phasing over five years of the current rate to a target rate (currently 4%) is assumed.
   iv. PV calculations are based on actual, current experience and expectations for persistency, morbidity, and interest rate.
   v. CompanyInsurer provide premium and claim cash flows may be adjusted based on assumption review.
   vi. Makeup percentage is similar to that attained by the loss ratio approach.

3. If-knew premium and makeup premium aspects – sample policy-level verification:
   a. Over a range of issues years, issue ages, benefit periods, and inflation protection:
      i. Calculate an estimate of the original premium.
         1. Based on original pricing assumptions for persistency, morbidity, investment returns, and expenses.
         2. Apply first principles:
            a. For each policy year, calculate PV of claims and expenses, applying mortality, lapse, morbidity, and expenses, discounting at original investment rates.
            b. Add the PV of claims expenses for each policy year to attain PV of claims & expenses at issue.
            c. Divide by the sum of the PV of an annuity of 1 per year.
            d. Multiply \[ \frac{b}{c} \] times \( 1 + \) originally assumed profit percentage to attain the original premium.
            e. This premium provides the basis for comparison against the makeup and if-knew premium.
      3. Replace the original premium with a benchmark premium:
         a. If the benchmark premium is higher than the original premium and original pricing (reflected in mortality, lapse, and investment return assumptions) was out of line with industry-average assumptions at the time of original pricing.
         b. The benchmark premium is phased back into the original premium proportionally over 20 years from issue.
c. The benchmark aspect is intended to prevent example, an insurer underpricing a product, gaining market share, and then immediately requesting a rate increase.

ii. Calculate an estimate of the makeup premium.
   1. Calculate the original dollar PV of profits for the sample policy using original pricing assumptions.
   2. Calculate an updated dollar PV of profits for the sample policy using:
      a. Actual history of premiums and claims.
      b. Expectations of future claims.
      c. “Backed into” makeup premium.
   3. Note that attaining the same dollar PV of profits for a sample policy leads to a lower makeup premium than attaining the same percentage PV of profits (as a percentage of premium).
      a. The reason for targeting the dollar instead of percentage is to avoid the dollar amount of profit being higher as premium rates increase.

iii. Calculate an estimate of the if-knew premium.
   1. The calculation is the same as for the original premium, except it is based on current assumptions instead of original pricing assumptions.
      a. Verifying the impact on expectation changes on rates
         i. While lapse, mortality, and interest rate experience and assumptions are fairly routine to track (for determination of the rate impact), morbidity experience and assumptions tend to be difficult to track.
         ii. A combination of information is relied upon to estimate the impact of morbidity expectation deviations (from original pricing) on rates. This information includes:
             1. Original and current claim incidence and claim length by age and other factors. Incidence and length are tracked separately for some companies and combined for others.
             2. Experience
             3. Impact on LLR of changes in expectations of morbidity.
             4. Industry information and trends (for reasonableness checks).
      c. Assumptions underlying the calculations of estimates of premiums may be adjusted as part of the review. For instance:
         i. If sample policy verification shows less impact on rates due to changes in lapse, mortality, interest rate, and morbidity expectations than demonstrated in the company’s aggregate projections, past or projected premiums or claims may be adjusted in the original, makeup, or if-knew premium calculations.
         ii. If there is wide variance in practice among companies in morbidity assumptions at ages where data is of low credibility, adjustments may be made to help ensure similar situations resulting in similar rate increase approval amounts.
            1. A balanced approach is pursued, recognizing that providing full or zero credit for partially credible experience may result in harmful consequences (excessive rates or later rate shocks).
2. Any reductions to rate increases caused by lack of credible experience can potentially be reversed in subsequent rate increase requests as credibility increases.
   iii. Similar adjustments may apply when incomplete or inconsistent information is provided by the company insurer (after initial attempts to resolve significant differences or gaps).

4. Reconciliation of aggregate and sample policy applications:
   a. In many cases, the aggregate and sample policy applications will result in similar current LLRs.
   b. In other cases, some steps are taken to understand the difference, including additional requests for information.
   c. Because the sample policy application considers information only related to premium-paying policyholders, it is possible that differences between the aggregate and sample policy application are caused by inclusion of past premiums and all claims related to non-premium payers in the aggregate information.
   d. When reconciliation does now occur after rounds of communication, decisions will be made based on the information provided.

5. Blending – same for aggregate and sample policy applications:
   a. The weighting towards the makeup premium is the percentage of original policyholders remaining.
   b. The weighting towards the if-knew premium is the percentage of original policyholders no longer having active policies, or 1 minus the percentage in ii.
   c. The blending of the if-knew premium and makeup premium helps ensure remaining policyholders are not held responsible for paying for adverse experience associated with past policyholders.
   d. The blending also helps limit cumulative rate increases at later durations; as the percentage of remaining policyholders approaches zero, the blended approval amount approaches the if-knew premium.

6. Cost-sharing formula that increases the company insurer burden as cumulative rate increases rise:
   a. The cumulative-since-issue, weighted if-knew / makeup premium-based increase is reduced by:
      i. No haircut for the first 15%;
      ii. 10% for the portion of cumulative rate increase between 15% and 50%;
      iii. 25% for the portion of cumulative rate increase between 50% and 100%;
      iv. 35% for the portion of cumulative rate increase between 100% and 150%;
      v. 50% for the portion of cumulative rate increase in excess of 150%.

7. Reduction for past rate increase:
   a. Take one plus the cost-sharing-adjusted blend amount and divide by one plus the previous, cumulative rate increases, then subtract one. This is the approvable rate increase.

8. Summary
   a. Review current assumptions.
b. Calculate aggregate if-knew premium and makeup premium amounts. Calculate the blended amount.

c. Calculate the sample policy estimated original premium, if-knew premium, and makeup premium. Calculate the blended amount.

d. Reconcile aggregate and sample policy blended amounts. Set this blended amount aside.

e. Apply the cost-sharing formula to the blended amount.

f. Deduct past rate increases.

g. Example – if:

i. The original premium is $1,000

ii. Makeup premium is $3,000

iii. If-knew premium is $1,500

iv. 60% of policyholders remain

v. Past rate increases are 50%

vi. Blended amount is:

1. $3,000 / $1,000 * 0.60 +
2. $1,500 / $1,000 * 0.40
3. − 1 =
4. 180% + 60% − 1 = 240% − 1 = 140%

vii. Cost sharing is:

1. 100% * 0.15 +
2. 90% * 0.35 +
3. 75% * 0.5 +
4. 65% * 0.4 =
5. 110%

viii. Deduction for past rate increases results in:

1. (1 + 1.1) / (1 + .50) − 1 =
2. 40%

**Texas PPV Formula**

Details on the PPV Formula of the Texas approach to the actuarial review of rate changes include the following. To reiterate, the formula is limited to active, premium-paying policyholders.

For rate stabilized policies:

\[
\text{rate increase } \% = \frac{\Delta PV (\text{future incurred claims}) - \left(\frac{.85 + .85C}{1 + C}\right) \Delta PV (\text{future earned premiums})}{.85 PV_{\text{current}} (\text{future earned premiums})}
\]

Where:
\[ \Delta \text{ indicates the change in PV due to the change in actuarial assumptions between the time of the last rate increase (or original pricing if no prior rate increase) and the current assumptions.} \]

\[ C \text{ is the cumulative % rate increase to date. For example, if the current rate (prior to the proposed rate increase) is 50% higher than the rate at initial pricing, then } C = 0.5. \]

The current subscript in the denominator indicates that the PV should be computed using current assumptions. The future earned premiums in the formula are based on the current premiums prior to the proposed rate increase. (State insurance regulators may wish to consider the addition of margin to the rate increase. For example, the } \Delta PV(\text{future incurred claims}) \text{ term in the above formula could be multiplied by } (1 + \text{margin}).)

For pre-rate stabilized policies, we use 0.6 in place of 0.58 and 0.8 in place of 0.85:

\[ \text{rate increase } \% = \frac{\Delta PV(\text{future incurred claims}) - (0.6 + 0.8C)\Delta PV(\text{future earned premiums})}{0.8 PV_{\text{current}}(\text{future earned premiums})} \]

Prior to the time that Texas adopted the PPV approach, a past requested rate increase may have been reduced by the state insurance regulator by a method other than the PPV approach. In this situation, for a current filing, the state insurance regulator may make adjustments to the current approvable amount based on what would have been approved had PPV been used in the prior filing.

**C.D. Appendix D—Principles of RBOs Associated with LTCI Rate Increases**

In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup (“LTCI_RBO_(EX)_Subgroup”) of the Long-Term Care Insurance (EX) Task Force, was charged to “Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.” In completing this charge, the Subgroup developed the following list of RBO principles to provide guidance for evaluating RBO offerings.

**A. Principles and Issues**

As related to:

1. Fairness and equity for policyholders who elect an RBO:
   - If some policyholders facing a rate increase are being offered an RBO but not others, an adequate explanation is needed.
   - Each RBO should provide reasonable value relative to the default option of accepting the rate increase and maintaining the current benefit level.

2. Fairness and equity for policyholders who choose to accept rate increases and continue LTCI coverage at their current benefit level:
The extent of potential anti-selection should be analyzed, with consideration of the impact on the financial stability of the remaining block of business and the resulting effect on the remaining policyholders.

3. Clarity of communication with policyholders eligible for an RBO:
   - Policyholders should be provided with maximum opportunity and adequate information to make decisions in their best interest.
   - Companies should present RBOs in clear and simple language, format and content, with clear instructions on how to proceed and whom to contact for assistance.

4. Consideration of encouragement or requirement for an companyinsurer to offer certain RBOs:
   - State insurance regulators should evaluate legal constraints, the impact on remaining policyholders and companyinsurer finances, and the impact on Medicaid budgets if encouraging or requiring reduced LTCI benefits.

5. Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible:
   - Regulators and interested parties should continue to study the idea of offerings being made by insurers including potentially being tied to rate increases, [e.g., providing hand railings for fall prevention in high-risk homes], and identifying the pros and cons of such an approach.

B. Widely Established RBOs in Lieu of Rate Increases

1. Reduce inflation protection going forward, while preserving accumulated inflation protection.
2. Reduce daily benefit.
3. Decrease benefit period/maximum benefit pool.
4. Increase elimination period.
5. Contingent nonforfeiture (CNE).
   i. Claim amount can be the sum of past premiums paid.
   ii. Only receive that benefit if the policyholder qualifies for a claim.

C. Less Common RBOs for Potential Discussion

1. Cash buyout.
2. Copay percentage on benefits.

As the industry continues to innovate new RBOs for consumers, such as the two listed above, the MSA Review process will likewise develop and evolve to consider the reasonableness of these RBOs. The LTCI (EX)-Task Force will encourage its appointed Subgroup or an appropriate NAIC actuarial committee or group, to collectively consider new RBOs, as they arise, that provides for input and technical advice from actuaries to states as they exercise their authority in considering RBOs as part of rate filings.

D.E. Appendix E—Guiding Principles on LTCI RBOs Presented in Policyholder Notification Materials
In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force LT C RBO (EX) Subgroup of the LT C (EX) Task Force adopted the following guiding principles to ensure quality of consumer notices of rate increases and RBOs. This section seeks to provide guiding principles in answering this question: “What are the recommendations for ensuring long-term care insurance policyholders have maximized opportunity to make reduced benefit decisions that are in their best interest?”

To complete the charge, the LT C RBO (EX) SS Subgroup 1) evaluated the quality of consumer notices and RBO materials presented to policyholders; 2) considered the relevant lessons learned and consumer focus group studies from the liquidation of LT C insurer Penn Treaty Network of America; 3) reviewed existing RBO consumer notice checklists or principles from multiple states (i.e., Nebraska, Pennsylvania, Texas and Vermont); and 4) addressed stakeholder comments on RBO principles.

This document is intended to establish consistent high-level guiding principles for long-term care insurance reduced benefit options - LT C RBOs presented in policyholder notification materials. These principles are guidance and do not carry the weight of law or impose any legal liability.

Recognizing that each component outlined in these principles will not apply in all circumstances, this section:

- RECOMMENDS that insurance companies recognize these fundamental principles.
- CALLS ON all insurance companies to consider the following principles in communicating reduced benefit option RBOs available to consumers in the event of a rate increase.
- UNDERLINES that the following principles are complementary and should be considered as a whole.

### Filing Rate Action Letters

Insurers should consider:

- Sending rate actions after the state has approved the rate action filing.
- Making the rate action effective on a policy anniversary date, recognizing that the Long-Term Care Insurance Model Regulation (R641) allows for the next anniversary date or next billing date.
- Mailing rate increase notification letters at least 45 days prior to the date(s) a rate action becomes effective, consistent with any applicable state laws and/or regulations.
- Sending rate increase notifications each year for rate increases that are phased-in over multiple years.
- Disclosing all associated future planned rate increases approved by state insurance regulators in the initial and phased-in rate increase notification letters.
- Filing rate action letter templates in the NAIC System for Electronic Rate and Form Filing (SERFF) rate increase filing to include statements of variability and sample letters highlighting the differences between the communications, consistent with any applicable state laws and/or regulations.
- Presenting innovative options to state insurance regulators prior to filing new reduced benefit option RBOs.
  - This enables state insurance regulators to evaluate potential anti-selection, adverse morbidity, and implications to consumers and future claims experience.
Readability and Accessibility

Insurers should consider:

- Drafting a rate action letter that is easy to follow, flows logically, and displays the essential information and/or the primary action first, followed by the nonessential information.
- Presenting the reduced benefit option RBOs in a way that is comprehensible, memorable, and adjusted to the needs of the audience.
- Using cover pages, a table of contents, glossaries, plain language, headers, maximized white space, and appropriate font size and reading level for the intended audience.
- Using illustrative tools, such as bullet points or illustrations, as appropriate, and graphs or charts enabling a side-by-side comparison.
- Including definitions of complex terms; and if a term, subject, or warning is repeated throughout the communication, consider making the language consistent throughout the document.
- Including a question and answer Q&A section that is succinct but answers the commonly asked questions in plain language.
- Providing appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language.

Identification

Insurers should consider drafting the RBO communication in a way that helps policyholders understand:

- What is happening.2
- Why is it happening to them.2
  - Ensure the letter does not negatively reference the state insurance department.
- When it is happening.2
- What they can do about it.2
- How do they take action.2

Communication Touch and Tone

Insurers should consider:

- Drafting the communication in a way that helps policyholders envision or reflect on the reason(s) why they purchased a long-term care insurance LTCI policy.
- Conveying as much empathy as possible regarding the impact a rate action(s) may have on policyholders.
- Presenting reduced benefit option RBOs fairly, refraining from the use of bolding, repeating or emphasizing one option over another.
- Displaying the policyholder’s ability to maintain current benefits by paying the increased premium.
- Using word choices that appreciate how those words could influence a policyholder’s decision.
  - For instance, consider using “now” instead of “must”; or consider using “mitigation options,” “offset premium impact” or “manage an increase” instead of “avoid an increase.”
Consultation and Contact Information

The insurer should consider listing multiple contacts in the communication in an easy-to-identify location to include when available: phone number, email address, and website when available. For example:

- Customer service.
- Lapse notifier.
- Insurance producer.
- State insurance department.
- State Health Insurance Assistance Program (SHIP).

The insurer should consider suggesting policyholders consult a family member or other trusted advisor, such as:

- Lapse notifier.
- Insurance producer.
- Financial advisor.
- Certified personal accountant or tax advisor (in the event cash buyouts are offered).

Understanding Policy Options

Insurers should consider the presentation of the communication by:

- Identifying what necessitated the communication on the first page.
  - For example, the header could say, “Your Long-Term Care Premiums Are Increasing.”
- Including the reduced benefit option RBOs with the rate action letter.
- Limiting the number of options displayed on the letter to no more than four or five.
- Identifying which reduced benefit option RBO(s) have limited time frames.
- Advising policyholders that they can ask about reducing their benefits at any time, regardless of a rate increase.
- Providing enough information in the communication to make a decision.
  - If supplemental materials (e.g., insurer’s website) are provided, they would enhance the policyholder’s understanding, but not be necessary to use when making a decision.

Insurers should consider indicating the window of time to act by:

- Clearly indicating what the policyholder’s premium will increase to and by when.
- Displaying the due date(s) in an easy-to-identify location and repeating it multiple times throughout the document.
- Clearly differentiating due date(s) for each RBO, if available for a limited time.

Insurers should consider including disclosures regarding rate increase history by:

- Disclosing that future rate actions could occur.
- Advising if prior rate actions have or have not occurred to include:
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- Policy form(s) impacted.
- Calendar year(s) the policy form(s) was available for purchase.
- Percentage of increase approved to include the minimum and maximum, if they vary by benefit type.
- Reminding policyholders that their policy is guaranteed renewable.

Insurers should consider advising policyholders of their current benefits:

- For example, the communication could disclose the policyholder’s current benefits to include:
  - Daily maximum amount.
  - Inflation option.
  - Current pool of benefits for policies with a limited pool of benefits.

Insurers should consider personal needs decision-making by:

- Only listing reduced benefit option RBOs that are available to the policyholder.
- Calling on policyholders to reflect on how each option could impact them personally.
- Prompting policyholders to consider their unique situation to include their current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and the potential need for institutionalized care.
- Reminding policyholders to consider the cost of care in the area and setting where they expect to receive care.
- Informing policyholders of factors that impact long-term care LTC costs, such as:
  - The average cost of care for in-home care, assisted living, and nursing home care in their area.
  - The inflation rate of the cost of care for in-home and nursing home care in their area.
  - The average age and duration of a long-term care LTC claim for in-home and nursing home care.
  - Factors that influence the age, duration, and cost of a claim.
- Disclosing to policyholders when an RBO falls below the cost of care in their area.
- Calculating for policyholders the number of days or months a paid-up option could cover based on the cost of care in their area.
  - Buyout or cash-out disclosures.
    - The cash offerings, if any, should disclose to policyholders that the option could result in a taxable event, and they should consult with their certified personal accountant and/or tax advisor before electing this option.

Insurers should consider the value of each option by:

- Disclosing if the RBOs may not be of equal value and are dependent on the unique situation of each policyholder.

Insurers should consider communicating the impact of options by:

- Displaying the options in a way that enables policyholders to compare options, including details such as:
  - Daily/monthly benefit.
• Benefit period.
• Inflation option.
• Maximum lifetime amount.
• Premium increase percentage and/or new premium.
• Nonforfeiture (NFO) or contingent nonforfeiture (CNF) amount.
• If the policy is Partnership qualified, changes to benefits may impact Partnership status.
• Current premium.

• Providing a series of questions to help policyholders contemplate the implications of each action, such as:
  
  o What will happen if they take no action?
  o What will happen if they make no payment before the policy anniversary date?
  o If they accept the full increase without reducing their benefits, how will they handle potential future rate increases?
  o If they elect the cash buyout, there could be tax implications.
  o If they elect a paid-up nonforfeiture option NFO, how long will the reduced benefit last if they had a claim?
  o If they were to increase their elimination period from 30 days to 100 days, do they have enough funds to cover those expenses?
  o Partnership policies: Will reducing the benefits remove Partnership qualification? If so, the letter should explain that their asset protection may be removed or reduced.

When rate actions span over multiple years, insurers should consider:

• Disclosing the full rate increase amount, how it is spread out across multiple years, and all associated future planned rate increases approved by state insurance regulators.
• Specifying if the premium increase referenced is the first, second, third, last, etc.
• Offering contingent nonforfeiture CNF based on the full increase amount and offered with each phase of the rate action.
• Notifying policyholders at least 45 days in advance of each phase of the rate increase, consistent with any applicable state laws and/or regulations.
VII. EXHIBITS

A. EXHIBIT A—SAMPLE MSA ADVISORY REPORT

FROM: Long-Term Care Insurance (LTCI) Multistate Actuarial Rate Review Team
DATE: [Date]
RE: ABC Insurance Company – Block LTC1 – Draft of Initial MSA Advisory Report

Executive Summary

The LTCI Multistate Actuarial Rate Review Team (MSA Team) recommends a rate increase of 35% to be approved for inflation-protected products and 20% to be approved for products with no inflation, related to ABC Company’s block.

Higher rate increases are recommended for states where past cumulative rate increases below 55% have been approved. Reduced benefit options (RBOs) may be selected to help manage the impact of the rate increase.

Analysis by the MSA Team resulted in the recommended rate increase being consistent with that resulting from the actuarially justified Texas and Minnesota approaches. The recommended rate increases are below the increases that would have resulted from the lifetime loss ratio approach and the rate stability rules.

Background

The MSA Team was formed to assist the Long-Term Care Insurance (EX) Task Force in developing a consistent national approach for reviewing LTCI rates, which results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.

The members are: [List names and state of members]. Starting in the first half of 2020, the MSA Team accepted rate increase [insert proposal submitting date as part of a pilot program]. The MSA Review became operational on [insert date].

This MSA Advisory Report is related to the rate increase [insert proposal submitting date] filed by ABC Company for its LTC 1 block sold between 2003 and 2006. The MSA Team’s actuarial analysis is provided below. The intention is that states can utilize this analysis and feel comfortable accepting the MSA Advisory Report recommendation when taking action on the upcoming ABC filings that will be made to the states.

MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer. As this is a state-approved product, each state will ultimately be responsible for approving, partially approving, or disapproving the rate increase. A goal

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8 Information contained in this sample report is an example only and is not derived from any actual rate filing.
of the Task Force is for as much consistency as possible to occur between states in the rate increase approvals.

Insurer’s Request Proposal

ABC Company requests a rate increase of 60% to be approved for inflation-protected products and 40% to be approved for products with no inflation.

In addition, ABC Company is requesting higher rate increases for states that did not grant full approval of prior rate increase requests, consistent with the MSA Team’s goal of attaining the same resulting rate tables in each state for a given product. [Staff87][DG88]

Workstream-Related Review Aspects

Actuarial Review

At the direction of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, the MSA Team applied the Minnesota and Texas approaches to calculate the recommended, approvable rate increases. Aspects of the Minnesota approach that result in lower rate increases than those resulting from loss ratio-based approaches contained in many states’ laws and rules include:

- Reduction in rate increases at later policy durations to address shrinking block issues.
- Elimination of rate increases related to inappropriate recovery of past losses.

Minnesota also has additional unique aspects: 1) consideration of adverse investment expectations related to the decline in market interest rates, 2) adjustments to projected costs to ensure the impact of uncertainty is adequately borne by the insurer; and 3) a cost-sharing formula applied in typical circumstances.

Even though these additional aspects are outside the pure loss-ratio requirements, they fall in line with legal provisions that rates shall be fair, reasonable, and not misleading.

The Minnesota approach, including application of the typical-circumstance cost-sharing formula, results in an approvable rate increase of 35% for inflation-protected products and 20% for products with no inflation protection.

The Texas approach results in an approvable rate increase of 29% in aggregate.

The MSA Team’s recommendation, in consideration of the Minnesota and Texas approaches, is to approve a rate increase of 35% for inflation-protected products and 20% for products with no inflation protection.

Higher rate increases are recommended for states where past cumulative rate increases below 55% have been approved.

The MSA Team reviewed support for the assumptions, experience, and projections provided by the insurer and performed validation steps to review the insurer-provided information for reasonableness. Details regarding the actuarial review are provided in Appendix 1. Also, the initial submission and subsequent
correspondence between the insurer and the MSA Team are available on SERFF. The SERFF tracking number is ABCC-123456789.

**Consideration of Differences in Histories of States’ Rate Increase Approvals**

According to the Historical Rate Level Summary, Appendix D in the insurer’s filing, past rate increase approvals by state have varied and can be categorized as follows:

- 25 states have granted full or near-full approval of ABC Company’s past requests (at or near 55%, cumulative).
- 18 states have granted cumulative approvals averaging 45%.
- Five states have granted cumulative approvals averaging 27%.
- Two states have granted cumulative approvals averaging 15%.

The insurer’s stated goal is to bring rates in all states up to an equivalent rate level. Currently, the average annual premium rates for a policyholder range from below $1,700 in some states (with the lowest past approvals) to over $2,200 in other states (with the highest past approvals).

The MSA Team’s recommendation is based on a goal of rates per benefit unit being uniform between states going forward.

A table of examples of recommended rate increases based on past cumulative approval history is provided in Appendix 2.

**Non-actuarial & Valuation/Solvency Considerations**

Non-actuarial considerations, including flexibility regarding the phase-in of rate increases, waiting periods between rate increases being coordinated with phase-in periods, and other issues are being discussed at the Task Force and the Subgroup.

Even with future claims potentially being reduced due to COVID-19-related behavioral impact, ABC Company will continue to experience substantial losses on this block.

Regarding coordination of rate and reserving reviews, the insurer states that assumptions underlying the rate increase are consistent with assumptions underlying the reserve adequacy testing.

**RBOs – Review for Reasonableness**

Unless a rider was purchased, ABC Company policyholders facing a rate increase will be offered the following applicable options in lieu of a rate increase:

1) Extending the elimination period.
2) Decreasing the benefit period.
3) Reducing future inflation accumulation.

The insurer produced rate tables which demonstrate that the RBOs provide reasonable value in relation to a case of a policyholder retaining full benefits and paying the full rate increase.
Financial Impact for Insurer
The requested rate increase associated with recent adverse development would result in around $50 million of reduced losses for this block according to information contained in the actuarial memorandum.

Mix of Business

From the insurer’s actuarial memorandum:

Enrollees:
- Total enrollees as of date of proposal filing: 15,000
- Inflation protection: 9,000 (inflation protection) and 6,000 (no inflation)
- Benefit period: 8,500 (lifetime benefits) and 6,500 (limited benefits)

Product type: Expense reimbursement
- Average issue age: 58
- Average attained age: 75
- Annualized premium: $30 million; $2,000 average per policyholder

Appendix 1

Drivers of Rate Increase RequestProposal – Summary

The primary drivers, summarized in the insurer actuarial memorandum, were lower lapses and longer average claim length. The insurer assumptions were based on actual-to-expected adjustments, based in part by insurer experience that has become more credible in recent years. The assumptions were determined to be reasonable and in line with industry and actuarial averages.

Details Regarding Minnesota Approach

For an average (in terms of benefit period and issue age), 5% compound inflation-protected cell:
- Makeup cumulative rate increase: 177% (the increase from original rates needed going forward to get the block to the financial position contemplated at original pricing)
- This increase is equal to the increase that would result from a pure loss ratio approach.
- If-knew cumulative rate increase: 36% (the increase from original rates needed if the insurer could go back to the past and reprice the product given information it knows now)
- Proportion of original policyholders remaining in force, based on insurer original and updated assumptions: 62%
- Blended if-knew / makeup rate cumulative rate increase since issue: 123%
- $ = 0.62 * 177% + (1 - 0.62) * 36%, adjusted for rounding
- Insurer cost share based on Minnesota formula (see Appendix 3): 12%
- Recommended cumulative rate increase since issue: 109%
- $ = (1 - 0.12) * 1.23, adjusted for rounding
- Past cumulative rate increases: 55%
- Actuarial recommended rate increase from current rates: 35%
- $ = (1 + 1.09) / (1 + 0.55) – 1, adjusted for rounding
- Final actuarial recommended rate increase from current rates (for the inflation-protected cell):
  - 35%
  - Minimum of: calculated approval rate of 35% and insurer request proposal of 60%
- Using the same methodology, the final actuarial recommended rate increase from current rates (for the non-inflation-protected cell): 20%

Note that the Minnesota approach includes the reflection of declining interest rates which tends to lead to adverse investment returns compared to expectations in original pricing. Also, where applicable, insurer morbidity assumptions are adjusted downward due to a lack of credible support at extremely high ages, and a general lack of complete support for aspects of morbidity assumptions, including uncertainty regarding future benefit utilization.

Details Regarding Texas Approach
- Insurer Calculation (aggregate): 52%

PPV calculations
- Texas Life & Health Actuarial Office (LHAO) PPV Calculation (aggregate): 29%

LHAO Comments
- For the purposes of the MSA report, and as a component of the calculation of the approvable rate increase, Texas recommends an actuarially justified PPV calculated amount of 29%.

Texas rate stabilized PPV Formula:

\[
\text{rate increase } \% = \frac{\Delta PV(future \ incurred \ claims) - (\frac{.58 + .85 \ C}{1+C}) \Delta PV(future \ earned \ premiums)}{.85 PV(current \ future \ earned \ premiums)}
\]

Reconciliation of Minnesota and Texas Approaches

The Texas PPV calculated amount of 29% aligns well with the Minnesota approach’s recommended rate increase of 35% for inflation-protected policies and 20% for non-inflation-protected policies when the distribution of inflation-protected vs. non-inflation-protected cells is applied. The MSA Team’s recommended rate increase is 35% for inflation-protected policies and 20% for non-inflation-protected policies.

Recommended rate increases by state, in consideration of various histories of rate increase approvals, are listed in Appendix 2.

Filings—Correspondence Summary
- Template information request for multi-state rate increase filings, based on the list adopted by the Health Actuarial (B) Task Force on March 23, 2018.
- New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
- Rate increase history that reflects the filed increase.
• Actuarial Memorandum justifying the new rate schedule, which includes:
  o Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
  o Reasons for the rate increase, including which pricing assumptions were not realized and why.
  o Statement that policy design, underwriting, and claims handling practices were considered.
  o A demonstration that actual and projected costs exceed anticipated costs and the margin.
  o The method and assumptions used in determining projected values should be reviewed in light of reported experience and compared to the original pricing assumptions and current assumptions.
  o Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
    ▪ Comparison with asset adequacy testing reserve assumptions.
    ▪ Provide actuarial assumptions from original pricing and most recent rate increase filing, and have the original actuarial memorandum available upon request.
  o Guidance Manual Checklist items: summaries, including past rate adjustments; average premium; distribution of business, including rate increases by state; underwriting; policy design and margins; actuarial assumptions; experience data; loss ratios; rationale for increase; and reserve description.
  o Assert that analysis complies with Actuarial Standards of Practice, including No. 18 and No. 41.
  o Numerical exhibits should be provided in Microsoft Excel spreadsheets with active formulas maintained, where possible.

• Rate Comparison Statement of renewal premiums with new business premiums, if applicable.

• Policyholder notification letter – should be clear and accurate.
  o Provide a description of options for policyholders in lieu of or to reduce the increase.
  o If inflation protection is removed or reduced, is accumulated inflation protection vested?
  o Explain the comparison of value between the rate increase and policyholder options.
  o Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
  o How are partnership policies addressed?

• Supplementary information, based on a list developed by the MSA Team following the review of initial pilot program filings/proposals:
  o Information on benefit utilization.
  o Attribution of rate increase by factor.
  o RBO history and reasonability analysis.
  o Investment returns.
  o Expected loss ratio.
  o Shock lapse history.
  o Waiver of premium handling.
  o Actual-to-expected differences.
  o Assumption consistency with Actuarial Guideline 51 asset adequacy testing.
Following initial review of the filing proposal, additional information was requested by the MSA Team related to:
- Original pricing assumptions.
- Lapse assumption by duration.
- Premiums and incurred claims by calendar year based on original assumptions.
- Distribution of in force by inflation protection.
- Loss ratios by lifetime/non-lifetime benefit period and with/without inflation protection.
- Description of waiver of premium handling in premium and claim projections.
- Commentary on COVID-19 short-term and long-term LTC impact.

Appendix 2 [Staff93][DG92]

Examples of Rate Increases If an RBO is Not Selected

<table>
<thead>
<tr>
<th>Jurisdiction Example*</th>
<th>Past Cumulative Approved Increases</th>
<th>Increase to catch up</th>
<th>Recommended New</th>
<th>2021 Recommended Rate Incr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: state with average past approvals</td>
<td>55%</td>
<td>0%</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Example: state with lower than average past approvals</td>
<td>27%</td>
<td>22%</td>
<td>35%</td>
<td>65%</td>
</tr>
</tbody>
</table>

*The recommendation for each state is based on the actual past cumulative approved increases in that state.

Appendix 3 [Staff93][DG94]

Potential Cost Sharing Formula for Typical Circumstance

Cumulative rate increase since issue date is haircut by:
- No haircut for the first 15%.
- 10% for the portion of cumulative rate increase between 15% and 50%.
- 25% for the portion of cumulative rate increase between 50% and 100%.
- 35% for the portion of cumulative rate increase between 100% and 150%.
- 50% for the portion of cumulative rate increase in excess of 150%.

Example: if the Texas approach of pre-cost sharing Minnesota approach results in a cumulative 210% rate increase since issue:
- Break 210% into the following components: 15%, 35%, 50%, 50%, 60%
• Post haircut approval is 100% of 15% + 90% of 35% + 75% of 50% + 65% of 50% + 50% of 60%
  • = 15% + 32% + 38% + 33% + 30%
  • = 147%

Legal justification for the cost-sharing formula is that the insurer should have had more information about the possibility of triple-digit rate increases than the consumer had.

Adjustments to the formula may be desired when an insurer’s solvency position is dependent on a certain level of rate increase approval. That is not the case with this insurer or filing proposal.
The Long-Term Care Insurance Multistate Rate Review (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Sept. 28, 2021. The following Subgroup members participated: Michael Conway, Chair (CO); Paul Lombardo (CT); David Altmaier (FL); Andria Seip (IA); Stephen Chamblee (IN); Stewart Guerin (LA); Karen Dennis (MI); Fred Andersen (MN); Russel Toal (NM); Jessica K. Altman (PA); Matt Gendron (RI); Michael Wise (SC); Barbara Snyder (TX); Tomasz Serbinowski (UT); Bob Grissom (VA); Anna Van Fleet (VT); Lichiou Lee (WA); and Joylynn Fix (WV). Also participating was: Barbara D. Richardson (NV).

1. Discussed Comments on an MSA Framework Draft

Mr. Conway said the purpose of today’s meeting is to review the changes that have been made to the Actuarial sections of the draft Long-Term Care Insurance (LTCI) Multi-State Rate Review Framework (MSA Framework) in response to the comments received from their first exposure. He said the Actuarial sections have been exposed for a second public comment period ending Oct. 28.

Mr. Andersen gave a summary of the changes to the Actuarial sections of the draft MSA Framework, using a marked-up version of the draft (Attachment Two-A) and a summary of received comments (Attachment Two-B) as references. He said comments were received from the Washington State Office of the Insurance Commissioner, the Vermont Department of Financial Regulation (DFR), the American Academy of Actuaries (Academy), the American Council of Life Insurers (ACLI) and the America’s Health Insurance Plans (AHIP), and FinancialMedic LLC.

Mr. Conway said several comments were received requesting more specificity on how the Multistate Actuarial LTCI Rate Review Team (MSA Team) will apply either the Minnesota or Texas approach and other technical details of the process. He said the MSA Framework is intended to be a framework for the MSA Team’s rate review process, and it will not include every detail of every aspect the MSA Team will consider as it conducts its reviews. He said the MSA Team will apply actuarial judgement in its reviews that is not able to be captured in its entirety in the MSA Framework.

Mr. Conway said the MSA Framework is intended to be a tool for states to use in determining the rate increase each state will ultimately approve, and each state will reserve the right to make a rate increase decision that is not the one recommended in any given MSA Team Advisory Report. He said he hopes the MSA Team Advisory Reports can be used by states to arrive at rate increase approval determinations more expeditiously.

Ms. Richardson asked whether the MSA Team considers the number of policyholders in each state when making its recommendations. Mr. Andersen said this is a non-actuarial issue, and the MSA Team strives to achieve rate equity among all states, irrespective of the number of policyholders in a given state.

Mr. Toal said he supports the concept of rate equity among policyholders in different states. He said this also needs to be balanced with the concepts of reasonableness and affordability. He said rate increases of 150% to 200% are not affordable to policyholders in New Mexico, and the issues of reasonableness and affordability need to be part of the MSA Framework’s review process. Mr. Conway said these concerns fall into the non-actuarial considerations category, and he agreed that these issues need to be discussed. Mr. Andersen said the Minnesota method attempts to address reasonableness in that it produces rate increase recommendations lower than those using a loss ratio approach. He said it is important to note that even in light of large rate increases, given the expected increase in claims costs, reasonableness is part of the review process.

Jan Graeber (American Council of Life Insurers—ACLI) said there could be more clarity on how the Minnesota and Texas rate review methodologies will be applied, such as commentary on which methodology better addresses issues such as small remaining blocks of policies and other high-level issues. She suggested that a walk-through of the MSA review process using a sample rate increase filing may be helpful. Mr. Andersen said the MSA Team has researched including more clarity as requested, but it has found that the differences in filings make stating which methodology is preferred for various categories difficult. He said the MSA Team will continue to research these issues. Mr. Lombardo said the MSA Team has not reviewed...
many filings at this point, and he noted that the MSA Framework will be updated as needed as more filings have been reviewed. He said at this time, the MSA Team does not have enough information to provide the level of detail that Ms. Graeber requested.

Ms. Graeber suggested that the Long-Term Care Pricing (B) Subgroup revisit its document that outlines the Minnesota and Texas methodologies and determine if it can be used to add clarity to the MSA Framework. Mr. Andersen said he agrees with this approach, and he suggested developing some case studies to apply the MSA Framework process to. Mr. Conway said any methodology used in the MSA Framework will be required to produce an actuarially justified result.

Birny Birnbaum (Center for Economic Justice—CEJ) said there is no requirement that insurers return excess premiums collected if experience proves to be better than expected. He said he considers this to be a violation of the principle of reasonableness. He said for the MSA Framework process to be transparent, MSA Team Advisory Reports need to be made publicly available. Mr. Conway said the level of detail for each report that is publicly available will be dependent on a given state’s confidentiality requirements.

Mr. Conway said the Operational sections of the MSA Framework have been exposed for a second public comment period, and comments are due Oct. 11. He said after the Oct. 28 comment deadline for Actuarial sections, the Subgroup will meet to discuss comments received on both the Actuarial and Operational sections. He said the Subgroup’s ultimate goal is to adopt the final version of the MSA Framework prior to the Fall National Meeting, where it will be presented to the Long-Term Care Insurance (EX) Task Force for its consideration.

Having no further business, the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup adjourned.
LONG-TERM CARE INSURANCE
MULTI-STATE
RATE REVIEW FRAMEWORK

Drafted by the
Ad Hoc Drafting Group1 of the
NAIC Long-Term Care Insurance (EX) Task Force

1 The Ad Hoc Drafting Group consists of representatives from state insurance departments in Minnesota, Nebraska, Texas, Virginia, and Washington
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V. ACTUARIAL REVIEW

A. MSA Team’s Actuarial Review Considerations

In conducting its actuarial review of a rate proposal, the MSA Team will consider assumptions, projections and other information provided by the insurer as outlined in Appendix B. The MSA actuarial review process will be evaluated and evolve over time as more proposals are reviewed.

The Minnesota and Texas approaches ensure remaining policyholders do not make up for losses associated with past policyholders. Professional judgment is used to address agreed upon policy issues, including handling of incomplete or non-fully credible data. The Minnesota approach also considers adverse investment expectations related to the decline in market interest rates, and a cost-sharing formula is applied. The Texas approach ensures rate changes reflect prospective changes in expectations. More detail of each approach is provided in the following sections.

The MSA Team will consider the following in performing their review, applying their expertise and professional judgement to the review as well as reviewing the actuarial formulas and results.

- Review company insurer experience, company insurer narrative explanation, and relevant industry studies.
- Assess reasonability of assumptions for lapse, mortality, morbidity, and interest rates.
- Validate and adjust or request new projections of claim costs and premiums by year.
  - Validate that the patterns of claims and premium projections over time match reasonably align those reflected in the assumptions.
  - Adjust or request new projections of claims and premium to the extent any underlying assumptions are deemed unreasonable or unsupported by the MSA Team. Any differences will initially result in correspondence between MSA Team and insurer, via SERFF.
  - After verifying loss ratio compliance, apply both the Minnesota and Texas approaches for each rate proposal submitted.

which ensure remaining policyholders do not make up for losses associated with past policyholders.

In developing a recommendation, the MSA Team will apply a balanced approach and professional judgement for each rate proposal based on the characteristics of the block reviewed to determine the method most appropriate. The MSA Team’s recommendation will not be the lowest or the highest percentage method just because it is the lowest or the highest. Rather, the recommendation may be the result of either the Texas or Minnesota approach, a blend of the two approaches, or using professional judgement the MSA Team may recommend a rate increase outside of these two approaches. Other methods may evolve over time that may be incorporated into the future process that generate similar or unique results. In developing a recommendation, the MSA Team will apply regulatory actuarial professional judgement, for instance when considering, the extent to which less-than-fully credible older-age morbidity should be projected to cause adverse experience. a balanced approach is applied as opposed to denying a rate increase, which could lead to a spike in the future, or approving the rate increase as if there was full credibility, leading to rates that could be too high.
The MSA Team will consider how to reflect the differences in the histories of states’ rate increase approvals. Current approach includes:

- The MSA Team’s recommendation results in the same rate per unit in each state following the current rate increase round (leading to higher percentage rate increases in states that approved lower rate increases in the past).
- Analysis will continue on state cost differences impacting justifiable rate increases. As of May 2021, there does not appear to be substantial evidence that policyholders who purchased policies in lower-cost states should receive lower percentage rate increases. Part of the reason is that there was a tendency for people in lower-cost areas to purchase less coverage. Their premium rates will continue to be lower than rates for policyholders with more coverage, even if percentage rate increases are the same.
- Any recommendation from the MSA Team for a catch-up increase aims to achieve only current rate equity between states and not lifetime rate equity between states.

Consideration of Solvency Concerns:

If concerns exist regarding an insurer’s financial solvency and the impact of rate increases on future solvency, each state department of insurance, by their authority over rate approval, has the flexibility to consider solvency adjustments in these rare instances. In rare, non-typical circumstances, adjustments could be considered within the MSA Review process, including consultation with states as part of the MSA Advisory Report comment period.

Follow-Up Filings on the Same Block:

Any subsequent rate increase proposal to the MSA Team on a block of business previously reviewed by the MSA Team needs to involve development of adverse experience and/or expectations. In the absence of adverse experience or expectation development, the MSA Team will consider a reasonable explanation from an insurer for an increase in credibility of morbidity data of being the reason for a rate increase. Prior rate increases would need to be implemented before implementation of a subsequent rate increase. The MSA Team will not consider a new rate increase request on a block that did not receive the full percentage rate increase requested without the experience, expectation, or credibility criteria noted above. If an insurer did not receive the full percentage rate increase and has no adverse changes in experience or expectations, the insurer should work directly with the applicable state department of insurance.

B. Loss Ratio Approach

Key aspects of the loss ratio approach to the actuarial review of rate changes include:

1. At policy issuance, pricing based on a lifetime loss-ratio target is typically established. A common target is 60%, which means the present value of claims is targeted to equal 60% of the present value of premiums. In some instances, products may be priced with a projected lifetime loss ratio in excess of 60%. The remainder goes towards sales-related costs, administrative expenses, expenses related to claims, and profit. Note that 60% is a required minimum loss ratio under the pre-rate stability rules; newer policies may be priced with lower expected loss ratios. Refer to state law or regulation modeled from the Long-term Care Insurance Model Regulation (#641), Section 19 for more details on compliance with loss ratio standards.
2. As lapses and mortality have generally been lower than expected, more people have reached ages where claims tend to occur than originally expected. In some cases, this has resulted in a substantial increase in the present value of claims; thus, resulting in substantially higher expected lifetime loss ratios than originally targeted. For companies where morbidity expectations have increased over original assumptions, lifetime loss ratios would be even higher.

3. The loss ratio approach increases future premiums to a level (referred to as make-up premium) such that the original loss ratio target is once again attained.

4. The loss ratio approach, one of the minimum standards in many states’ statutes, is evaluated by the MSA Team. However, there is general recognition that this approach produces rate increases that are too high and do not recognize other typical statutory standards such as fair and reasonable rates.
   a. The loss ratio approach also does not recognize actuarial considerations such as the shrinking block issue, where past losses being absorbed by a shrinking number of remaining policyholders would lead to unreasonably high-rate increases. This concern was the main driver of the Minnesota, Texas, and other approaches.
   b. The loss ratio approach shifts all the risk to the policyholders. If the company is allowed always to return to the 60% loss ratio, there may be a lower incentive for more responsible pricing.

5. For rate-stabilized business, lifetime loss ratios are broken out, such as in a 58% / 85% pattern, where the 58% reflects the portion of initial premiums and the 85% reflects the portion of the increased premium available to pay the claims. For relevant blocks, this standard is analyzed by the MSA Team. If this standard produced lower increases than the Minnesota and Texas approaches, it would produce the recommended rate increase.

C. Minnesota Approach

Key aspects of the Minnesota approach to the actuarial review of rate changes include:

1. Blended if-knew / makeup approach to address the shrinking block issue.
   a. The if-knew concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
   b. The makeup concept is for a premium to be charged going forward to return the block to its original lifetime loss ratio.
   c. The blending method helps ensure concepts discussed in public NAIC LTC subgroup calls from 2015 to 2019 are incorporated, including the concept that rates will not substantially rise as the block shrinks (as policyholder persistency falls over time).

---

2. Cost-sharing formula that increases the companyinsurer’s burden as cumulative rate increases rise.
   a. This addition to company the insurer’s burden moves rates away from a direction that could potentially be seen as misleading. The companyinsurer likely had or should have had more information on the likelihood of large rate increases than the consumer had at the time the policy was issued.

3. Assumption review
   a. Verification that the companyinsurer’s original and current assumptions are indeed drivers of the magnitude increase in lifetime loss ratio presented by the companyinsurer.
   b. Verification of appropriateness of current assumptions.
      i. A combination of credible companyinsurer experience, relevant industry experience, and regulatory-professional judgement is applied.
      ii. For areas of uncertainty, such as older-age morbidity, conservatism may be added to the companyinsurer-provided assumptions. This conservatism can be released as credible experience develops.

4. Interest rate / investment return component
   a. The Minnesota approach considers changes in expectations regarding interest rates and related investment returns in a manner consistent with how other key assumptions are considered. Reasons include:
      i. Changes in market interest rates are among the key factors driving profits and losses associated with blocks of LTC business.
      ii. In the Minnesota approach, all factors impacting the business are considered.
         1. If interest rates rise, this would tend to lead to lower rate increase approvals. Note, in this scenario, if interest rate changes were not considered, it is possible an companyinsurer would get approval for rate increases even when profits on the block were higher than expected.
         2. If interest rates fall, this would tend to lead to higher rate increase approvals.
      iii. To prevent shifting of “good assets” and “bad assets” to supporting LTC rates, and to prevent an companyinsurer from increasing rates based on risky investments that turned into losses, an index of average corporate bond yields (e.g., Moody’s) is relied on to reflect experience and current expectations.
      iv. Original pricing typically includes an assumption on investment returns (for which premiums and other positive cash flows are assumed to accumulate). This forms the interest component of the original assumption.
      v. The original pricing investment return in iv is compared to the average corporate bond yields in iii to determine the adversity associated with the interest rate factor.

5. Anti-bait and switch adjustment Original Assumption Adjustment
a. If original mortality, lapse, or investment return assumptions were out of line with industry-average assumptions at the time of original pricing, the original premium is replaced by a “benchmark premium”.
   i. This results in a lower rate increase.
   ii. This adjustment wears off over 20 years from policy issue.
      1. The rationale for the wearing off of this adjustment is the assumption that no company insurer would intentionally underprice a product knowing it would suffer losses for 20 years and then hope to offset a portion of that loss with a rate increase.
   iii. This adjustment is intended to prevent bait & switch, where, e.g., an company insurer would underprice a product, gain market share, and then immediately request a rate increase.

D. Texas Approach

The Texas approach to the actuarial review of rate changes was developed in response to the NAIC Long-Term Care Pricing (B) Subgroup’s discussions regarding the recoupment of past losses in LTCI rate increases. The Texas approach relies upon a formula intended to prevent the recoupment of past losses by calculating the actuarily justified rate increase for premium-paying policyholders based solely on projected future (prospective) claims and premiums.

Key aspects of the Texas approach to the actuarial review of rate changes include:

1. Past losses are assumed by the company insurer and not by existing policyholders. An approach that considers past claims in the calculation of the rate increase, such as a lifetime loss ratio approach, permits to some extent, the recoupment of past losses.

2. Calculates the rate increase needed to fund the prospective premium deficiency for active, premium-paying policyholders based on an actuarially supported change in assumption(s). This ensures that active policyholders do not pay for the past claims of policyholders who no longer pay premium.

3. Data Requirements for Calculation:
   a. The following calendar year projections, including totals, for current premium-paying policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate:
      i. Present Value of Future Benefits (PVFB) under current assumptions.
      ii. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
      iii. Present Value of Future Premiums (PVFP) under current assumptions.
      iv. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
         • (Note that for all 4 projections above, the projection period is typically 40-50 years, although some companies project for 60 or more years.)
To emphasize, these projections should only include active policyholders currently paying premium and should not include any policyholders not paying premium (e.g., policies on waiver, on claim, or paid up), regardless of the reason. Projections under current actuarial assumptions must not include policyholder behavior as a result of the proposed premium rate increase, such as a shock lapse assumption.

Also, the company insurer should identify and explain any estimates or adjustments to the data, as applicable.

4. Assumptions
   a. Rate increases are commonly driven by a change to the persistency, morbidity, or mortality assumption, or a combination of the three.
   b. Verification that assumption change(s) are supported by credible data.
   c. The interest rate is the same for all four projections. This ensures that interest rate risk is assumed by the company insurer, not the policyholder.

The formula used in TX approach is provided in Appendix C.

E. Reduced Benefit Options (RBO)

In 2020, Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup (“LTCI RBO (EX) Subgroup”) of the LTCI (EX) Task Force, developed a list of RBO principles to provide guidance for evaluating RBO offerings in Appendix D.

1. RBOs in MSA Advisory Report

As part of the MSA Review, the MSA Team will perform a limited review of the reasonableness of RBOs included in the rate proposal that are extracontractual. The MSA Advisory Report will highlight how the company insurer demonstrates the proposed RBOs’ reasonableness. Note that the MSA Team will not perform an assessment of RBOs in relation to individual state specific requirements for RBOs. The purpose of the guidance in the MSA Advisory Report is to provide initial information about the RBOs with which the state insurance regulators can then utilize to perform a more detailed assessment specific to their state’s requirements. As the MSA Review process develops and as the LTCI RBO (EX) Subgroup continues its work, this area of review may evolve.

2. Future RBOs

As the industry continues to innovate new RBOs for consumers, the MSA Review process will likewise develop and evolve to consider the reasonableness of RBOs. Additionally, as the MSA Review process evolves, additional regulatory expertise with RBOs may be added to the MSA Team in the future. To achieve more consistency across states in their understanding and consideration of RBOs, the LTCI (EX) Task Force will encourage its appointed Subgroup and/or an appropriate NAIC actuarial committee or group, to collectively consider new RBOs, as they arise. This process will provide for input and technical advice from actuaries and non-actuarial experts to the state insurance departments as they exercise their authority in considering RBOs as part of rate filings. States and insurers are therefore encouraged to discuss new and developing RBOs through this process.
F. Non-Actuarial Considerations

The LTCI (EX) Task Force continues to review and consider non-actuarial considerations impacting states’ approval or disapproval of LTCI rate changes to develop consensus among jurisdictions and develop recommendations for application of these considerations. These considerations include such topics as:

- Caps or limits on approved rate changes
- Phase-in of approved rate changes over a period of years
- Waiting periods between rate change requests
- Considerations of prior rate change approvals and disapprovals
- Limits or disapproval on rate changes based solely or predominately on number of policyholders in a particular state
- Limits or disapproval on rate changes based on attained age of the policyholder
- Fair and reasonableness considerations for policyholders
- Impact of the rate change on the financial solvency of the insurer

1. Considerations in MSA Advisory Report

As part of the MSA Review, the MSA Team will identify relevant aspects of the insurer’s rate proposal, based on the information provided by the insurer, that may be impacted by a state’s non-actuarial considerations. Note that the MSA Team will not perform a state-by-state review of each state’s non-actuarial considerations, statutes, or practices. Instead, the MSA Team will highlight in the MSA Advisory Report those aspects of the rate proposal that relate to or that may be impacted by non-actuarial considerations. The purpose of this guidance in the MSA Advisory Report is to prompt state insurance regulators to contemplate those impacted aspects of the rate proposal when completing their individual state’s rate review. For example, the MSA Advisory Report may highlight:

- If cumulative rate increases are high, as this may impact the cost sharing formula
- If a rate proposal is for a block of business where the average policyholder age is predominately 85 or above, as this may impact states that consider age caps
- If it is determined the block of business will likely continue to incur substantial financial losses and impose a potential solvency concern, as this may impact the potential need for adjustments to the cost-sharing formula
- Aspects of coordination of rate and reserving review, as this may signify adjustments to the methodology assumptions used by the MSA Team in their review

2. Future Non-Actuarial Considerations

The MSA review process will continue to develop and evolve as it is implemented. To achieve more consistency and minimize the number of differences across states in their application of other non-actuarial considerations in rate review criteria for LTCI rate filings, the LTCI (EX) Task Force will encourage its appointed Subgroup or an appropriate NAIC actuarial committee or group, to collectively consider new future non-actuarial considerations, as they arise. This process will provide for input and technical advice from actuaries to states as they exercise their authority in considering non-actuarial factors. States are therefore encouraged to discuss new and developing practices and/or recommendations in this area.
VI.C. APPENDIX C—ACTUARIAL APPROACH DETAIL

A. Minnesota Approach

Details on the key aspects of the Minnesota approach to the actuarial review of rate changes include:

1. Review of current assumptions for appropriateness, reasonableness, justification, and support.
   a. A combination of credible company insurer experience, relevant industry experience, and regulatory professional judgement is applied.

2. If-knew premium and makeup premium aspects – aggregate application
   a. Makeup percentage
      i. \( \frac{[PV \text{ (claims)} / \text{original LLR}] - PV \text{ (past premium)}}{PV \text{ (future premium)}} - 1 \)
      ii. Premiums in the formula reflect the actual rate level.
   b. If-knew percentage
      i. \( \frac{[PV \text{ (claims)} / PV \text{ (premiums)}]}{\text{original LLR}} - 1 \)
      ii. Premiums in the formula are at the original rate level.
      iii. The concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
   c. Definitions and explanations
      i. PV means present value
      ii. LLR means lifetime loss ratio
      iii. Interest rates underlying PVs and LLRs are based on:
         1. For original PVs and LLRs, the interest rate is the investment return assumed in original pricing. Note that this rate is typically different than the statutory LLR discount rate.
         2. For current PVs, the interest rates are the average corporate bond yields over time for each year minus 0.25% (to account for expected defaults). For projections beyond the current year, phasing over 5 years of the current rate to a target rate (currently 4%) is assumed.
      iv. PV calculations are based on actual, current experience and expectations for persistency, morbidity, and interest rate
      v. Company insurer provide premium and claim cash flows may be adjusted based on assumption review.
      vi. Makeup percentage is similar to that attained by the loss ratio approach.

3. If-knew premium and makeup premium aspects – sample policy-level verification
   a. Over a range of issues years, issue ages, benefit periods, and inflation protection:
      i. Calculate an estimate of the original premium
         1. Based on original pricing assumptions for persistency, morbidity, investment returns, and expenses.
2. Apply first principles
   a. For each policy year, calculate PV of claims and expenses, applying mortality, lapse, morbidity, and expenses, discounting at original investment rates.
   b. Add the PV of claims expenses for each policy year to attain PV of claims & expenses at issue.
   c. Divide by the sum of the PV of an annuity of 1 per year
   d. Multiply \( \frac{\text{b}}{\text{c}} \) times \((1 + \text{originally assumed profit percentage})\) to attain the original premium.
   e. This premium provides the basis for comparison against the makeup and if-knew premium.

3. Replace the original premium with a benchmark premium
   a. If the benchmark premium is higher than the original premium and original pricing (reflected in mortality, lapse, and investment return assumptions) were out of line with industry-average assumptions at the time of original pricing.
   b. The benchmark premium is phased back into the original premium proportionally over 20 years from issue.
   c. The benchmark aspect is intended to prevent bait & switch.

ii. Calculate an estimate of the makeup premium.
   1. Calculate the original dollar PV of profits for the sample policy using original pricing assumptions.
   2. Calculate an updated dollar PV of profits for the sample policy using:
      a. Actual history of premiums and claims.
      b. Expectations of future claims.
      c. “Backed into” makeup premium.
   3. Note that attaining the same dollar PV of profits for a sample policy leads to a lower makeup premium than attaining the same percentage PV of profits (as a percentage of premium).
      a. The reason for target the dollar instead of percentage is to avoid the dollar amount of profit being higher as premium rates increase.

iii. Calculate an estimate of the if-knew premium.
   1. The calculation is the same as for the original premium, except it is based on current assumptions instead of original pricing assumptions.

b. Verifying the impact on expectation changes on rates
   i. While lapse, mortality, and interest rate experience and assumptions are fairly routine to track (for determination of the rate impact), morbidity experience and assumptions tend to be difficult to track.
   ii. A combination of information is relied up to estimate the impact of morbidity expectation deviations (from original pricing) on rates. This information includes:
      1. Original and current claim incidence and claim length by age and other factors. Incidence and length are tracked separately for some companies and combined for others.
      2. Experience
3. Impact on LLR of changes in expectations of morbidity.
4. Industry information and trends (for reasonableness checks).
   c. Assumptions underlying the calculations of estimates of premiums may be adjusted as part of the review. For instance:
      i. If sample policy verification shows less impact on rates due to changes in lapse, mortality, interest rate, and morbidity expectations than demonstrated in the company's aggregate projections, past or projected premiums or claims may be adjusted in the original, makeup, or if-knew premium calculations.
      ii. If there is wide variance in practice among companies in morbidity assumptions at ages where data is of low credibility, adjustments may be made to help ensure similar situations result in similar rate increase approval amounts.
         1. A balanced approach is pursued, recognizing that providing full or zero credit for partially credible experience may result in harmful consequences (excessive rates or later rate shocks).
         2. Any reductions to rate increases caused by lack of credible experience can potentially be reversed in subsequent rate increase requests as credibility increases.
      iii. Similar adjustments may apply when incomplete or inconsistent information is provided by the company (after initial attempts to resolve significant differences or gaps).
4. Reconciliation of aggregate and sample policy applications
   a. In many cases, the aggregate and sample policy applications will result in similar current LLRs.
   b. In other cases, some steps are taken to understand the difference, including additional requests for information.
   c. Because the sample policy application considers information only related to premium-paying policyholders, it is possible that differences between the aggregate and sample policy application are caused by inclusion of past premiums and all claims related to non-premium payers in the aggregate information.
   d. When reconciliation does now occur after rounds of communication, decisions will be made based on the information provided.
5. Blending – same for aggregate and sample policy applications
   a. The weighting towards the makeup premium is the percentage of original policyholders remaining.
   b. The weighting towards the if-knew premium is the percentage of original policyholders no longer having active policies, or 1 minus the percentage in ii.
   c. The blending of the if-knew premium and makeup premium helps ensure remaining policyholders are not held responsible for paying for adverse experience associated with past policyholders.
   d. The blending also helps limit cumulative rate increases at later durations; as the percentage of remaining policyholders approaches zero, the blended approval amount approaches the if-knew premium.
6. Cost-sharing formula that increases the company insurer burden as cumulative rate increases rise.
   a. The cumulative-since-issue, weighted if-knew / makeup premium-based increase is reduced by:
      i. No haircut for the first 15%;
      ii. 10% for the portion of cumulative rate increase between 15% and 50%;
      iii. 25% for the portion of cumulative rate increase between 50% and 100%;
      iv. 35% for the portion of cumulative rate increase between 100% and 150%;
      v. 50% for the portion of cumulative rate increase in excess of 150%.

7. Reduction for past rate increase:
   a. Take one plus the cost-sharing-adjusted blend amount and divide by one plus the previous, cumulative rate increases. Then subtract one. This is the approvable rate increase.

8. Summary
   a. Review current assumptions
   b. Calculate aggregate if-knew premium and makeup premium amounts. Calculate the blended amount.
   c. Calculate the sample policy estimated original premium, if-knew premium, and makeup premium. Calculate the blended amount.
   d. Reconcile aggregate and sample policy blended amounts. Set this blended amount aside.
   e. Apply the cost-sharing formula to the blended amount.
   f. Deduct past rate increases.
   g. Example – if:
      i. the original premium is $1,000
      ii. makeup premium is $3,000;
      iii. if-knew premium is $1,500;
      iv. 60% of policyholders remain;
      v. Past rate increases are 50%:
      vi. Blended amount is:
         1. $3,000 / $1,000 * .60 +
         2. $1,500 / $1,000 * .40
         3. – 1 =
         4. 180% + 60% - 1 = 240% - 1 = 140%.
      vii. Cost sharing is:
         1. 100% * .15 +
         2. 90% * .35 +
         3. 75% * .5 +
         4. 65% * .4 =
viii. Deduction for past rate increases results in:

1. \[
\frac{(1 + 1.1)}{(1 + .50)} - 1 =
\]

2. 40%.

B. Texas PPV Formula

Details on the PPV Formula of the Texas approach to the actuarial review of rate changes include the following. To reiterate, the formula is limited to active, premium-paying policyholders.

For rate stabilized policies:

\[
\text{rate increase} \% = \frac{\Delta PV \left( \text{future incurred claims} \right) - \left( \frac{.58 + .85C}{1 + C} \right) \Delta PV \left( \text{future earned premiums} \right)}{.85 PV_{current} \left( \text{future earned premiums} \right)}
\]

Where:

\( \Delta \) indicates the change in PV due to the change in actuarial assumptions between the time of the last rate increase (or original pricing if no prior rate increase) and the current assumptions.

\( C \) is the cumulative % rate increase to date. For example, if the current rate (prior to the proposed rate increase) is 50% higher than the rate at initial pricing, then \( C = .5 \).

The current subscript in the denominator indicates that the PV should be computed using current assumptions. The future earned premiums in the formula are based on the current premiums prior to the proposed rate increase. (Regulators may wish to consider the addition of margin to the rate increase. For example, the \( \Delta PV(\text{future incurred claims}) \) term in the above formula could be multiplied by \( (1 + \text{margin}) \).

For pre-rate stabilized policies, we use .6 in place of .58 and .8 in place of .85:

\[
\text{rate increase} \% = \frac{\Delta PV \left( \text{future incurred claims} \right) - \left( \frac{.6 + .8C}{1 + C} \right) \Delta PV \left( \text{future earned premiums} \right)}{.8 PV_{current} \left( \text{future earned premiums} \right)}
\]

Prior to the time that Texas adopted the PPV approach, a past requested rate increase may have been reduced by the regulator by a method other than the PPV approach. In this situation, for a current filing, the regulator may make adjustments to the current approvable amount based on what would have been approved had PPV been used in the prior filing.
VI.D. APPENDIX D—PRINCIPLES FOR REDUCED BENEFIT OPTIONS (RBO) ASSOCIATED WITH LTCI RATE INCREASES

In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup (“LTCI RBO (EX) Subgroup”) of the LTCI (EX) Task Force, was charged to “Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.” In completing this charge, the Subgroup developed the following list of RBO principles to provide guidance for evaluating RBO offerings.

A. Principles and Issues

As related to:

1. Fairness and equity for policyholders who elect an RBO:
   - If some policyholders facing a rate increase are being offered an RBO but not others, an adequate explanation is needed.
   - Each RBO should provide reasonable value relative to the default option of accepting the rate increase and maintaining the current benefit level.

2. Fairness and equity for policyholders who choose to accept rate increases and continue LTCI coverage at their current benefit level:
   - The extent of potential anti-selection should be analyzed, with consideration of the impact on the financial stability of the remaining block of business and the resulting effect on the remaining policyholders.

3. Clarity of communication with policyholders eligible for an RBO:
   - Policyholders should be provided with maximum opportunity and adequate information to make decisions in their best interest.
   - Companies should present RBOs in clear and simple language, format and content, with clear instructions on how to proceed and whom to contact for assistance.

4. Consideration of encouragement or requirement for an companyinsurer to offer certain RBOs:
   - Regulators should evaluate legal constraints, the impact on remaining policyholders and companyinsurer finances, and the impact on Medicaid budgets if encouraging or requiring reduced LTCI benefits.

5. Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible:
   - Regulators and interested parties should continue to study the idea of offerings being made by insurers including potentially being tied to rate increases, e.g., providing hand railings for fall prevention in high-risk homes, and identifying the pros and cons of such an approach.
B. Widely Established RBOs in Lieu of Rate Increases

1. Reduce inflation protection going forward, while preserving accumulated inflation protection.
2. Reduce daily benefit.
3. Decrease benefit period/maximum benefit pool.
4. Increase elimination period.
5. Contingent nonforfeiture.
   i. Claim amount can be sum of past premiums paid.
   ii. Only receive that benefit if the policyholder qualifies for a claim.

C. Less Common RBOs for Potential Discussion

1. Cash buyout.
2. Copay percentage on benefits.

As the industry continues to innovate new RBOs for consumers, such as the two listed above, the MSA review process will likewise develop and evolve to consider the reasonableness of these RBOs. The LTCI (EX) Task Force will encourage its appointed Subgroup or an appropriate NAIC actuarial committee or group, to collectively consider new RBOs, as they arise, that provides for input and technical advice from actuaries to states as they exercise their authority in considering RBOs as part of rate filings.

VI.E. APPENDIX E—GUIDING PRINCIPLES ON LTCI REDUCED BENEFIT OPTIONS PRESENTED IN POLICYHOLDER NOTIFICATION MATERIALS

In 2020, LTCI RBO (EX) Subgroup of the LTCI (EX) Task Force adopted the following guiding principles to ensure quality of consumer notices of rate increases and RBOs. This section seeks to provide guiding principles in answering this question: “What are the recommendations for ensuring long-term care insurance policyholders have maximized opportunity to make reduced benefit decisions that are in their best interest?”

To complete the charge, the LTCI RBO (EX) Subgroup 1) evaluated the quality of consumer notices and RBO materials presented to policyholders; 2) considered the relevant lessons learned and consumer focus group studies from the liquidation of LTC insurer Penn Treaty Network of America; 3) reviewed existing RBO consumer notice checklists or principles from multiple states (i.e., Nebraska, Pennsylvania, Texas and Vermont); and 4) addressed stakeholder comments on RBO principles.

This document is intended to establish consistent high-level guiding principles for long-term care insurance reduced benefit options presented in policyholder notification materials. These principles are guidance and do not carry the weight of law or impose any legal liability.

Recognizing that each component outlined in these principles will not apply in all circumstances, this section:

- RECOMMENDS that insurance companies recognize these fundamental principles.
CALLS ON all insurance companies to consider the following principles in communicating reduced benefit options available to consumers in the event of a rate increase.

UNDERLINES that the following principles are complementary and should be considered as a whole.

A. Filing Rate Action Letters

Insurers should consider:

- Sending rate actions after the state has approved the rate action filing.
- Making the rate action effective on a policy anniversary date, recognizing that the Long-Term Care Insurance Model Regulation (#641) allows for the next anniversary date or next billing date.
- Mailing rate increase notification letters at least 45 days prior to the date(s) a rate action becomes effective, consistent with any applicable state laws and/or regulations.
- Sending rate increase notifications each year for rate increases that are phased-in over multiple years.
- Disclosing all associated future planned rate increases approved by regulators in the initial and phased-in rate increase notification letters.
- Filing rate action letter templates in the NAIC System for Electronic Rate and Form Filing (SERFF) rate increase filing to include statements of variability and sample letters highlighting the differences between the communications, consistent with any applicable state laws and/or regulations.
- Presenting innovative options to state insurance regulators prior to filing new reduced benefit options.
  - This enables regulators to evaluate potential anti-selection, adverse morbidity, and implications to consumers and future claims experience.

B. Readability and Accessibility

Insurers should consider:

- Drafting a rate action letter that is easy to follow, flows logically, and displays the essential information and/or the primary action first, followed by the nonessential information.
- Presenting the reduced benefit options in a way that is comprehensible, memorable, and adjusted to the needs of the audience.
- Using cover pages, a table of contents, glossaries, plain language, headers, maximized white space, and appropriate font size and reading level for the intended audience.
- Using illustrative tools, such as bullet points or illustrations as appropriate, and graphs or charts enabling a side-by-side comparison.
- Including definitions of complex terms; and if a term, subject or warning is repeated throughout the communication, consider making the language consistent throughout the document.
- Including a question-and-answer section that is succinct but answers the commonly asked questions in plain language.
- Providing appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language.
C. Identification

Insurers should consider drafting the RBO communication in a way that helps policyholders understand:

- What is happening?
- Why is it happening to them?
  - Ensure the letter does not negatively reference the state insurance department.
- When is it happening?
- What can they do about it?
- How do they take action?

D. Communication Touch and Tone

Insurers should consider:

- Drafting the communication in a way that helps policyholders envision or reflect on the reason(s) why they purchased a long-term care insurance policy.
- Conveying as much empathy as possible regarding the impact a rate action(s) may have on policyholders.
- Presenting reduced benefit options fairly, refraining from the use of bolding, repeating or emphasizing one option over another.
- Displaying the policyholder’s ability to maintain current benefits by paying the increased premium.
- Using word choices that appreciate how those words could influence a policyholder’s decision.
  - For instance, consider using “now” instead of “must”; or “mitigation options,” “offset premium impact” or “manage an increase” instead of “avoid an increase.”

E. Consultation and Contact Information

The insurer should consider listing multiple contacts in the communication in an easy-to-identify location to include when available; phone number; email address; and website. For example:

- Customer service.
- Lapse notifier.
- Insurance producer.
- State insurance department.
- State Health Insurance Assistance Program (SHIP).

The insurer should consider suggesting policyholders consult a family member or other trusted advisor, such as:

- Lapse notifier.
- Insurance producer.
- Financial advisor.
- Certified personal accountant or tax advisor (in the event cash buyouts are offered).

F. Understanding Policy Options

Insurers should consider the presentation of the communication by:

- Identifying what necessitated the communication on the first page.
  - For example, the header could say, “Your Long-Term Care Premiums Are Increasing.”
- Including the reduced benefit options with the rate action letter.
Limiting the number of options displayed on the letter to no more than four or five.

Identifying which reduced benefit option(s) have limited time frames.

Advising policyholders that they can ask about reducing their benefits at any time, regardless of a rate increase.

Providing enough information in the communication to make a decision.
  - If supplemental materials (e.g., insurer’s website) are provided, they would enhance the policyholder’s understanding, but not be necessary to use when making a decision.

Insurers should consider indicating the window of time to act by:

- Clearly indicating what the policyholder’s premium will increase to and by when.
- Displaying the due date(s) in an easy-to-identify location and repeating it multiple times throughout the document.
- Clearly differentiating due date(s) for each RBO, if available for a limited time.

Insurers should consider including disclosures regarding rate increase history:

- Disclosing that future rate actions could occur.
- Advising if prior rate actions have or have not occurred to include:
  - Policy form(s) impacted.
  - Calendar year(s) the policy form(s) was available for purchase.
  - Percentage of increase approved to include the minimum and maximum, if they vary by benefit type.
- Reminding policyholders that their policy is guaranteed renewable.

Insurers should consider advising policyholders of their current benefits:

- For example, the communication could disclose the policyholder’s current benefits to include:
  - Daily maximum amount.
  - Inflation option.
  - Current pool of benefits for policies with a limited pool of benefits.

Insurers should consider personal needs decision-making by:

- Only listing reduced benefit options that are available to the policyholder.
- Calling on policyholders to reflect on how each option could impact them personally.
- Prompting policyholders to consider their unique situation to include their current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and the potential need for institutionalized care.
- Reminding policyholders to consider the cost of care in the area and setting where they expect to receive care.
- Informing policyholders of factors that impact long-term care costs, such as:
  - The average cost of care for in-home care, assisted living, and nursing home care in their area.
  - The inflation rate of the cost of care for in-home and nursing home care in their area.
  - The average age and duration of a long-term care claim for in-home and nursing home care.
  - Factors that influence the age, duration and cost of a claim.
- Disclosing to policyholders when an RBO falls below the cost of care in their area.
- Calculating for policyholders the number of days or months a paid-up option could cover based on the cost of care in their area.
  - Buyout or cash-out disclosures.
The cash offerings, if any, should disclose to policyholders that the option could result in a taxable event and they should consult with their certified personal accountant and/or tax advisor before electing this option.

Insurers should consider the value of each option by:
- Disclosing if the RBOs may not be of equal value and are dependent on the unique situation of each policyholder.

Insurers should consider communicating the impact of options by:
- Displaying the options in a way that enables policyholders to compare options, including details such as:
  - Daily/monthly benefit.
  - Benefit period.
  - Inflation option.
  - Maximum lifetime amount.
  - Premium increase percentage and/or new premium.
  - Nonforfeiture (NFO) or contingent nonforfeiture (CNF) amount.
  - If the policy is Partnership qualified, changes to benefits may impact Partnership status.
  - Current premium.
- Providing a series of questions to help policyholders contemplate the implications of each action, such as:
  - What will happen if they take no action?
  - What will happen if they make no payment before the policy anniversary date?
  - If they accept the full increase without reducing their benefits, how will they handle potential future rate increases?
  - If they elect the cash buyout, there could be tax implications.
  - If they elect a paid-up nonforfeiture option, how long will the reduced benefit last if they had a claim?
  - If they were to increase their elimination period from 30 days to 100 days, do they have enough funds to cover those expenses?
  - Partnership policies: Will reducing the benefits remove Partnership qualification? If so, the letter should explain that their asset protection may be removed or reduced.

When rate actions span over multiple years, insurers should consider:
- Disclosing the full rate increase amount, how it is spread out across multiple years, and all associated future planned rate increases approved by regulators.
- Specifying if the premium increase referenced is the first, second, third, last, etc.
- Offering contingent nonforfeiture based on the full increase amount and offered with each phase of the rate action.
- Notifying policyholders at least 45 days in advance of each phase of the rate increase, consistent with any applicable state laws and/or regulations.
Summary of Comments on MSA Actuarial Framework Exposure – July 26, 2021

- See comment letters for full text.

<table>
<thead>
<tr>
<th>General Comments on Actuarial Approaches</th>
<th>Where/How Addressed in Framework</th>
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<tbody>
<tr>
<td>1 Washington</td>
<td>Section I.E.1 states that the MSA Review is not specific to any state’s law and that individual states retain ultimate authority for rate decisions. No further edits to framework.</td>
</tr>
<tr>
<td>2 American Academy of Actuaries (May comment letter)</td>
<td>Actuarial considerations are important; however, other considerations factor into a state’s decision. Actuaries vetted the MN &amp; TX approaches for several years in public LTC pricing SG sessions. See subsequent comment letter. No further edits to the Framework.</td>
</tr>
<tr>
<td>3 American Academy of Actuaries (May Comment Letter)</td>
<td>See subsequent comment letter. MN and TX approaches are included in the Framework. No further edits to the Framework.</td>
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<tr>
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<td>ACLI/AHIP (May Comment Letter)</td>
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Team may be guided by ASOP No.413 regarding appropriate communications and disclosures when issuing an actuarial opinion in an MSA Advisory Report. Specifically, disclosures may be necessary where material assumptions or methods are specified by applicable law (statutes, regulations, and other legally binding authority) or selected by another party.

<table>
<thead>
<tr>
<th>Decision Making Process / Transparency / Which Method Applies</th>
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<td>6 Academy</td>
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<tr>
<td><strong>Decision-making Process of the Multi-State Actuarial (MSA) Team:</strong></td>
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<td>7 Academy</td>
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| 9/15/21 | ACLI/AHIP | 4. The MSA's Actuarial Review standards/recommendations for participating states should include an acknowledgment that the recommendations for rate approvals do not reflect lifetime rate inequalities resulting from inconsistencies in the amount and/or timing of historical rate approvals between states, even on policies that offer identical coverage. We believe the standards should encourage states to work with filing companies to address these inequities and that the MSA Team should continue to assess this issue to determine if more specific guidance is appropriate.

At this time the MSA recommendation, for the filed rate increase, could be what the Texas or Minnesota method generates a blend of the two methods, or using professional actuarial judgement the MSA Team may recommend a rate increase outside of these two methods. Our methods may evolve over time as the MSA Team continues to study the future process that may generate similar or unique results.

See edit to Section V.A.

No edits to the Framework.

No edits to Section V.A.

No edits to Section V.A.

No edits to Section V.A.

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See added sentence to this bullet in Section V.A.

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See edit to Section V.A.

See edit to Section V.A.

See added sentence to this bullet in Section V.A.

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<th>Section V.B. Loss Ratio Approach</th>
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| **Academy**                     | The tone of several sections of the document seems to unnecessarily impute suspect motivations to companies who sold and/or currently sell LTC insurance:  
Section V.B.4(b) states that the loss ratio method results in “low incentive for responsible pricing.” Practicing LTC pricing actuaries are responsible for compliance with all relevant actuarial standards of practice, and a company has incentives to price appropriately. Most companies would prefer to receive premium sooner rather than later. Additionally, there are the costs associated with filing and implementing a rate increase and the impact on policyholders of premium adjustments.  
See edit to this bullet in Section V.B.4.b.  
|  
| **Financial Medic LLC**         | Addressing Actuarial Review, Loss Ratio Approach, Section B, point 4:  
The admission that past losses, known as premiums that were insufficient since inception, confirms our independent findings. We find evidence that some regulators reject the past loss theory without foundation of data science and accounting practices. We add that it is not merely the principle of past underpricing that is subject to recapture. The LRA is based on present value (PV) calculations, thus the shrinking number of policyholders (SNOP) are also charged interest based on the carrier’s discount rates, as though signing an LTCI contract involved a hidden lending arrangements.  
Typical example (2021): A recent rate increase for a large carrier expands SNOP premium to 4.02x original premium though the book remains considerably underpriced using LRA (at an LLR of 111%). Through standard accounting procedures, the new premium is calculable and allocatable to 3 distinct components. We do not see recovery of principal and its interest being reported in narratives or financial statements from LTCI actuaries in carrier filings or regulatory final dispositions. This non-disclosure misleads all LTCI stakeholders. We note that the expanding pie in premium growth in rate filings 2020+ are mainly due to the two recovery components while Fair Pricing remains static.  
We ask how the industry came about the LRA method and not Repriced in Accordance with Level Premium Precepts (Fair Pricing) as the product was originally intended and sold to clients.  
The Actuarial Review raises fundamental questions as to the technical purity of rate adjudication methods yet the industry appears to be unduly focused on RBO. This is *cart before the horse logic* in our professional opinion.  
MN & TX deal with the past loss issue, but in different ways.  
No edits to the Framework. |
<table>
<thead>
<tr>
<th></th>
<th>Academy</th>
<th>(Framework V.B.5)</th>
<th>Section I.E.1 states that the MSA Review is not specific to any state’s law and that individual states retain ultimate authority for rate decisions. No further edits to framework.</th>
</tr>
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<tr>
<td>18</td>
<td>Academy</td>
<td>For rate-stabilized business, the draft states that the 58/85 test “would produce the recommended rate increase” if lower than the Minnesota and Texas approaches. Why would these approaches potentially override and reduce the recommended rate increase, when the rate stability model was already intended to address the issues with loss ratio regulation described in the preceding paragraph of the Framework?</td>
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<tr>
<td>19</td>
<td>Academy</td>
<td>Section V.C.1(c) cites “concepts discussed in public NAIC LTC pricing subgroup calls from 2015 to 2019,” which provides inadequate documentation to include in a regulatory procedure document. Rate filing actuaries may not be aware of the content of past calls. We suggest citation to particular documents, such as adopted summaries or minutes of the referenced calls, if available. Added footnote in Section V.D. to NAIC Library for past proceedings.</td>
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</table>
| 20 | Academy | The tone of several sections of the document seems to unnecessarily impute suspect motivations to companies who sold and/or currently sell LTC insurance:  
- Section V.C.2(a) refers to “a direction that could be seen as misleading.” Subparagraph (a) could be deleted entirely without affecting the definition of the Minnesota approach.  
- Section V.C.5, “anti-bait and switch adjustment,” where we suggest a less pejorative term could be used. In the context of a rate increase review, see our comments above regarding industry standards and benchmarking. The concern regarding potential deliberate underpricing to boost market share, expressed in subparagraph 5(a)(iii), is best addressed in the context of an initial rate review by regulators. Edited paragraph title. Topic under consideration for future discussion among actuary groups. No other specific changes to the Framework. |  |
| 21 | Academy | Section V.C.5(a) refers to “industry-average assumptions at the time of original pricing” for LTC products.  
- Where are these averages reliably to be found?  
- How are variations in product, carrier, distribution channel, and other factors taken into account?  
- What level of deviation from these averages (in one or more assumptions) would be considered “out of line” and trigger the use of “benchmark premium,” rather than actual original premium, in the MSA Review Team’s review process?  
- Recognizing that regulators who approved a company’s original product and rate filings had the opportunity to review all relevant assumptions at the time of filing, and may not have enforced or suggested the use of industry averages at that time, it may not be appropriate to determine benchmark premiums with 20/20 hindsight uniformly for all product filings and company characteristics. There was enough demand to eliminate incentive for bait & switch that a broad-brush approach was developed – not perfect but generally effective. Mortality, lapse, and investment returns are focus – able to look at average assumptions for each year of issue. Topic under consideration for future discussion among actuary groups. No edits to the Framework as these topics are more detailed than intended for the Framework. |  |
<p>| 22 | ACLI/AHIP | 7. The description of the Minnesota methodology includes a focus on underlying assumptions and indicates that the reviews are benchmarking to industry-average assumptions. See response to Academy comment #21. | Added “e.g., Moody’s” |</p>
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<tr>
<th>#</th>
<th>Source</th>
<th>Section</th>
<th>Text</th>
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| 23 | ACLI/AHIP | 8. | How are those assumptions calculated?  
Will they be provided to companies?  
Similarly, what is the “average corporate yield bond” index that will be used under the Minnesota method? |
|   | ACLI/AHIP | 9. | The “anti-bait and switch adjustment” under the Minnesota method appears to suggest the insurers intentionally underpriced LTC products.  
How would the MSA Team make this determination?  
How are the “industry-average assumptions at the time of original pricing” determined?  
Are product and underwriting differences accounted for?  
How far from the industry average is considered reasonable?  
Wouldn’t such assumptions only be considered unreasonable in hindsight considering the product was originally approved by the state insurance department? |
|   | ACLI/AHIP | 10. | The Minnesota Approach accounts for changes in interest rates; the Texas Approach explicitly does not.  
How do these conflicting approaches achieve similar results?  
The same is true in cases of solvency concern – the document states that the cost-sharing formula in the Minnesota Approach can be adjusted.  
How will the cost-sharing formula be adjusted?  
How is solvency accounted for in the Texas Approach? |
|   | ACLI/AHIP | 13. | The Framework states that the MSA Team’s review of rate proposals will resemble a state-specific rate review process utilizing consistent actuarial standards and methodologies. In addition, the MSA Team will apply the Minnesota (Blended If-Knew/Make-Up) and Texas (Prospective Present Value) approaches, as described in the 2018 NAIC LTC Pricing Subgroup’s paper – Long-term Care Insurance Approaches to Reviewing Premium Rate Increases (“NAIC Pricing Subgroup’s Paper”), to calculate recommended, approvable rate increases. In reviewing the methodologies, we noticed that specific components of the Texas method are not clearly included. In addition, there were changes or additions to adjustments made to the Minnesota method. The NAIC LTC Pricing Subgroup’s paper was the result of a deliberate and collaborative effort on the part of regulators and industry in 2018, during which each method was fully vetted. We believe that any kind of change to the methods outlined in that document should occur only after the same robust discussion and review. For example: |
|   | ACLI/AHIP | 13. | Framework allows for flexibility when applying the MN, TX or any other approach to deal with unforeseen circumstances, data limitations, etc. Circumstances will be addressed on a case-by-case basis.  
Catch up and transition are concepts applied after the TX PPV is calculated. The base TX PPV amount applies to a typical case (across states). |
<p>|   | ACLI/AHIP | 13. | No edits to the Framework. |</p>
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<td>a.</td>
<td>Under the Texas method, the catch-up and transitional provisions are not clearly included. As outlined in the NAIC LTC Pricing Subgroup's Paper, we believe these are valid and important adjustments that should be considered when applying the Texas method. The catch-up provision is intended to account for necessary additional premiums in a new rate increase related to assumptions provided to the department at the time of a previous rate increase request that were not approved in conjunction with the prior filing(s). Likewise, the transition provision, for pre-rate stability products and other products where the last rate increase request was voluntarily reduced by the company, provides the ability to make a single filing to provide the full amount of premium necessary to meet the actuarial certification.</td>
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<td>26</td>
<td>ACLI/AHIP</td>
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<tr>
<td>13.b.</td>
<td>With respect to the “anti-bait and switch adjustment” under the Minnesota method, we strongly disagree with the inclusion of this adjustment. We believe the name itself draws a legal conclusion and submit that any reference to this type of adjustment should be categorized as an “original assumption adjustment”.</td>
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<td>27</td>
<td>Financial Medic LLC</td>
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<td>Our firm agrees with what the Texas Approach is designed to address, Section D points 1 and 2. Point 3 describes a general methodology of looking at forward “deltas” (both present value premiums &amp; claims, along with rate history) as the primary drivers of rate changes. Appendix C, Section B provides a formula that allows our firm to back test with a small code snippet to our LTCI processing subsystem that already had a forensic analysis capability. We encountered cases were the future claim “delta” was small relative to future premium “delta” such that a premium reduction would be called for. The Texas approach provides a useful filtering mechanism. (refer to the full comment letter for example). The claim “delta” was exactly zero, a perfect overlap, yet the regulatory agency granted a 40% increase. The stock language of the actuarial narrative based the increase on an expected deterioration of future claims. Accounting procedures refute the actuarial narrative but a simple picture tells the story even better absent professional formalities. The Texas proposal acknowledges that the methodology would not work for a first time increase as not “deltas’ exist. Moreover, we discovered the formula by itself is not a complete specification. For example, when measuring future “deltas” form one filing to the next, the specification does not clarify the source of PVs to be used for the baseline (old) filing. In our experience, many rate requests are not granted in full thus the baseline filing would not be a good source of information unless there were a recalculation of PV futures as adjusted by the actual rate increase.</td>
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<td>MN &amp; TX approaches address issue with past losses.</td>
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<td>No edits to the Framework.</td>
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that would cause stakeholders to question why any methodological changes in being proposed, much less implemented, after significant economic harm. Our firm has received questions from clients, who (1) have lapsed, (2) paid more premium that they thought they should have, or (3) exercised an RBO – “have we been injured by the Loss Ratio Approach”? answering a resounding “yes”!

<table>
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<tr>
<th>Section V.F. Non-Actuarial Considerations</th>
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<td>28 Academy</td>
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<tr>
<td>The Framework contains various non-actuarial considerations that may be contemplated as part of the rate recommendation. We believe it is important to recognize that many of these considerations, while listed as non-actuarial, have actuarial aspects or implications. For example, the phase-in of a rate change over a period of years necessitates a higher cumulative rate increase to have the same financial impact as a single rate increase. Similarly, if limitations are imposed on when a company can file a future rate increase, such as a rate guarantee period, a future request may need to be higher due to the cost of waiting. Caps or limits on rate increase approvals that are not based on actuarial considerations likewise increase the size of future rate increases. In this situation, where necessary premium rate increases are delayed, policyholders pay higher premiums, and the ultimate necessary premium level increases due to the delays in approvals. It should also be noted that the Minnesota and Texas approaches, while primarily actuarial in presentation, already include decisions based on non-actuarial considerations, such as specific cost-sharing provisions and disallowing interest rate deviations as a reason for a rate increase. Finally, we believe that the MSA Review process may ultimately add little value if its actuarial conclusions are frequently overridden at the state level by non-actuarial considerations. The task force may wish to consider the degree of commitment demonstrated by Participating States when evaluating the success of the MSA Review program in meeting the NAIC’s objective of “developing a consistent national approach for reviewing current LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner.”</td>
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<tr>
<td>29 Academy</td>
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<td>We note that “Fair and reasonableness considerations” is listed in Section V.F (Non-Actuarial Considerations). This is a broad and not-well-defined category allowing wide latitude in regulatory decision-making regarding the results of an analysis, distinct from the justification of actuarial assumptions.</td>
</tr>
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Non-actuarial considerations are topics for future discussion.

No edits to the Framework.
|   | ACLI/AHIP | 9. Will the MSA Team recommendation reflect any non-actuarial considerations or is the document simply acknowledging their existence?  
10. A clear distinction needs to be made between non-actuarial considerations that should inform the MSA Team’s recommendations (like company solvency) and non-actuarial considerations that states might apply to the MSA Team’s recommendation (rate caps, phasing, age limits). The former should be a factor in the MSA Team’s regulatory actuarial judgment. To achieve The Task Force’s goal of a consistent national approach to rate actions, the MSA Team should seek to discourage the latter (unless required by a clear state statutory mandate).  
11. A primary goal of MSA Review Process is to achieve an adequate rate level for policyholders in all states. As proposed, the process gives states the discretion to continue to apply state-specific non-actuarial restrictions and caps on rate increase amounts. While we recognize the independence of each state’s authority, we note that allowing states to impose artificial rate caps on what the MSA Team has determined to be an actuarially justified rate likely will perpetuate the historical discrepancies between states, which will not address cross-state inequities. It will also undermine the Task Force’s charge to develop “a consistent national approach” to achieve “actuarially appropriate increases.” | #9 – acknowledging their existence. Non-actuarial considerations are outside the MSA team’s review.  
#10 - Solvency considerations are outside the calculation and are a consideration of individual states.  
See added subparagraph to Section V.A.  
#11 - States retain authority for final rate decisions.  
Non-actuarial considerations (caps, phasing, etc.) are topics for future discussion. |
|   | Washington | Can the rate changes recommended by the MSA team be implemented by all states and meet existing state laws and rules? If not, does this invalidate the actuarial work of the MSA team? Some states have capped an LTCI rate increase regardless of actuarial justification. If the MSA team recommends a higher rate increase than a particular state’s capped rate increase, the actuarial assumptions may no longer be valid. Also, those states without a rate cap will be continuing to subsidize the states with a rate cap. | Section I.E.1 states that the MSA Review is not specific to any state’s law and that individual states retain ultimate authority for rate decisions.  
Non-actuarial considerations are topics for future discussion.  
No edits to framework. |
| 31 | Vermont | On p. 14, in appendix D, Principles for Reduced Benefit Options (RBO) Associated with LTCI Rate Increases, it reads:  
*Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible:*  
- Regulators and interested parties should continue to study the idea of offerings being made by insurers including potentially being tied to rate increases, e.g., providing hand railings for fall prevention in high-risk homes, and identifying the pros and cons of such an approach. | VT provided an additional sentence. “In the case that an offering is tied to a rate increase, and involves the collection of consumer data, regulators should ensure that data collection and use is clearly disclosed and easily understood, that the consumer is made aware of any other available options, that the offer is not discriminatory, and that the rate impact is correlated to the offering. Consumer data should |

Appendix D. Principles for RBOs associated with LTCI rate increases
Rate increases for long-term care policies typically add thousands of dollars to the annual premium paid for the policy. These types of rate increases are significant and may be a hardship to elderly consumers on fixed incomes. Consumers may not be able to consider their own best interest in the face of a significant change to annual expenses. Any offer associated with a rate action, and which involves the collection of data through artificial intelligence should clearly explain how information will be collected and used to avoid profiting and potential discriminator actions on behalf of the insurer. Also, any offer to an insured tied to rate increases should be supported with data showing why and how the rate impact is directly correlated to the offer.

Consider this example:

- A consumer on a fixed income receives notice that long-term care premiums will increase by $3,000 annually.
- That consumer now faces $3,000 of new expenses.
- If the consumer checks a box, they will receive a smart device that will collect data from their home and computer.
- If they select this option, they will not have to pay any rate increase.

The consumer may not be in the position to act in their own best interest and may not be able to consider these options carefully for several reasons. First, the consumer may not fully understand the technology proposed, the data to be collected, and the privacy implications. Second, the consumer may not realize that there may be several other options to modify their policy and reduce premiums besides accepting the new technology option. The technology option may seem like the only choice available.

The MSA subgroup should consider keeping the wellness program offers separate from implementation of large rate increases (greater than 10%). Then, there would be no question that the consumer was coerced, rather than persuaded, to take part in any wellness program.

Appendix E. Guiding Principles for LTCI RBOs Options Presented in Policyholder Notification Materials

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<th>33</th>
<th>Academy</th>
<th>There is a potential interaction between the NAIC’s Reduced Benefit Options workstream and the MSA Review. Appendix E, “Guiding Principles on LTCI Reduced Benefit Options Presented in Policyholder Notification Materials,” suggests that insurers should consider “disclosing all associated future planned rate increases approved by regulators” in their rate increase notification letters.</th>
</tr>
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</table>
|  | | • Will the existence of an MSA Review report with a recommended cumulative rate level impose any obligation on an insurer to disclose the likelihood of future rate increases to reach this level? | Goal is for MSA recommendation to be the final rate review unless the block’s expectations deteriorate, or adverse morbidity experience becomes more credible.

Not be collected to be monetized for profit or for advertising.”

Referred VT comment letter to RBO Subgroup for input as the Subgroup is currently discussing wellness initiatives.
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<td>• How would any such disclosure apply to Participating and/or non-Participating states?</td>
<td>Disclosing all associated future planned rate increases approved by a state is already being applied in state’s rate reviews.</td>
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<tr>
<td>34</td>
<td>ACLI/AHIP</td>
<td>No edits to Framework.</td>
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<td></td>
<td>We appreciate the subgroup’s acceptance of many of our recommended changes now reflected into Appendix E. However, there are a few suggestions made in our May 24th letter that were not accepted by the subgroup. We welcome the opportunity to discuss further refinements to this document as the work evolves.</td>
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<td>35</td>
<td>ACLI/AHIP</td>
<td>Comments on the Operational Section of the Framework</td>
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<td>13. Finally, as mentioned in our previous comment letter, we encourage the subgroup to include a formal trigger to review and amend the Framework annually.</td>
<td>Process is expected to continually evolve and be evaluated.</td>
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<td>Responsibility for the Framework updates is addressed in section I.A and feedback from states in section III.E.</td>
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<tr>
<td>36</td>
<td>Washington</td>
<td>No edits to the Framework.</td>
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<td>Is this binding? If not, limited participation might impact goal of nationwide uniformity and defeat the purposes of MSA rate review.</td>
<td>Section I.E.1 states that the MSA Review is not specific to any state’s law and that individual states retain ultimate authority for rate decisions.</td>
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<td>Several states have made it clear that they are not willing to participate in or accept the results of the MSA rate review, thus hampering the ability of MSA rate review to achieve its stated goal of nationwide uniformity. In order to achieve a more consistent rate review approach and minimize the differences across states, most states (if not all) need to participate in the MSA rate review program and make use of the final results mandatory.</td>
<td>Regarding benefits of MSA results, see edit to I.B &amp; I.D of the Operational section second exposure draft.</td>
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<td>If the MSA rate review is not binding on participating states and is instead treated as a recommendation, state actuarial reviewers will use their own actuarial judgement to evaluate the MSA rate review and then apply state-specific laws and rules. The results will be different and therefore inconsistent. Enough state must bind themselves to the MSA rate review results in order for this approach to be effective.</td>
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<td>The current status of LTCI rate review at the Interstate Insurance Product Regulation Compact (IIPRC) informs this concern. At least a half dozen of the IIPRC states have opted out of IIPRC LTC review standards. This lack of uniformity is exacerbated by the IIPRC only being allowed to consider rate increases for policies that the IIPRC originally approved, and only for increases up to 15%. These challenges for the IIPRC suggest similar challenges may exist for MSA rate review.</td>
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<tr>
<td>37</td>
<td>Washington</td>
<td>Can the MSA Team review meet the proprietary or confidentiality requirements of the participating States? MSA rate reviews will be done by drawing on staff support from various state insurance departments. Can the MSA Team effectively maintain confidentiality and meet individual state’s proprietary information law?</td>
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<tr>
<td>38</td>
<td>Washington</td>
<td>Appendix A: MSA (Advisory) Report: The actuarial requirements in the report should not conflict with various state’s laws, rules, and procedures. The report’s wording will also need to be edited carefully whether it is just a recommendation or if there are conflicts with state regulations. The report should also address that actuarial standards and expectations still apply, since the team members are expected to contribute their actuarial expertise.</td>
</tr>
<tr>
<td>39</td>
<td>Academy</td>
<td>Appendix B: Information Checklist • Item A.1. should provide clarification for the desired issue state for group products (i.e., master group policy issue state or certificate issue state). • Some items from subsections A and B are at least partially duplicative. Specifically, items regarding attribution of rate increase, waiver of premium handling, and assumption comparisons to asset adequacy testing are repeated in both locations. • We encourage Participating States to agree that the listing of information for an MSA Review (as outlined in Appendix B) is exhaustive. If no further requests for information are needed as part of a specific state review, the filing process could be streamlined for both filers and reviewers.</td>
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December 6, 2021

Commissioner Michael Conway
Chairman, NAIC LTC Multi-State Rate Review (EX) Subgroup

Dear Commissioner Conway and Subgroup Members,

The American Council of Life Insurers (ACLI)\(^1\) and the America’s Health Insurance Plans (AHIP)\(^2\) appreciate
the opportunity to comment on the third draft of the Actuarial Section of the Long-Term Care Insurance
(LTC) Multi-State Rate Review Framework, exposed by the NAIC LTC (EX) Task Force on November 15, 2021.

The ACLI and AHIP fully support the charge of the NAIC LTC (EX) Task Force to develop a consistent national
approach for reviewing current LTC rates that results in actuarially appropriate increases being granted by
the states in a timely manner that eliminates cross-state rate inequities. We applaud the LTC Multi-State
Rate Review Subgroup for the time, effort, and thought that were put into the development of a framework
to achieve this charge.

As stated in our previous comment letters, insurers best protect their policyholders when they can fulfill
the obligations they made to these policyholders. This is accomplished when insurers have some level of
predictability in their ability to effectively manage their current and future LTC business over time. At its
core, this level of predictability can only be achieved through transparency and consistency within the
Multi-State Rate Review Process, specifically with respect to the methodology used to calculate the
increase recommended by the Multi-State Actuarial Team.

While some fundamental questions outlined in our prior comment letters remain, we recognize that many
questions about this new process will need to be addressed over time as regulatory and industry
experience evolves. We remain committed to continuing to work with the Task Force and Subgroup to
achieve a robust process that is beneficial to both states and industry.

Sincerely,

Jan M. Graeber
ACLI Senior Actuary

Ray Nelson
AHIP Consulting Actuary

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\(^1\) The American Council of Life Insurers advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care (LTC) insurance, disability income insurance, reinsurance, dental, vision, and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States.

\(^2\) AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.
Memo

To: Commissioner Conway, Chair, Long Term Care Insurance Multistate Rate Review Subgroup
From: Tricia Matson, Partner
Date: December 6, 2021
Subject: RRC comments regarding Long Term Care Insurance Multistate Rate Review Framework

Background

The Long Term Care Insurance Multistate Rate Review Subgroup ("the Subgroup") exposed a Long Term Care Insurance (LTCI) Multistate Rate Review Framework ("the Framework") which covers a potential approach to increase consistency of LTCI rate review actions across states and improve efficiency of LTCI rate reviews for insurers. RRC appreciates the opportunity to offer our comments. Should you have any questions, we would be glad to discuss our comments with you and the Subgroup members.

RRC Comments

1. Overall, we applaud these efforts. We understand that there are current industry challenges associated with differences in rate approval practices among states and agree with efforts to increase uniformity of those practices while continuing to maintain the individual state decision making authority.

2. Regarding the involvement of and coordination with the Interstate Insurance Product Regulation Commission ("Compact"), it is unclear from the Framework why the MSA Team was determined to be the appropriate body to review the rates, rather than the Compact. It might be helpful to clarify this in the Framework.

3. On page 5, the document indicates that a uniform national system should lead to "more accurate reviews, theoretically reducing some of the need for ongoing rate increase filings." Based on our experience, current state-based rate reviews are not subject to inaccuracy, so we would suggest removing or rewording this. We believe that a uniform national system has many benefits, but we do not believe that improving accuracy is one of them.

4. Page 5 also states that the MSA Advisory Reports "are only for use by Participating States in considering and evaluating rate filings." There is also language to minimize misuse of the MSA Advisory Reports by the insurers submitting the filings. It is not clear why the MSA Advisory Reports are shared with the insurers. If they are only for the Participating States, and there are concerns about potential misuse by the insurers, perhaps a better approach would be to provide them only to the Participating States for their use in the ultimate rating decision. This may also reduce risk in the event that the MSA Advisory Report recommendations differ significantly from the final state decision.

5. Regarding the qualifications of an MSA team member on page 7, we recommend adding that some minimum number (and at least one) of the members meet the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States.
6. Page 8 indicates that an MSA member will likely spend 20 hours per month. With 5 to 7 MSA members, it appears that 20 hours may not be sufficient, depending on the volume of submitted filings. We suggest considering alternative options to add additional supporting resources, spread work among resources, or increase the time commitment of MSA members, in the event needed.

7. Page 10 provides the eligibility criteria for submission of filings. Because certain criteria are somewhat arbitrary (e.g., impacting 20 states and at least 5,000 policyholders), we are in favor of the additional language allowing the MSA Team to apply judgment in considering filings for inclusion that do not strictly meet the criteria. You may also consider whether the criteria might be revised in the future to enable incorporation of more filings, in particular if results are highly beneficial.

8. Regarding the timeframes for completing reviews outlined on page 12, we recognize that precise timeframes are not possible due to the level of uncertainty. However, we suggest outlining some general time constraints, similar to what exists in current state laws (i.e., deemer dates), to improve accountability and enable more robust planning by the Participating States and the insurers.

9. Page 14 indicates that one of the items that may be considered in a feedback survey is the “number of rate proposals approved by the MSA Review Team.” Since the state, and not the MSA Review Team, is the ultimate approving party, we suggest changing “approved” to “reviewed”.

10. On page 15, the Framework notes that the MSA Team’s recommendations may include a goal of achieving the same rate per unit in each state, resulting in higher increases in states that have not approved as many historical rate increases. While such an approach could improve equity/remove subsidization across states, it could also reduce equity/increase subsidization among individual policyholders, since policyholders that stay in force might be subject to “catch up” rate increases thereby subsidizing policyholders that lapsed. We would encourage approaches that focus on reducing inappropriate cross subsidization based on prospective considerations, rather than approaches that simply move inappropriate cross subsidization from one group to another.

11. Regarding Appendix B, it may be helpful to develop templates for carriers to submit information. We have found in our LTC rate filing reviews that the nature and depth of information can vary significantly from filing to filing and use of standard templates may enable the MSA Team to review the filings more efficiently.

12. On page 23, we suggest adding a requirement that the assumption information provided must include sufficient rationale such that another actuary qualified in the same practice area can understand how the assumption was developed, as required by ASOP 41. We specifically mention this because we often find that filings do not include this level of detail, and this information will be important for the MSA Team to review.

13. On page 24, we suggest adding a requirement to provide information about past reserve strengthening and premium deficiency reserves held, to help the reviewers understand if actions taken in reserves are reasonably consistent with the need for premium increases. On this same page, we suggest adding a requirement to provide support for the determination of the maximum valuation interest rate (i.e., the weighted average calculation across issue years).

14. On page 25, we suggest adding a requirement to identify how potential antiselection was addressed in the projection associated with election of Reduced Benefit Options.
15. Regarding Exhibit A, the sample MSA Advisory Report, we suggest including the disclosures required under applicable actuarial standards of practice (ASOPs). For example, ASOP 41, *Actuarial Communications*, requires disclosure of the information date, the applicable law, reliance on others, if any assumptions were determined to be unreasonable or could not be assessed for reasonableness, and that the actuary is qualified to provide the statement of actuarial opinion.

Thank you for the opportunity to provide comments on this important initiative. I can be reached at tricia.matson@riskreg.com or (860) 305-0701 if you or other Subgroup members have any questions.
The following proposed revisions were made since the Nov. 15 exposure draft in response to comments received and are reflected in the December 2021 draft LTCI MSA Framework.

- Page 4, I.D. Benefits of Participating in the MSA Review: Third bullet describing benefits for insurers was deleted in response to comment from RRC. 
  
Finally, the consistency of one uniform national system for reviewing rate increase proposals should lead to more accurate reviews, theoretically reducing some of the need for ongoing rate increase filings.

- Page 11, IV.E. Feedback to the MSA Team: In #2, replaced “approved” with “reviewed” as suggested by RRC.

- Page 22, Appendix C: Minnesota Approach 2.a.ii edited:
  - Premiums in the formula reflect the actual rate level. To ensure past increases are not doubled counted, past premiums in the formula in 2.a.i should reflect actual rate level, including past increases; while PV (future premium) in 2.a.i. should be based upon the original rate level.
Long-Term Care Insurance Multistate Rate Review Framework

Draft as of December 2021

NAIC Long-Term Care Insurance (EX) Task Force
PREFACE

The Long-Term Care Insurance Multistate Rate Review Framework (LTCI MSA Framework) was drafted by the Ad Hoc Drafting Group of the NAIC Long-Term Care Insurance (EX) Task Force. The Ad Hoc Drafting Group consists of representatives from state insurance departments in Connecticut, Minnesota, Nebraska, Texas, Virginia, and Washington.

The LTCI MSA Framework was adopted by the NAIC Long-Term Care Insurance Multistate Rate Review (EX) Subgroup and the Long-Term Care Insurance (EX) Task Force on [insert date], and the NAIC Executive Committee and Plenary on [insert date].
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I. INTRODUCTION

A. Purpose

The NAIC charged the Long-Term Care Insurance (EX) Task Force with developing a consistent national approach for reviewing current long-term care insurance (LTCI) rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. Considering that charge and the threat posed by the current LTCI environment both to consumers and the state-based system (SBS) of insurance regulation, the Task Force developed this framework for a multi-state actuarial (MSA) LTCI rate review process (MSA Review).

This framework is based upon the extensive efforts of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, including its experience with a pilot program conducted by the pilot program’s rate review team (Pilot Team). As part of that pilot program, the Pilot Team reviewed LTCI premium rate increase proposals and issued MSA Advisory Reports recommending actuarially justified state-by-state rate increases. This framework aims to institutionalize a refined version of the Pilot Team’s approach to create a voluntary and efficient MSA Review that produces reliable and nationally consistent rate recommendations that state insurance regulators and insurers can depend upon. The MSA Review has been designed to leverage the limited LTCI actuarial expertise among state insurance departments by combining that expertise into a single review process analyzing in force LTCI premium rate increase proposals or rate proposal and producing an MSA Advisory Report for the benefit and use of all state insurance departments. Note that rate decrease proposals can be contemplated within the MSA Review. The same concepts of this MSA Framework would be applied, if such a rate decrease proposal is received for MSA Review. The goal of this framework is to create a process that will not only encourage insurers to submit their LTCI products for multi-state review, but also provide insurance departments the requisite confidence in the MSA Review so they will voluntarily utilize the Multistate Actuarial LTCI Rate Review Team’s (MSA Team’s) recommendations when conducting their own state level reviews of in force LTCI rate increase filings. Ultimately, the MSA Review is designed to foster as much consistency as possible between states in their respective approaches to rate increases.

The purpose of this document is to function as a framework for the MSA Review that communicates to NAIC members, state insurance department staff, and external stakeholders how the MSA Review works to the benefit of state insurance departments and how insurers might engage in the MSA Review. This MSA framework is intended to communicate the governance, policies, procedures, and actuarial methodologies supporting the MSA Review. State insurance regulators can utilize the information and guidance contained herein to understand the basis of the MSA Team’s MSA Advisory Reports. Insurance companies can access the information and guidance contained herein to understand how to engage in the MSA Review, and how the MSA Advisory Report may affect the insurer’s in force LTCI premium rate increase filing decisions and interactions with individual state insurance regulators.

This document will be maintained by NAIC staff under the oversight of the Task Force and be revised as directed by the Task Force or an appointed subgroup. This document will be part of the NAIC library of official publications and copyrighted.

B. State Participation in the MSA Review

The MSA Review of an insurer’s rate proposal will be available to state insurance departments who are both an Impacted State and a Participating State. These are defined as follows.

- “Impacted State” is defined as the domestic state, or any state for which the product associated with the insurer’s in force LTCI premium rate increase proposal is or has been issued.

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1 “Premium rate increase proposal(s)” or “rate proposal(s)” in this document refers only to an insurer’s request for review of a proposed in force LTCI premium rate increase or decrease under the MSA Review.
2 The term “rate increase filing” or “rate filing(s)” in this document refers only to the in force LTCI premium rate request(s) that is submitted to individual state departments of insurance (DOI) for a regulatory decision. Filings refer to both rate increase filings and rate decrease filings.
Participating State” is defined as any impacted state insurance department that agrees to participate in the MSA Review. Participation is voluntary as described in Section IE(1) below. Participation may include activities such as, but not limited to, receiving notifications of rate increase proposals in System for Electronic Rate and Form Filing (SERFF), participation in communication/webinars with the MSA Team, and access to the MSA Advisory Report.

Note that state participation is expected to increase in the future as the MSA Review process continues to be developed and refined.

C. General Description of the MSA Review

The MSA Review provides for a consistent actuarial review process that will result in an MSA Advisory Report, which state insurance departments may consider when deciding on an insurer’s rate increase filing or to supplement the state’s own review process.

The MSA Review is conducted by a team of state’s regulatory actuaries with expertise in LTCI rate review. Each review will be led by a designated member of the MSA Team. The review process is supported by NAIC staff and Interstate Insurance Product Regulation Commission (Compact) staff, who will administratively assist insurers in making requests to utilize the MSA process and facilitate communication between the insurer, the MSA Team and [Participating/Impacted TBD] States. The NAIC’s electronic infrastructure, SERFF, will be used to streamline the rate proposal and review process. Although the administrative services of Compact staff and SERFF’s Compact filing platform are utilized in the MSA Review, MSA rate proposals are reviewed, and MSA Advisory Reports are prepared by the MSA Team. MSA rate proposals are not Compact filings, and Compact staff will not have any role in determining the substantive content of the MSA Advisory Reports.

The MSA Review begins when an insurer expresses interest in an MSA Review being performed for an in force LTCI rate proposal to the MSA Team through SERFF or supporting NAIC or Compact staff. The eligibility of the rate proposal will be reviewed and determined by the MSA Team with assistance, as needed, from supporting staff.

The MSA Review of eligible rate proposals will resemble a state-specific rate review process utilizing consistent actuarial standards and methodologies. The MSA Team will apply the Minnesota and Texas approaches to calculate recommended, approvable rate increases. While aspects of the Minnesota and Texas approaches may result in lower rate increases than those resulting from loss ratio-based approaches and are outside the pure loss ratio requirements contained in many states’ laws and rules, the approaches fall in line with legal provisions that rates shall be fair, reasonable, and not misleading. The MSA Team will review support for the assumptions, experience, and projections provided by the insurer and perform validation steps to review the insurer-provided information for reasonableness. The MSA Team will document how the proposal complies with the regulatory approach utilized by the MSA Team for Participating States. See Section V for more details on the actuarial review.

Throughout the MSA Review, the MSA Team will provide updates to the insurer. The MSA Team will deliver the final MSA Advisory Report to the insurer and address any questions the insurer has about the results of the Review.

Additionally, the review will consider reduced benefit options (RBOs) that are offered in lieu of the requested rate increases and factor in non-actuarial considerations.

At the completion of the review, the MSA Team will draft an MSA Advisory Report for Participating States and insurers that provides both summary and detail information about the rate proposal, the review methodologies, the analysis and other considerations of the team, and the recommendation for rate increases as outlined in Appendix A. The MSA Advisory Report will also indicate whether the recommendation differs from the insurer’s proposal. Participating States can utilize the MSA Advisory Report or supplement their own state’s rate review with it as

1 Certain processes for Impacted vs. Participating States are yet to be determined (TBD).
described in the following Section ID. Participating States may also utilize the information filed with the MSA Team in addition to the Advisory Report as appropriate.

The rate proposal, review process, actuarial methodologies, and other review considerations are detailed within this framework document and accompanying appendices.

D. Benefits of Participating in the MSA Review

Both state insurance regulators and insurers will benefit by participating in the MSA Review in multiple ways. For state insurance regulators:

- First, they will be able to leverage the demonstrated expertise of the MSA Team in reviewing in force LTCI rate increase filings in their state. It is recognized that multiple states may not have significant actuarial expertise with LTCI, so participation in the MSA Review will allow those states to build on the specific, dedicated LTCI actuarial expertise of the MSA Team.
- Second, state insurance regulators will be able to utilize the MSA Team to promote consistency of actuarial reviews among filings submitted by all insurers to states and actuarial reviews across all states. Because the MSA Team is using the same dedicated approach to in force LTCI rate increase reviews, states who utilize the MSA Team will have the benefit of using the same consistent methodology that is relied upon by other state insurance departments when reviewing in force LTCI rate increase filings in their state.
- Third, the MSA Review allows for more state regulatory actuaries to work with or under the supervision of qualified actuaries, which affords them an opportunity to establish LTCI-specific qualifications in making actuarial opinions. This is particularly important when we consider that requirements to be a qualified actuary include years of experience under the supervision of another already qualified actuary in that subject matter.
- Finally, participating in the MSA Review will allow all state insurance regulators to share questions and information regarding a particular rate proposal or review methodologies; thus, increasing each state’s knowledge base in this area and promoting a more consistent national approach to in force LTCI rate review.

Note that states’ use of and reliance on the MSA Advisory Report is expected to increase in the future as the MSA Review continues to be developed and refined, and the benefits of the MSA Review described above become more evident.

Long-Term Care (LTC) insurers will likewise see multiple benefits in participating in the MSA Review:

- First, by utilizing the MSA Review and through the receipt of MSA information and the MSA Advisory Report from the MSA Team, insurers should see increased efficiency and reduced timelines for nationwide premium rate increase filings. As the MSA Team delivers the MSA Advisory Report for a rate proposal to Participating States, it has functionally reduced the review time for each state, meaning that LTC insurers should see more efficient and timely reviews from these states.
- Second, participating in the MSA Review will provide LTC insurers with one consistent recommendation to be used when making rate increase filings to all states, thus reducing the carrier’s workload in developing often widely differing filings for states’ review.

E. Disclaimers and Limitations

State Authority Over Rate Increase Approvals

The MSA Advisory Report is a recommendation to Participating States based upon the methodologies adopted by the MSA Review. The recommendations are not specific to, and do not account for, the requirements of any specific state’s laws or regulations. The MSA Review is not intended, nor should it be considered, to supplant or otherwise replace any state’s regulatory authority, responsibility, and/or decision making. Each state remains ultimately
responsible for approving, partially approving, or disapproving any rate increase in accordance with applicable state law.

A Participating State’s use of the MSA Advisory Report’s recommendations with respect to one filing does not require that state to consider or use any MSA Advisory Report recommendations with respect to any other filing. The MSA Review in no way: 1) eliminates the insurer’s obligation to file for a rate increase in each Participating State; or, 2) modifies the substantive or procedural requirements for making such a filing. While encouraged to adopt the recommendations of the MSA Review in each of their state filings, insurers are not obligated to align their individual state rate filings with the recommendations contained within the MSA Advisory Report.

The MSA Advisory Reports, including the recommendations contained therein, are only for use by Participating States in considering and evaluating rate filings. The MSA Advisory Reports or their conclusions shall not be utilized by any insurer in a rate filing submitted to a non-Participating State, nor shall the MSA Advisory Reports be used outside of each state insurance regulator’s own review process or challenge the results of any individual state’s determination of whether to grant, partially grant, or deny a rate increase.

Information Sharing Between State Insurance Departments

The MSA Review, including, but not limited to, meetings, calls, and correspondence on insurer-specific matters are held in regulator-to-regulator sessions and are confidential. In addition, if certain information and documents related to specific companies that are confidential under the state law of an MSA Team member or a Participating State need to be shared with other state insurance regulators, such sharing will occur as authorized by state law, and pursuant to the Master Information Sharing and Confidentiality Agreement (Master Agreement) between states that governs the sharing of information among state insurance regulators. Through the Master Agreement, state insurance regulators affirm that any confidential information received from another state insurance regulator will be maintained as confidential and represent that they have the authority to protect such information from disclosure.

Confidentiality of the Rate Proposal

Members of the MSA Team and Participating States affirm and represent that they will provide any in force LTCI rate proposal, as discussed herein with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state’s laws and regulations.

Confidentiality of the MSA Reports

Likewise, members of the MSA Team and Participating States affirm and represent that they will provide any MSA Advisory Report(s), as discussed herein with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state’s laws and regulations for rate filings.

F. Governing Body and Role of the NAIC Long-Term Care Insurance (EX) Task Force

The Long-Term Care Insurance (EX) Task Force is expected to remain in place for the foreseeable future to oversee the implementation of the MSA Review, and related MSA Advisory Reports, and to provide a discussion forum for MSA-related activities. The Task Force or any successor will continuously evaluate the effectiveness and efficiency of the MSA Review for the benefit of state insurance regulators and provide direction, as needed. The Task Force may create one or more subgroups to carry out its oversight responsibilities.

Membership and leadership of the Task Force will be selected by the NAIC president and president-elect as part of the annual committee assignment meeting held in January. Selection of the membership and leadership may consider a variety of criteria, including commissioner participation, insurance department staff competencies, market size, domestic LTC insurers, and other criteria considered appropriate for an effective governance system.
II. MSA TEAM

The MSA Team comprises state insurance department actuarial staff. MSA Team members are chosen by their skill set and LTCI actuarial experience. The Long-Term Care Insurance (EX) Task Force, or its appointed subgroup, will determine the appropriate experience and skill set for qualifying members for the MSA Team. It is expected that state participants will provide expertise and technical knowledge specifically regarding the array of LTCI products and solvency considerations. The desired MSA Team membership composition should include a minimum of five and up to seven members.

Membership must follow the requirements below and be approved by the chair of the Task Force or the chair of an appointed subgroup. The following outlines the qualifications, duties, participation expectations and resources required for MSA Team members.

A. Qualifications of an MSA Team Member

To be eligible to participate as a member of the MSA Team, a state insurance regulator is required to:

- Hold a senior actuarial position in a state insurance department in life insurance, health insurance, or LTCI.
- Be recommended by the insurance commissioner of the state in which the actuary serves.
- Have over five years of relevant LTCI insurance experience.
- Hold an Associate of the Society of Actuaries (ASA) designation.
- Currently participates as a member of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup (or an equivalent Subgroup appointed by the Long-Term Care Insurance (EX) Task Force) and the LTC Pricing (B) Subgroup.
- Be a member of the American Academy of Actuaries (Academy) (at least one member).

Additionally, the following qualifications are preferred:

- Hold a Fellow of the Society of Actuaries (FSA) designation
- Have spent at least one year engaged in discussions of either the Task Force or its appointed Subgroup

As both state insurance regulators and the MSA Review may benefit by developing and expanding specific LTCI actuarial expertise through participation in this process, having one or more suitably experienced and qualified actuaries participate in and supervise the work of the MSA Team is critical to the viability of the MSA process. Participation also provides opportunities for additional actuaries to meet the requirements of the U.S. Qualification Standards applicable to members of the Academy and other U.S. actuarial organizations as they relate to LTCI.

Consideration will be given to joint membership where two actuaries within a state combine to meet the criteria stated above.

Consultants engaged by the state insurance department would not be considered for MSA Team membership.

B. Duties of an MSA Team Member

- Active involvement with the MSA Team, with an expected average commitment of 20 hours per month (see Section IV for details of the MSA Review and activities of a team member).
- Participate in all MSA Team calls and meetings (unless an extraordinary situation occurs).
- Review and analyze materials related to MSA rate proposals.
- Provide input on the MSA Advisory Reports, including regarding the recommended rate increase approval amounts.
- Maintain confidentiality of MSA Team meetings, calls, correspondence, and the matters discussed therein to the extent permitted by state law and protect from disclosure any confidential information received.
pursuant to the Master Agreement. MSA Team members should communicate any request for public disclosure of MSA information or any obligation to disclose.

- Active involvement within NAIC LTCI actuarial groups.
- Willingness to provide expertise to assist other states.

C. Participation of an MSA Team Member

Except for webinars and other general communications with state insurance departments, participation in the MSA Review conference calls and meetings related to the review of a specific rate proposal will be limited to named MSA Team members, supporting NAIC or Compact staff members who will be assisting the MSA Team, and the chair and vice chair of the Long-Term Care Insurance (EX) Task Force, or its appointed subgroup. Other interested state insurance regulators (e.g., domiciliary state insurance regulators) may be invited to participate on a call at the discretion of the MSA Team or the chair or vice chair of the Task Force or its appointed subgroup.

D. MSA Associate Program

The MSA Associate Program within the MSA Framework is intended to encourage and engage state insurance regulators to become actively involved in the MSA process. Additionally, a benefit of the program is to provide an educational opportunity for state insurance department regulatory actuaries that wish to gain expertise in LTCI. Regulatory actuaries can participate with varying levels of involvement or for different purposes as described. Regulatory actuaries may participate:

- As a mentee. The mentee would participate in aspects of the MSA Review. An MSA Team member will serve as a mentor to another state regulatory actuary and provide one-on-one guidance.
- To gain more knowledge and understanding of the Minnesota and Texas actuarial approaches.
- To share their own expertise through feedback to the MSA Team on MSA Advisory Reports to better enhance the overall MSA process.
- To participate on an ad hoc limited basis, i.e., where a regulatory actuary would like to participate but is unable to make the required time commitment.
- To meet the U.S. Qualification Standards applicable to members of the Academy and other U.S. actuarial organizations as they relate to LTCI by serving under the supervision of a qualified actuary on the MSA Team.
- To serve as a peer reviewer of the MSA Advisory Reports.

E. Conflicts, Confidentiality, and Authority of the MSA Team

Authority of the MSA Team

Members of the MSA Team serve on a purely voluntary basis, and any member’s participation shall not be viewed or construed to be any official act, determination, or finding on behalf of their respective jurisdictions.

Disclosures and Confidentiality Obligations, as Applicable

All members of the MSA Team acknowledge and understand that the MSA Review, including, but not limited to, meetings, calls, and correspondence are confidential and may not be shared, transmitted, or otherwise reproduced in any manner. Additionally, all members of the MSA Team affirm and represent that they will: a) provide any in force LTCI rate proposal with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state’s laws and regulations; and, b) provide any MSA Advisory Report with the same protection from disclosure, if any, as provided by the confidentiality provisions contained within their state’s laws and regulations for rate filings.

Conflict of Interest Avoidance Procedures and Certifications
No member of the MSA Team may own, maintain, or otherwise direct any financial interest in any company or its affiliates subject to the regulation of any individual state, nor may any member serve or otherwise be affiliated with the management or board of directors in any company or its affiliates subject to the regulation of any individual state. All conflicts of interest, whether real or perceived are prohibited and no member of the MSA Team shall engage in any behaviors that would result in or create the appearance of impropriety.

F. Required NAIC and Compact Resources

The MSA Team will require administrative and technical support from the NAIC. As the MSA Review develops, it is expected that NAIC support resources will play an integral role in managing the overall program. Administrative staff support will be needed to support MSA Team communications and manage record keeping for underlying workpapers and final MSA Advisory Reports associated with each rate proposal, etc. Additionally, it is possible that limited actuarial support will be needed for the analysis of rate proposals, including preparing data files, gathering information, performing limited actuarial analysis procedures, drafting MSA Advisory Reports, and monitoring interactions among the state insurance departments and the MSA Team. Dedicated staff support for the ongoing work of the Long-Term Care Insurance (EX) Task Force will be needed as well. As more experience with rate proposal volumes and average analysis time is gained, the full complement of human resources required will be better understood.

The MSA Team and supporting NAIC and Compact staff will use the NAIC SERFF electronic infrastructure to receive insurer rate increase proposals and correspond with insurers. As needed, the MSA Team or supporting NAIC and Compact staff may communicate with the insurer outside of SERFF. The material substance of such communication can be documented within SERFF. NAIC and Compact staff will communicate with insurers only at the direction of the MSA Team. Compact staff will perform administrative work related to MSA rate increase proposals at the direction of the MSA Team and as described in this framework.

III. REQUESTING AN MSA REVIEW

A. Scope and Eligibility of a Rate Proposals for MSA Review

The following are the preferred eligibility criteria for requesting an MSA Review of a rate proposal.

- Must be an in force LTCI product (individual or group).
- Must be seeking a rate increase in at least 20 states and must affect at least 5,000 policyholders nationwide.
- Includes any stand-alone LTCI product approved by states, not by the Compact.
- For Compact-approved products meeting certain criteria, the Compact office will provide the first-level advisory review subject to the input and quality review of the MSA.

It is recognized that rate proposals vary from insurer to insurer. The above criteria and the timelines provided below are general guidelines. The MSA Team has the authority to weigh the benefits of the MSA Review for state insurance departments and the insurer against available MSA Team resources when considering the eligibility of rate proposals and the timeline for completion. Based on these considerations, the MSA Team, at its discretion, may elect to perform an MSA Review on a rate proposal that does not satisfy the above eligibility criteria.

The MSA Team reserves the right to deny a proposal that does not meet eligibility criteria. An insurer will be notified if the proposal for an MSA Review is denied.

An insurer may ask questions for more information about a potential rate proposal through communication to supporting NAIC and Compact staff and the MSA Team. This will be accomplished through a Communication Form that will be available on the Compact web page. Supporting NAIC and Compact staff will work with the insurer to complete the necessary steps to assess eligibility, discuss any technical or other issues, and answer questions.
The insurer will have access to primary and supplementary checklists in Appendix B that provide guidance to the insurer for information that should be included in a complete MSA rate proposal requested through the NAIC’s SERFF application.

B. Process for Requesting an MSA Review

As noted in Section IC above, the MSA Review will utilize the Compact’s multistate review platform within the NAIC’s SERFF application and its format for in force LTCI rate increase proposals. Therefore, a state may participate in the MSA Review without being a member of the Compact. The following describes a few key elements of the process for insurers and state insurance regulators:

- The insurer will work with NAIC and Compact support staff and the MSA Team to make a seamless rate increase proposal.
- Instructions containing a checklist for information required to be included in the rate increase proposal, as reflected in Appendix B, will be available to insurers through the Compact’s web page or within SERFF.
- The insurer shall include in the rate proposal a list of all states for which the product associated with the rate increase proposal is or has been issued. Participating States will have access to view the insurer’s rate proposal and review correspondence in SERFF.
- Fee schedule for using the MSA Review [TBD].
- Rate increase proposals for MSA Review within SERFF will be clearly identified as separate from Compact filings.
- The supporting NAIC and Compact staff through SERFF will notify the Impacted States upon receipt of the rate increase proposal with the SERFF Tracking Number.
- The MSA Team may utilize a “queue” process for managing workload and resources for incoming rate increase proposals through SERFF.
- The MSA Team may utilize Listserv or other communication means for inter-team communications.
- The MSA Team’s review of objections and insurer responses are completed through SERFF.

C. Certification

The insurer shall provide certifications signed by an officer of the insurer that it acknowledges and understands the non-binding effect of the MSA Review and MSA Advisory Report. The certification shall also provide, and the insurer shall agree, that it will not utilize or otherwise use the MSA Review and/or the resulting MSA Advisory Report to challenge, either through litigation or any applicable administrative procedure(s), any state’s decision to approve, partially approve, or disapprove a rate increase filing except when: 1) the individual state is a (Participating/Impacted State [TBD]) that affirmatively relied on the MSA Review and/or the MSA Advisory Report in making its determination; or 2) the individual state consents in writing to use of the MSA Review and/or the MSA Advisory Report.

Failure to abide by the terms of the insurer’s certification will result in the insurer and its affiliates being excluded from any future MSA Reviews, and it will permit the MSA Team to terminate, at its sole discretion, any other ongoing review(s) related to the insurer and its affiliates.

Should the MSA Team exclude any insurer and its affiliates for failure to adhere to its certification, the MSA Team, at its sole discretion, may permit the insurer and its affiliates to resume submitting rate proposals for review upon written request of the insurer.

IV. REVIEW OF THE RATE PROPOSAL

A. Receipt of a Rate Proposal
The MSA rate review process begins when an insurer expresses interest in an MSA Review being performed for a rate proposal. This interest can be expressed through completion of a Communication Form, which will be available through the Compact web page. The initial request will be reviewed by the MSA Team lead reviewer and/or supporting NAIC and Compact staff. Once an insurer has completed this initial communication and meets the criteria for requesting an MSA Review, the insurer will work with supporting NAIC and Compact staff and the MSA Team to complete the rate increase proposal in SERFF. The MSA Team will be notified, via SERFF, when the rate increase proposal is available for review.

The supporting NAIC and Compact staff will notify (Participating/Impacted States [TBD]) via SERFF or e-mail when rate increase proposals are submitted, correspondence between the MSA Team and insurer is sent or received in SERFF, the MSA Advisory Report is available, and other pertinent activities occur during the review.

B. Completion of the MSA Review

The MSA Team shall designate a lead reviewer to perform the initial review of each rate proposal. Once the rate increase proposal is made through SERFF, the MSA Review will resemble a state-specific review process.

The MSA Team will meet periodically to discuss the review and determine any needed correspondence with the insurer. Objections and communications with filers will be conducted through SERFF, like any state-specific filing or Compact filing, to maintain a record of the key review items. Other supplemental communication between the insurer and the MSA Team or supporting NAIC and Compact staff, may occur, such as conference calls or emails, as appropriate.

The timeframe for completing the MSA Team’s review and drafting the MSA Advisory Report will be dependent upon the completeness of the rate proposal and the size and complexity of the block of policies for which the rate increase applies. The MSA Team may utilize a “queue” process for managing workload and resources for incoming rate increase proposals through SERFF. The timeliness of any necessary communication between the MSA Team and the insurer to resolve questions or request/receive additional information about the rate proposal will affect the completion of the review.

As the MSA Team completes its review: 1) the insurer will receive initial communication of a completed review, and a final MSA Advisory Report with recommendations will be drafted and communicated to state insurance departments within the next month, which may serve as a signal for a potential ideal time for the insurer to prepare to submit the state-specific filings to each state; and 2) the insurer will receive sufficient information regarding the MSA Team’s recommendation to allow the insurer an opportunity to review the recommendation and in the event that the MSA Team recommendation differs from the proposal submitted by the insurer, the insurer will be given the opportunity to interact with the MSA Team in order to ask questions, and understand the MSA Team’s reasoning.

C. Preparation and Distribution of the MSA Advisory Report

Upon completion of the actuarial review, the MSA Team will prepare a draft MSA Advisory Report for the rate proposal. The reports will be made available within SERFF “reviewer notes” for Participating States. Supporting NAIC and Compact staff will maintain a distribution list and send notifications of the availability of reports to Participating States. Consultants engaged by state insurance department staff to perform rate reviews would be given access to the MSA Advisory Report, subject to the terms of the agreement between the consultant and the Participating State insurance department.

Consultants who are bound by the actuarial Code of Professional Conduct, adopted by the Academy of Actuaries, the Society of Actuaries (SOA) and the Conference of Consulting Actuaries (CCA), should consider whether receipt of the MSA Advisory Report is acceptable under Precept 7 regarding Conflicts of Interest. For other professions, similar consideration should be made if bound by similar professionalism standards.
Prior to finalizing the MSA Advisory Report, the MSA Team will present the draft MSA Advisory Report to Participating States on a regulatory-only call, as deemed necessary, to provide an overview of the recommendations and respond to questions from Participating States.

The MSA Team will issue the final MSA Advisory Report to the Participating States and the insurer after consideration of any comments and questions from Participating States.

The MSA Advisory Report will include standardized content, as reflected in Appendix A, with modifications, as necessary, for any unique factors specific to the rate proposal. The content and format are based on feedback received from state insurance departments and the Long-Term Care Insurance (EX) Task Force during the pilot project.

The content and format of the MSA Advisory Report may be modified in the future under the direction of the Task Force, or an appointed subgroup, as the MSA Team gains more experience in generating the reports and receives more feedback from Participating States and the insurer, through this process.

D. Timeline for Review and Distribution of the MSA Advisory Report

The draft MSA Advisory Report will be made available to Participating States for a two-week comment period prior to being finalized. The following timeline for this comment period and distribution of the final MSA Advisory Report will be adhered to as close as possible, barring timing delays due to holidays or other unexpected events. Note that the MSA Review is intended to occur before filings are made to the state insurance departments, therefore not affecting state insurance departments’ required timelines for review. However, use of the MSA Advisory Report by the state is expected to reduce the amount of time required for the state to complete its review.

Pre-Distribution - Share the draft MSA Advisory Report with the insurer. The insurer will be given the opportunity to interact with the MSA Team to ask questions and understand the MSA Team’s reasoning.

- Day 1 – Distribution of a draft MSA Advisory Report to all Participating States.
- Day 5-7 – Regulator-to-regulator conference call of all Participating States during which the MSA Team will present the recommendations in the MSA Advisory Report and seek comments from states.
- Day 21 – Deadline for comments on the draft MSA Advisory Report.
- Day 35 – Distribution of the final MSA Advisory Report, with consideration of comments, to Participating States and the insurer.
- Date TBD by the Insurer – Individual rate increase filings submitted to each state insurance department.
- Date TBD by each state’s DOI – Approval or disapproval of the rate increase filing submitted in each state.

E. Feedback to the MSA Team

At the direction of the Long-Term Care Insurance (EX) Task Force, or an appointed subgroup, state insurance departments will be requested to periodically provide data and feedback on their state rate increase approval amounts and their state’s use of and reliance on the MSA Advisory Reports. The following items may be considered in a feedback survey:

1. The number of rate proposals made with the MSA Review Team.
2. The number of rate proposals reviewed by the MSA Review Team.
3. Information regarding states approval of MSA recommendations.
4. Feedback on additional information states requested.
5. Feedback regarding how the review process and methodology could be improved.

State responses will be confidential pursuant to the Master Agreement, and aggregated results of feedback surveys will not specifically identify state responses. The MSA Team and state insurance regulators welcome feedback from insurers on their experience using the MSA Review Process. This collective feedback will aid the Task Force in understanding the practical effects of the MSA Review in achieving the goal of developing a more consistent state-
based approach for reviewing LTCI rate proposals that result in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. The feedback will also help refine the review process, improve future reports to better meet participants’ needs, and make updates to this MSA Framework. Finally, the feedback will assist NAIC leadership in making decisions regarding the technology and staff resources needed for the continued success of the project. Aggregated feedback results will be shared with Participating States and insurers as determined appropriate.

V. ACTUARIAL REVIEW

A. MSA Team’s Actuarial Review Considerations

In conducting its actuarial review of a rate proposal, the MSA Team will consider assumptions, projections, and other information provided by the insurer as outlined in Appendix B. The MSA actuarial review process will be evaluated and evolve over time as more rate proposals are reviewed.

The Minnesota and Texas approaches ensure remaining policyholders do not make up for losses associated with past policyholders. Professional judgment is used to address agreed upon policy issues, including the handling of incomplete or non-fully credible data. The Minnesota approach also considers adverse investment expectations related to the decline in market interest rates, and a cost-sharing formula is applied. The Texas approach ensures rate changes reflect prospective changes in expectations. More detail of each approach is provided in the following sections.

The MSA Team will consider the following in performing their review, applying their expertise and professional judgement to the review, and reviewing the actuarial formulas and results:

- Review insurer experience, insurer narrative explanation, and relevant industry studies.
- Assess reasonability of assumptions for lapse, mortality, morbidity, and interest rates.
- Validate and adjust or request new projections of claim costs and premiums by year.
  - Validate that the patterns of claims and premium projections over time reasonably align those reflected in the assumptions.
  - Adjust or request new projections of claims and premium to the extent that any underlying assumptions are deemed unreasonable or unsupported by the MSA Team. Any differences will initially result in correspondence between the MSA Team and the insurer via SERFF.
  - After verifying loss ratio compliance, apply both the Minnesota and Texas approaches for each rate proposal submitted.

In developing a recommendation, the MSA Team will apply a balanced approach and professional judgement for each rate proposal based on the characteristics of the block reviewed to determine the most appropriate method. The MSA Team’s recommendation will not be the lowest or the highest percentage method just because it is the lowest or the highest. Rather, the recommendation may be the result of either the Texas or Minnesota approach, a blend of the two approaches: or using professional judgement, the MSA Team may recommend a rate increase outside of these two approaches. Other methods may evolve over time that may be incorporated into the future process that generate similar or unique results. In applying professional judgement, (e.g., when considering the extent to which less-than-fully credible older-age morbidity should be projected to cause adverse experience), a balanced approach is applied as opposed to denying a rate increase, which could lead to a spike in the future, or approving the rate increase as if there was full credibility, which could lead to rates that could be too high. As the MSA Team reviews more rate proposals, it will consider and evaluate the characteristics of the rate proposals as it refines the blending of the two methods.

The MSA Team will consider how to reflect the differences in the histories of states’ rate approvals. Current approach includes:
The MSA Team’s recommendation results in the same rate per unit in each state following the current rate increase round, leading to higher percentage rate increases in states that approved lower rate increases in the past.

Analysis of state cost differences affecting justifiable rate increases will continue. As of May 2021, there does not appear to be substantial evidence that policyholders who purchased policies in lower-cost states should receive lower percentage rate increases. Part of the reason is that there was a tendency for people in lower-cost areas to purchase less coverage. Their premium rates will continue to be lower than rates for policyholders with more coverage, even if percentage rate increases are the same.

Any recommendation from the MSA Team for a catch-up increase aims to achieve only current rate equity between states and not lifetime rate equity between states.

Consideration of Solvency Concerns

If concerns exist regarding an insurer’s financial solvency and the impact of rate increases on future solvency, each state DOI, by their authority over rate approval, has the flexibility to consider solvency adjustments in these rare instances. In rare, non-typical circumstances, adjustments could be considered within the MSA Review, including consultation with states as part of the MSA Advisory Report comment period.

Follow-Up Proposals on the Same Block

Any subsequent rate increase proposal to the MSA Team on a block of business previously reviewed by the MSA Team needs to involve the development of adverse experience and/or expectations. In the absence of adverse experience or expectation development, the MSA Team will consider a reasonable explanation from an insurer for an increase in credibility of morbidity data of being the reason for a rate increase. Prior rate increases would need to be implemented before the implementation of a subsequent rate increase. The MSA Team will not consider a new rate increase proposal on a block that did not receive the full percentage rate increase requested without the experience, expectation, or credibility criteria noted above. If an insurer did not receive the full percentage rate increase and has no adverse changes in experience or expectations, the insurer should work directly with the applicable state DOI.

B. Loss Ratio Approach

Key aspects of the loss ratio approach to the actuarial review of rate changes include:

1. At policy issuance, pricing based on a lifetime loss ratio target is typically established. A common target is 60%, which means the present value of claims is targeted to equal 60% of the present value of premiums. In some instances, products may be priced with a projected lifetime loss ratio in excess of 60%. The remainder goes towards sales-related costs, administrative expenses, expenses related to claims, and profit. Note that 60% is a required minimum loss ratio under the pre-rate stability rules; newer policies may be priced with lower expected loss ratios. Refer to state law or regulation modeled from the Long-Term Care Insurance Model Regulation (§641), Section 19 for more details on compliance with loss ratio standards.

2. As lapses and mortality have generally been lower than expected, more people have reached ages where claims tend to occur than originally expected. In some cases, this has resulted in a substantial increase in the present value of claims; thus, resulting in substantially higher expected lifetime loss ratios than originally targeted. For companies where morbidity expectations have increased over original assumptions, lifetime loss ratios would be even higher.

3. The loss ratio approach increases future premiums to a level, referred to as make-up premium, such that the original loss ratio target is once again attained.
4. The loss ratio approach, one of the minimum standards in many states’ statutes, is evaluated by the MSA Team. However, there is general recognition that this approach produces rate increases that are too high and do not recognize other typical statutory standards, such as fair and reasonable rates.
   a. The loss ratio approach also does not recognize actuarial considerations such as the shrinking block issue, where past losses being absorbed by a shrinking number of remaining policyholders would lead to unreasonably high-rate increases. This concern was the main driver of the Minnesota, Texas, and other approaches.
   b. The loss ratio approach shifts all the risk to the policyholders. If the insurer is allowed to always return to the 60% loss ratio, there may be a lower incentive for more appropriate initial pricing.

5. For rate-stabilized business, lifetime loss ratios are broken out, such as in a 58%/85% pattern, where the 58% reflects the portion of initial premiums and the 85% reflects the portion of the increased premium available to pay the claims. For relevant blocks, this standard is analyzed by the MSA Team. If this standard produced lower increases than the Minnesota and Texas approaches, it would produce the recommended rate increase.

C. Minnesota Approach

Key aspects of the Minnesota approach to the actuarial review of rate changes include:

1. Blended if-knew / makeup approach to address the shrinking block issue.
   a. The if-knew concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
   b. The makeup concept is for a premium to be charged going forward to return the block to its original lifetime loss ratio.
   c. The blending method helps ensure concepts discussed in public NAIC Long-Term Care Pricing (B) Subgroup calls from 2015 to 2019 are incorporated, including the concept that rates will not substantially rise as the block shrinks, as policyholder persistency falls over time.

2. Cost-sharing formula that increases the insurer’s burden as cumulative rate increases rise.
   a. This addition to the insurer’s burden moves rates away from a direction that could potentially be seen as misleading. The insurer likely had or should have had more information on the likelihood of large rate increases than the consumer had at the time the policy was issued.

3. Assumption review.
   a. Verification that the insurer’s original and current assumptions are indeed drivers of the magnitude increase in lifetime loss ratio presented by the insurer.
   b. Verification of appropriateness of current assumptions.
      i. A combination of credible insurer experience, relevant industry experience, and professional judgement is applied.
      ii. For areas of uncertainty, such as older-age morbidity, conservatism may be added to the insurer-provided assumptions. This conservatism can be released as credible experience develops.

4. Interest rate / investment return component
   a. The Minnesota approach considers changes in expectations regarding interest rates and related investment returns in a manner consistent with how other key assumptions are considered. Reasons include:
      i. Changes in market interest rates are among the key factors driving profits and losses associated with blocks of LTC business.

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ii. In the Minnesota approach, all factors impacting the business are considered.
   1. If interest rates rise, this would tend to lead to lower rate increase approvals. Note, in this scenario, if interest rate changes were not considered, it is possible an insurer would get approval for rate increases even when profits on the block were higher than expected.
   2. If interest rates fall, this would tend to lead to higher rate increase approvals.

iii. To prevent shifting of “good assets” and “bad assets” to supporting LTC rates and prevent an insurer from increasing rates based on risky investments turned into losses, an index of average corporate bond yields (e.g., Moody’s) is relied on to reflect experience and current expectations.

iv. Original pricing typically includes an assumption on investment returns, for which premiums and other positive cash flows are assumed to accumulate. This forms the interest component of the original assumption.

v. The original pricing investment return in Section VC(4)iv is compared to the average corporate bond yields in Section VC(4)iii to determine the adversity associated with the interest rate factor.

5. Original Assumption Adjustment
   a. If original mortality, lapse, or investment return assumptions were out of line with industry-average assumptions at the time of original pricing, the original premium is replaced by a “benchmark premium.”
      i. This results in a lower rate increase.
      ii. This adjustment wears off over 20 years from policy issue.
         1. The rationale for the wearing off of this adjustment is the assumption that no insurer would intentionally underprice a product, knowing it would suffer losses for 20 years and then hope to offset a portion of that loss with a rate increase.
         iii. This adjustment is intended to prevent for example, an insurer underpricing a product, gaining market share, and then immediately requesting a rate increase.

D. Texas Approach

The Texas approach to the actuarial review of rate changes was developed in response to the NAIC Long-Term Care Pricing (B) Subgroup’s discussions regarding the recoupment of past losses in LTCI rate increases. The Texas approach relies upon a formula intended to prevent the recoupment of past losses by calculating the actuarially justified rate increase for premium-paying policyholders based solely on projected future (prospective) claims and premiums.

Key aspects of the Texas approach to the actuarial review of rate changes include:

1. Past losses are assumed by the insurer and not by existing policyholders. An approach that considers past claims in the calculation of the rate increase, such as a lifetime loss ratio approach, permits, the recoupment of past losses to some extent.

2. Calculates the rate increase needed to fund the prospective premium deficiency for active, premium-paying policyholders based on an actuarially supported change in assumption(s). This ensures that active policyholders do not pay for the past claims of policyholders who no longer pay premium.

3. Data Requirements for Calculation:
   a. The following calendar year projections, including totals, for current premium-paying policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate:
      i. Present Value of Future Benefits (PVFB) under current assumptions.
      ii. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
      iii. Present Value of Future Premiums (PVFP) under current assumptions.
      iv. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
1. Note that for all four projections above, the projection period is typically 40–50 years: although, some companies project for 60 or more years.

To emphasize, these projections should only include active policyholders currently paying premium and should not include any policyholders not paying premium (e.g., policies on waiver, on claim, or paid up) regardless of the reason. Projections under current actuarial assumptions must not include policyholder behavior as a result of the proposed premium rate increase, such as a shock lapse assumption.

Also, the insurer should identify and explain any estimates or adjustments to the data, as applicable.

4. Assumptions
   a. Rate increases are commonly driven by a change to the persistency, morbidity, mortality assumption, or a combination of the three.
   b. Verification that assumption change(s) are supported by credible data.
   c. The interest rate is the same for all four projections. This ensures that interest rate risk is assumed by the insurer, not the policyholder.

The formula used in the Texas approach is provided in Appendix C.

E. RBOs

In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force, developed a list of RBO principles to provide guidance for evaluating RBO offerings in Appendix D.

RBOs in the MSA Advisory Report

As part of the MSA Review, the MSA Team will perform a limited review of the reasonableness of RBOs included in the rate proposal that are extracontractual. The MSA Advisory Report will highlight how the insurer demonstrates the proposed RBOs’ reasonableness. Note that the MSA Team will not perform an assessment of RBOs in relation to individual state specific requirements for RBOs. The purpose of the guidance in the MSA Advisory Report is to provide initial information about the RBOs with which the state insurance regulators can then utilize to perform a more detailed assessment specific to their state’s requirements. As the MSA Review develops and as the Subgroup continues its work, this area of review may evolve.

Future RBOs

As the industry continues to innovate new RBOs for consumers, the MSA Review will likewise develop and evolve to consider the reasonableness of RBOs. Additionally, as the MSA Review evolves, additional regulatory expertise with RBOs may be added to the MSA Team in the future. To achieve more consistency across states in their understanding and consideration of RBOs, the Task Force will encourage its appointed Subgroup and/or an appropriate NAIC actuarial committee or group to collectively consider new RBOs as they arise. This process will provide for input and technical advice from actuaries and non-actuarial experts to the state insurance departments as they exercise their authority in considering RBOs as part of rate filings. States and insurers are therefore encouraged to discuss new and developing RBOs through this process.

F. Non-Actuarial Considerations

The Long-Term Care Insurance (EX) Task Force continues to review and consider non-actuarial considerations affecting states’ approval or disapproval of LTCI rate changes to develop consensus among jurisdictions and develop recommendations for application of these considerations. These considerations include such topics as:

1. Caps or limits on approved rate changes.
2. Phase-in of approved rate changes over a period of years.
3. Waiting periods between rate change requests.
4. Considerations of prior rate change approvals and disapprovals.
5. Limits or disapproval on rate changes based solely or predominately on the number of policyholders in a particular state.
6. Limits or disapproval on rate changes based on attained age of the policyholder.
7. Fair and reasonableness considerations for policyholders.
8. The impact of the rate change on the financial solvency of the insurer.

Considerations in the MSA Advisory Report

As part of the MSA Review, the MSA Team will identify relevant aspects of the insurer’s rate proposal, based on the information provided by the insurer, which may be affected by a state’s non-actuarial considerations. Note that the MSA Team will not perform a state-by-state review of each state’s non-actuarial considerations, statutes, or practices. Instead, the MSA Team will highlight in the MSA Advisory Report those aspects of the rate proposal that relate to or that may be affected by non-actuarial considerations. The purpose of this guidance in the MSA Advisory Report is to prompt state insurance regulators to contemplate those affected aspects of the rate proposal when completing their individual state's rate review. For example, the MSA Advisory Report may highlight:

- If cumulative rate increases are high, as this may affect the cost-sharing formula.
- If a rate proposal is for a block of business where the average policyholder age is predominately 85 or above, as this may affect states that consider age caps.
- If it is determined that the block of business will likely continue to incur substantial financial losses and impose a potential solvency concern, as this may affect the potential need for adjustments to the cost-sharing formula.
- Aspects of the coordination of rate and reserving review, as this may signify adjustments to the methodology assumptions used by the MSA Team in its review.

Future Non-Actuarial Considerations

The MSA Review will continue to develop and evolve as it is implemented. To achieve more consistency and minimize the number of differences across states in their application of other non-actuarial considerations in rate review criteria for LTCI rate filings, the Task Force will encourage its appointed Subgroup, or an appropriate NAIC actuarial committee or group, to collectively consider new future non-actuarial considerations as they arise. This process will provide for input and technical advice from actuaries to states as they exercise their authority in considering non-actuarial factors. States are therefore encouraged to discuss new and developing practices and/or recommendations in this area.

VI. APPENDICES

A. Appendix A – MSA Advisory Report Format

The MSA Advisory Report that is distributed to Participating State insurance departments and the insurer will generally follow a template that includes the following information. Note that degree of rigor in the review and the details and content of the MSA Advisory Report will depend on the magnitude of rate increase and the complexity of the rate proposal and the insurer’s financial condition. See also the sample MSA Advisory Report in Exhibit A.

1. Executive Summary.
   a. Overall recommended rate increase, before consideration of different states’ history of approvals.

2. Disclaimers.
   a. Purpose and intent of how states should use the MSA Advisory Report.
   b. Disclaimer that the MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer.
c. Statement that the in force rate increase filing submitted to the respective states shall be subject to the approval of each state, and each state's applicable state laws and regulations shall apply to the entire rate schedule increase filing.

3. Background on the MSA Review.

4. Explanation of the insurer’s Proposal.
   a. The explanation will be based on the aspects of the insurer’s rate proposal, which may include details as to whether the rate increase submitted for review involved different types of coverages or groupings.

5. Summary of the MSA Team’s rate review analysis, including these aspects:
   a. Actuarial review.
      i. The summary of the review and the MSA Team’s recommendation will be based on the aspects of the insurer’s rate proposal, and may include specific details of the review, for example analysis of projections, assumptions, margins, or other aspects.
   b. Summary of consideration of differences in the history of state’s rate increase approvals.
   c. Non-actuarial considerations and findings.
   d. Financial solvency-related aspects and adjustments.
   e. Review for reasonableness and clarity of RBOs.
   f. Summary information about the mix of business.

6. Appendices.
   a. Summary of the drivers of the rate proposal.
   b. Details regarding the Minnesota and Texas approaches as applied to the rate proposal.
   c. Summary of rate proposal correspondence.
   d. Examples of rate increases if an RBO is not selected.
   e. Potential cost–sharing formula for typical circumstances.

B. Appendix B – Information Checklist

At the request of the former Long-Term Care Insurance (B/E) Task Force, the Long-Term Care Pricing (B) Subgroup developed a single checklist that reflects significant aspects of LTCI rate increase review inquiries from all states. In this context, “checklist” means the list or template of inquiries that states typically send at the beginning of reviews of state-specific rate increase filings.

This document contains aspects of the NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation1 (Guidance Manual) and checklists developed by several other states. This consolidated checklist is not intended to prevent a state from asking for additional information. The intent is to take a step toward moving away from 50 states having 50 different checklists to a more efficient process nationally to provide the most important information needed to determine an approvable rate increase. To keep the template at a manageable length, it is anticipated that this template will result in states attaining 90–100% of the information necessary to decide on approvable rate increases. State and block specifics will generate the other 0-10% of requests. As states apply this checklist, it or an improved version may be considered for a future addition to the Guidance Manual.

Information Required for an MSA Review of a Rate Proposal

1 https://www.naic.org/documents/committees_b_senior_issues_100609_b_s_guidance_manual.pdf
The following provides a checklist of information necessary for a complete rate proposal to the MSA Review. This checklist is consistent with the “Consolidated, Most Commonly Asked Questions – States’ LTC Rate Increase Reviews” as adopted by the Health Actuarial (B) Task Force on March 23, 2018.

1. Identify all states for which the product associated with the rate proposal is or has been issued.

2. New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
   a. Provide rate increase percentages by policy form number and clear mapping of these numbers to any alternative terminology describing policies stated in the actuarial memorandum and other supporting documents.
   b. Provide the cumulative rate change since inception, after the requested rate increase, for each of the rating scenarios.

3. Rate increase history that reflects the filed increase.
   a. Provide the month, year, and percentage amount of all previous rate revisions.
   b. Provide the SERFF MSA numbers associated with all previous rate revisions.

4. Actuarial memorandum justifying the new rate schedule, which includes:
   a. Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
      i. The projection should be by year.
      ii. Provide the count of covered lives and count of claims incurred by year.
      iii. Provide separate experience summaries and projections for significant subsets of policies with substantially different benefit and premium features. Separate projections of costs for significant blocks of paid-up and premium-paying policies that should be provided.
      iv. Provide a comparison of state versus national mix of business. In addition, a state may request separate state and national data and projections. The insurer should accompany any state-specific information with commentary on credibility, materiality, and the impact on requested rate increase.

5. Reasons for the rate increase, including which pricing assumptions were not realized and why.
   a. Attribution analysis - presents the portion of the rate increase allocated to and the impact on the lifetime loss ratio from each change in assumption.
   b. Related to the issue of past losses, explain how the requested rate increase covers a policyholder’s own past premium deficiencies and/or subsidizes other policyholders’ past claims.
   c. Provide the original loss ratio target to allow for comparison of initially assumed premiums and claims and actual and projected premiums and claims.
   d. Provide commentary and analysis on how credibility of experience contributed to the development of the rate proposal.

6. Statement that policy design, underwriting, and claims handling practices were considered.
   a. Show how benefit features (e.g., inflation and length of benefit period) and premium features (e.g., limited pay and lifetime pay) impact requested increases.
   b. Specify whether waived premiums are included in earned premiums and incurred claims, including in the loss ratio target calculation; provide the waived premium amounts and impact on requested increase.
   c. Describe current practices with dates and quantification of the effect of any underwriting changes. Describe how adjustments to experience from policies with less restrictive underwriting are applied to claims expectations associated with policies with more restrictive underwriting.

6 https://content.naic.org/sites/default/files/inline-files/cmte_b_ltc_price_sg_180323_ltc_increase_reviews%20%289%29.docx
7. A demonstration that actual and projected costs exceed anticipated costs and the margin.

8. The method and assumptions used in determining projected values should be reviewed considering reported experience and compared to the original pricing assumptions and current assumptions.
   a. Provide applicable actual-to-expected ratios regarding key assumptions.
   b. Provide justification for any change in assumptions.

9. Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
   a. Explain the relevance of any data sources and resulting adjustments made relevant to the current rate proposal, particularly regarding the morbidity assumption.
   b. A comparison of the population or industry study to the in force related to the rate proposal should be performed, if applicable.
   c. Explain how claims cost expectations at older ages and later durations are developed if data is not fully credible at those ages and durations.
   d. Provide the year of the most recent morbidity experience study.

    a. Comparison with asset adequacy testing reserve assumptions.
       i. Explain the consistency regarding actuarial assumptions between the rate proposal and the most recent asset adequacy (reserve) testing.
       ii. Additional reserves that the insurer is holding above Health Insurance Reserves Model Regulation (#10) formula reserves should be provided, (such as premium deficiency reserves and Li—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) reserves.
    c. Provide actuarial assumptions from original pricing and most recent rate increase proposal and have the original actuarial memorandum available upon request.

11. Provide the following calendar year projections, including totals, for current premium paying nationwide policyholders only, prior to the rate increase, all discounted at the maximum valuation interest rate*:
    a. Present value of future benefits (PVFB) under current assumptions
    b. PVFB under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).
    c. Present value of future premiums (PVFP) under current assumptions.
    d. PVFP under prior assumptions (from prior rate increase filing, or if no prior increase, from original pricing).

   *To emphasize, these projections should include only active nationwide policyholders currently paying premium, and they should not include any policyholders not paying premium, regardless of the reason. Projections under current actuarial assumptions must not include policyholder behavior as a result of the proposed premium rate increase, such as a shock lapse assumption or benefit reduction assumption.

    b. Also, please identify the maximum valuation interest rate and ensure that it is the same for all four projections.

12. The Guidance Manual checklist items: 1) summaries (including past rate adjustments); 2) average premium; 3) distribution of business, including rate increases by state; 4) underwriting; 5) policy design and margins; 6) actuarial assumptions; 7) experience data; 8) loss ratios; 9) rationale for increase; and 10) reserve description.

13. Assert that analysis complies with Actuarial Standards of Practice (ASOPs), including 18 and 41.
14. Numerical exhibits should be provided in Microsoft Excel spreadsheets with active formulas maintained, where possible.

15. Rate Comparison Statement of renewal premiums with new business premiums, if applicable.

16. Policyholder notification letter should be clear and accurate.
   a. Provide a description of options for policyholders in lieu of or to reduce the increase.
   b. If inflation protection is removed or reduced, is accumulated inflation protection vested?
   c. Explain the comparison of value between the rate increase and policyholder options.
   d. Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
   e. How are partnership policies addressed?

17. Actuarial certification and rate stabilization information, as described in the Guidance Manual, and contingent benefit upon lapse information, including reserve treatment.

Supplemental Information

As part of the Long-Term Care Insurance (EX) Task Force’s pilot project in 2020–2021, the following supplemental information was identified by the MSA Team as beneficial; and, therefore, the Task Force may be requested to assist in the MSA Review.

1. Benefit utilization:
   a. Provide current, prior rate increase, and original assumptions, including first-projection year through ultimate utilization percentages for 5% compound inflation, lesser inflation, and zero inflation cells.
   b. Explain how benefit utilization assumptions vary by maximum daily benefit.
   c. Provide the cost of care inflation assumption implied in the benefit utilization assumption.

2. Attribution of rate increase
   a. Provide the attribution of rate increase by factor: morbidity, mortality, lapse, investment, and other.
   b. For the morbidity factor, break down the attribution by incidence, claim length, benefit utilization, and other.
   c. Provide information on the assumptions that are especially sensitive to small changes in assumptions.

3. RBOs
   a. Provide the history of RBOs offered and accepted for the block.
   b. Provide a reasonability analysis of the value of each significant type of offered RBO.

4. Investment returns:
   a. Provide original and updated / average investment return assumptions underlying the pricing.
   b. Explain how the updated assumption reflects experience.

5. Expected loss ratio:
   a. With respect to the initial rate filing and each subsequent rate increase filing, provide the target loss ratio.
   b. Provide separate ratios for lifetime premium periods and non-lifetime premium periods and for inflation-protected and non-inflation-protected blocks.

6. Shock lapse history:
   a. Provide shock lapse data related to prior rate increases on this block.

7. Waiver of premium handling:
a. Explain how policies with premiums waived are handled in the exhibits of premiums and incurred claims.
b. Explain how counting is appropriate (as opposed to double counting or undercounting).

8. Actual-to-expected differences:
   a. Explain how differences between actual and expected counts or percentages (in the provided exhibits) are reflected or not reflected in assumptions.

9. Assumption consistency with the most recent asset adequacy testing:
   a. Explain the consistency or any significant differences between assumptions underlying the rate increase proposal and those included in Actuarial Guideline 51 testing.

C. Appendix C—Actuarial Approach Detail

Minnesota Approach

Details on the key aspects of the Minnesota approach to the actuarial review of rate changes include:

1. Review of current assumptions for appropriateness, reasonableness, justification, and support.
   a. A combination of credible insurer experience, relevant industry experience, and professional judgement is applied.

2. If-knew premium and makeup premium aspects – aggregate application.
   a. Makeup percentage:
      i. \[
         \frac{[PV (claims) / original LLR] - PV [past premium]}{PV [future premium]} - 1.
      \]
      ii. To ensure past increases are not doubled counted, past premiums in the formula in 2.a.i should reflect actual rate level, including past increases; while PV (future premium) in 2.a.i. should be based upon the original rate level.
      iii.
   b. If-knew percentage:
      i. \[
         \frac{PV (claims) / PV [premiums]}{original LLR} - 1.
      \]
      ii. Premiums in the formula are at the original rate level.
      iii. The concept is to estimate a premium that would have been charged at issuance of the policy if information we know now on factors such as mortality, lapse, interest rates, and morbidity was available then.
   c. Definitions and explanations:
      i. PV means present value.
      ii. LLR means lifetime loss ratio.
      iii. Interest rates underlying PVs and LLRs are based on:
         1. For original PVs and LLRs, the interest rate is the investment return assumed in original pricing. Note that this rate is typically different than the statutory LLR discount rate.
         2. For current PVs, the interest rates are the average corporate bond yields over time for each year minus 0.25% (to account for expected defaults). For projections beyond the current year, phasing over five years of the current rate to a target rate (currently 4%) is assumed.
      iv. PV calculations are based on actual, current experience and expectations for persistency, morbidity, and interest rate.
      v. Insurer-provide premium and claim cash flows may be adjusted based on assumption review.
      vi. Makeup percentage is similar to that attained by the loss ratio approach.

3. If-knew premium and makeup premium aspects – sample policy-level verification.
   a. Over a range of issue years, issue ages, benefit periods, and inflation protection:
      i. Calculate an estimate of the original premium.
1. Based on original pricing assumptions for persistency, morbidity, investment returns, and expenses.
2. Apply first principles.
   a. For each policy year, calculate PV of claims and expenses, applying mortality, lapse, morbidity, and expenses, discounting at original investment rates.
   b. Add the PV of claims expenses for each policy year to attain PV of claims & expenses at issue.
   c. Divide by the sum of the PV of an annuity of 1 per year.
   d. Multiply \( \frac{b}{c} \) times \((1 + \text{originally assumed profit percentage})\) to attain the original premium.
   e. This premium provides the basis for comparison against the makeup and if-knew premium.
3. Replace the original premium with a benchmark premium.
   a. If the benchmark premium is higher than the original premium and original pricing (reflected in mortality, lapse, and investment return assumptions) was out of line with industry-average assumptions at the time of original pricing.
   b. The benchmark premium is phased back into the original premium proportionally over 20 years from issue.
   c. The benchmark aspect is intended to prevent, for example, an insurer underpricing a product, gaining market share, and then immediately requesting a rate increase.

ii. Calculate an estimate of the makeup premium.
1. Calculate the original dollar PV of profits for the sample policy using original pricing assumptions.
2. Calculate an updated dollar PV of profits for the sample policy using:
   a. Actual history of premiums and claims.
   b. Expectations of future claims.
   c. "Backed into" makeup premium.
3. Note that attaining the same dollar PV of profits for a sample policy leads to a lower makeup premium than attaining the same percentage PV of profits (as a percentage of premium).
   a. The reason for targeting the dollar instead of percentage is to avoid the dollar amount of profit being higher as premium rates increase.

iii. Calculate an estimate of the if-knew premium.
1. The calculation is the same as for the original premium, except it is based on current assumptions instead of original pricing assumptions.
   b. Verifying the impact on expectation changes on rates
      i. While lapse, mortality, and interest rate experience and assumptions are fairly routine to track (for determination of the rate impact), morbidity experience and assumptions tend to be difficult to track.
      ii. A combination of information is relied upon to estimate the impact of morbidity expectation deviations (from original pricing) on rates. This information includes:
         1. Original and current claim incidence and claim length by age and other factors.
         Incidence and length are tracked separately for some companies and combined for others.
         2. Experience
         3. Impact on LLR of changes in expectations of morbidity.
         4. Industry information and trends (for reasonableness checks).
   c. Assumptions underlying the calculations of estimates of premiums may be adjusted as part of the review. For instance:
      i. If sample policy verification shows less impact on rates due to changes in lapse, mortality, interest rate, and morbidity expectations than demonstrated in the insurer's aggregate projections, past or projected premiums or claims may be adjusted in the original, makeup, or if-knew premium calculations.
ii. If there is wide variance in practice among companies in morbidity assumptions at ages where data is of low credibility, adjustments may be made to help ensure similar situations resulting in similar rate increase approval amounts.

1. A balanced approach is pursued, recognizing that providing full or zero credit for partially credible experience may result in harmful consequences (excessive rates or later rate shocks).
2. Any reductions to rate increases caused by lack of credible experience can potentially be reversed in subsequent rate increase requests as credibility increases.

iii. Similar adjustments may apply when incomplete or inconsistent information is provided by the insurer (after initial attempts to resolve significant differences or gaps).

4. Reconciliation of aggregate and sample policy applications.
   a. In many cases, the aggregate and sample policy applications will result in similar current LLRs.
   b. In other cases, some steps are taken to understand the difference, including additional requests for information.
   c. Because the sample policy application considers information only related to premium-paying policyholders, it is possible that differences between the aggregate and sample policy application are caused by inclusion of past premiums and all claims related to non-premium payers in the aggregate information.
   d. When reconciliation occurs after rounds of communication, decisions will be made based on the information provided.

5. Blending – same for aggregate and sample policy applications.
   a. The weighting towards the makeup premium is the percentage of original policyholders remaining.
   b. The weighting towards the if-knew premium is the percentage of original policyholders no longer having active policies, or 1 minus the percentage in ii.
   c. The blending of the if-knew premium and makeup premium helps ensure remaining policyholders are not held responsible for paying for adverse experience associated with past policyholders.
   d. The blending also helps limit cumulative rate increases at later durations; as the percentage of remaining policyholders approaches zero, the blended approval amount approaches the if-knew premium.

6. Cost-sharing formula that increases the insurer burden as cumulative rate increases rise.
   a. The cumulative-since-issue, weighted if-knew / makeup premium-based increase is reduced by:
      i. No haircut for the first 15%.
      ii. 10% for the portion of cumulative rate increase between 15% and 50%.
      iii. 25% for the portion of cumulative rate increase between 50% and 100%.
      iv. 35% for the portion of cumulative rate increase between 100% and 150%.
      v. 50% for the portion of cumulative rate increase in excess of 150%.

7. Reduction for past rate increase:
   a. Take 1 plus the cost-sharing-adjusted blend amount and divide by 1 plus the previous, cumulative rate increases, then subtract 1. This is the approvable rate increase.

8. Summary.
   a. Review current assumptions.
   b. Calculate aggregate if-knew premium and makeup premium amounts. Calculate the blended amount.
c. Calculate the sample policy estimated original premium, if-knew premium, and makeup premium. Calculate the blended amount.
d. Reconcile aggregate and sample policy blended amounts. Set this blended amount aside.
e. Apply the cost-sharing formula to the blended amount.
f. Deduct past rate increases.
g. Example – if:
   i. The original premium is $1,000
   ii. Makeup premium is $3,000.
   iii. If-knew premium is $1,500.
   iv. 60% of policyholders remain.
   v. Past rate increases are 50%.
   vi. Blended amount is:
      1. \( \frac{3,000}{1,000} \times 0.60 + \)
      2. \( \frac{1,500}{1,000} \times 0.40 \)
      3. \(- 1 = \)
      4. \(180\% + 60\% - 1 = 240\% - 1 = 140\% \)
   vii. Cost sharing is:
      1. \(100\% \times 0.15 + \)
      2. \(90\% \times 0.35 + \)
      3. \(75\% \times 0.5 + \)
      4. \(65\% \times 0.4 = \)
      5. \(110\% \)
   viii. Deduction for past rate increases results in:
      1. \(\frac{(1 + 1.1)}{(1 + 5)} - 1 = \)
      2. \(40\% \)

**Texas PPV Formula**

Details on the PPV Formula of the Texas approach to the actuarial review of rate changes include the following. To reiterate, the formula is limited to **active, premium-paying policyholders**.

For rate stabilized policies:

\[
\Delta PV \text{ (future incurred claims)} = (\frac{58 + .85C}{1 + C}) \Delta PV \text{ (future earned premiums)}
\]

\[
\text{rate increase} \% = \frac{\Delta PV \text{ (future incurred claims)}}{.85 PV_{\text{current}} \text{ (future earned premiums)}}
\]

Where:

\( \Delta \) indicates the change in PV due to the change in actuarial assumptions between the time of the last rate increase (or original pricing if no prior rate increase) and the current assumptions.

\( C \) is the cumulative % rate increase to date. For example, if the current rate (prior to the proposed rate increase) is 50% higher than the rate at initial pricing, then \( C = 0.5 \).

The **current** subscript in the denominator indicates that the PV should be computed using current assumptions. The future earned premiums in the formula are based on the current premiums prior to the proposed rate increase.
(State insurance regulators may wish to consider the addition of margin to the rate increase. For example, the \( \Delta PV(\text{future incurred claims}) \) term in the above formula could be multiplied by \((1 + \text{margin})\).

For pre-rate stabilized policies, we use 0.6 in place of 0.58 and 0.8 in place of 0.85:

\[
\text{rate increase \%} = \frac{\Delta PV(\text{future incurred claims}) - \left(\frac{6 + 0.8 C}{1 + C}\right) \Delta PV(\text{future earned premiums})}{\text{PV current}(\text{future earned premiums})}
\]

Prior to the time that Texas adopted the PPV approach, a past requested rate increase may have been reduced by the state insurance regulator by a method other than the PPV approach. In this situation, for a current filing, the state insurance regulator may make adjustments to the current approvable amount based on what would have been approved had PPV been used in the prior filing.

D. Appendix D—Principles of RBOs Associated with LTCI Rate Increases

In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force, was charged to “Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.” In completing this charge, the Subgroup developed the following list of RBO principles to provide guidance for evaluating RBO offerings.

Principles and Issues

As related to:

1. Fairness and equity for policyholders who elect an RBO:
   - If some policyholders facing a rate increase are being offered an RBO but not others, an adequate explanation is needed.
   - Each RBO should provide reasonable value relative to the default option of accepting the rate increase and maintaining the current benefit level.

2. Fairness and equity for policyholders who choose to accept rate increases and continue LTCI coverage at their current benefit level:
   - The extent of potential anti-selection should be analyzed, with consideration of the impact on the financial stability of the remaining block of business and the resulting effect on the remaining policyholders.

3. Clarity of communication with policyholders eligible for an RBO:
   - Policyholders should be provided with maximum opportunity and adequate information to make decisions in their best interest.
   - Companies should present RBOs in clear and simple language, format, and content, with clear instructions on how to proceed and whom to contact for assistance.

4. Consideration of encouragement or requirement for an insurer to offer certain RBOs:
   - State insurance regulators should evaluate legal constraints, the impact on remaining policyholders and insurer finances, and the impact on Medicaid budgets if encouraging or requiring reduced LTCI benefits.
5. Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible:
   - Regulators and interested parties should continue to study the idea of offerings being made by insurers including potentially being tied to rate increases (e.g., providing hand railings for fall prevention in high-risk homes) and identifying the pros and cons of such an approach.

Widely Established RBOs in Lieu of Rate Increases

1. Reduce inflation protection going forward, while preserving accumulated inflation protection.
2. Reduce daily benefit.
3. Decrease benefit period/maximum benefit pool.
4. Increase elimination period.
5. Contingent nonforfeiture (CNF).
   i. Claim amount can be the sum of past premiums paid.
   ii. Only receive that benefit if the policyholder qualifies for a claim.

Less Common RBOs for Potential Discussion

1. Cash buyout.
2. Copay percentage on benefits.

As the industry continues to innovate new RBOs for consumers, such as the two listed above, the MSA Review will likewise develop and evolve to consider the reasonableness of these RBOs. The Task Force will encourage its appointed Subgroup or an appropriate NAIC actuarial committee or group, to collectively consider new RBOs, as they arise, that provides for input and technical advice from actuaries to states as they exercise their authority in considering RBOs as part of rate filings.

E. Appendix E—Guiding Principles on LTCI RBOs Presented in Policyholder Notification Materials

In 2020, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force adopted the following guiding principles to ensure quality of consumer notices of rate increases and RBOs. This section seeks to provide guiding principles in answering this question: “What are the recommendations for ensuring long-term care insurance policyholders have maximized opportunity to make reduced benefit decisions that are in their best interest?”

To complete the charge, the Subgroup 1) evaluated the quality of consumer notices and RBO materials presented to policyholders; 2) considered the relevant lessons learned and consumer focus group studies from the liquidation of LTC insurer Penn Treaty Network America; 3) reviewed existing RBO consumer notice checklists or principles from multiple states (i.e., Nebraska, Pennsylvania, Texas, and Vermont); and 4) addressed stakeholder comments on RBO principles.

This document is intended to establish consistent high-level guiding principles for LTCI RBOs presented in policyholder notification materials. These principles are guidance and do not carry the weight of law or impose any legal liability.

Recognizing that each component outlined in these principles will not apply in all circumstances, this section:

- RECOMMENDS that insurance companies recognize these fundamental principles.
- CALLS ON all insurance companies to consider the following principles in communicating RBOs available to consumers in the event of a rate increase.
- UNDERLINES that the following principles are complementary and should be considered as a whole.
Filing Rate Action Letters

Insurers should consider:

- Sending rate actions after the state has approved the rate action filing.
- Making the rate action effective on a policy anniversary date, recognizing that the Long-Term Care Insurance Model Regulation (#641) allows for the next anniversary date or next billing date.
- Mailing rate increase notification letters at least 45 days prior to the date(s) a rate action becomes effective, consistent with any applicable state laws and/or regulations.
- Sending rate increase notifications each year for rate increases that are phased-in over multiple years.
- Disclosing all associated future planned rate increases approved by state insurance regulators in the initial and phased-in rate increase notification letters.
- Filing rate action letter templates in the NAIC SERFF rate increase filing to include statements of variability and sample letters highlighting the differences between the communications, consistent with any applicable state laws and/or regulations.
- Presenting innovative options to state insurance regulators prior to filing new RBOs.
  - This enables state insurance regulators to evaluate potential anti-selection, adverse morbidity, and implications to consumers and future claims experience.

Readability and Accessibility

Insurers should consider:

- Drafting a rate action letter that is easy to follow, flows logically, and displays the essential information and/or the primary action first, followed by the nonessential information.
- Presenting the RBOs in a way that is comprehensible, memorable, and adjusted to the needs of the audience.
- Using cover pages, a table of contents, glossaries, plain language, headers, maximized white space, and appropriate font size and reading level for the intended audience.
- Using illustrative tools, such as bullet points or illustrations, as appropriate, and graphs or charts enabling a side-by-side comparison.
- Including definitions of complex terms; and if a term, subject, or warning is repeated throughout the communication, consider making the language consistent throughout the document.
- Including a Q&A section that is succinct but answers the commonly asked questions in plain language.
- Providing appropriate accommodations for policyholders with disabilities or policyholders for whom English is not a first language.

Identification

Insurers should consider drafting the RBO communication in a way that helps policyholders understand:

- What is happening.
- Why it is happening to them.
  - Ensure the letter does not negatively reference the state insurance department.
- When it is happening.
- What they can do about it.
- How they take action.

Communication Touch and Tone

Insurers should consider:
Drafting the communication in a way that helps policyholders envision or reflect on the reason(s) why they purchased an LTCI policy.

Conveying as much empathy as possible regarding the impact a rate action(s) may have on policyholders.

Presenting RBOs fairly, refraining from the use of bolding, repeating, or emphasizing one option over another.

Displaying the policyholder’s ability to maintain current benefits by paying the increased premium.

Using word choices that appreciate how those words could influence a policyholder’s decision.

For instance, consider using “now” instead of “must”; or consider using “mitigation options,” “offset premium impact” or “manage an increase” instead of “avoid an increase.”

Consultation and Contact Information

The insurer should consider listing multiple contacts in the communication in an easy-to-identify location to include phone number, email address, and website when available. For example:

- Customer service.
- Lapse notifier.
- Insurance producer.
- State insurance department.
- State Health Insurance Assistance Program (SHIP).

The insurer should consider suggesting policyholders consult a family member or other trusted advisor, such as:

- Lapse notifier.
- Insurance producer.
- Financial advisor.
- Certified personal accountant or tax advisor (in the event cash buyouts are offered).

Understanding Policy Options

Insurers should consider the presentation of the communication by:

- Identifying what necessitated the communication on the first page.
  - For example, the header could say, “Your Long-Term Care Premiums Are Increasing.”
- Including the RBOs with the rate action letter.
- Limiting the number of options displayed on the letter to no more than four or five.
- Identifying which RBO(s) have limited time frames.
- Advising policyholders that they can ask about reducing their benefits at any time, regardless of a rate increase.
- Providing enough information in the communication to make a decision.
  - If supplemental materials (e.g., insurer’s website) are provided, they would enhance the policyholder’s understanding, but not be necessary to use when making a decision.

Insurers should consider indicating the window of time to act by:

- Clearly indicating what the policyholder’s premium will increase to and by when.
- Displaying the due date(s) in an easy-to-identify location and repeating it multiple times throughout the document.
- Clearly differentiating due date(s) for each RBO, if available for a limited time.

Insurers should consider including disclosures regarding rate increase history by:
• Disclosing that future rate actions could occur.
• Advising if prior rate actions have or have not occurred to include:
  o Policy form(s) impacted.
  o Calendar year(s) the policy form(s) was available for purchase.
  o Percentage of increase approved to include the minimum and maximum if they vary by benefit type.
• Reminding policyholders that their policy is guaranteed renewable.

Insurers should consider advising policyholders of their current benefits:

• For example, the communication could disclose the policyholder’s current benefits to include:
  o Daily maximum amount.
  o Inflation option.
  o Current pool of benefits for policies with a limited pool of benefits.

Insurers should consider personal needs decision-making by:

• Only listing RBOs that are available to the policyholder.
• Calling on policyholders to reflect on how each option could impact them personally.
• Prompting policyholders to consider their unique situation to include their current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and the potential need for institutionalized care.
• Reminding policyholders to consider the cost of care in the area and setting where they expect to receive care.
• Informing policyholders of factors that impact LTC costs, such as:
  o The average cost of care for in-home care, assisted living, and nursing home care in their area.
  o The inflation rate of the cost of care for in-home and nursing home care in their area.
  o The average age and duration of an LTC claim for in-home and nursing home care.
  o Factors that influence the age, duration, and cost of a claim.
• Disclosing to policyholders when an RBO falls below the cost of care in their area.
• Calculating for policyholders the number of days or months a paid-up option could cover based on the cost of care in their area.
  o Buyout or cash-out disclosures.
  • The cash offerings, if any, should disclose to policyholders that the option could result in a taxable event, and they should consult with their certified personal accountant and/or tax advisor before electing this option.

Insurers should consider the value of each option by:

• Disclosing if the RBOs may not be of equal value and are dependent on the unique situation of each policyholder.

Insurers should consider communicating the impact of options by:

• Displaying the options in a way that enables policyholders to compare options, including details such as:
  o Daily/monthly benefit.
  o Benefit period.
  o Inflation option.
  o Maximum lifetime amount.
  o Premium increase percentage and/or new premium.
  o Nonforfeiture (NFO) or contingent nonforfeiture (CNF) amount.
  o If the policy is Partnership qualified, changes to benefits may impact Partnership status.
  o Current premium.
Providing a series of questions to help policyholders contemplate the implications of each action, such as:

- What will happen if they take no action?
- What will happen if they make no payment before the policy anniversary date?
- If they accept the full increase without reducing their benefits, how will they handle potential future rate increases?
- If they elect the cash buyout, there could be tax implications.
- If they elect a paid-up NFO, how long will the reduced benefit last if they had a claim?
- If they were to increase their elimination period from 30 days to 100 days, do they have enough funds to cover those expenses?
- Partnership policies: Will reducing the benefits remove Partnership qualification? If so, the letter should explain that their asset protection may be removed or reduced.

When rate actions span over multiple years, insurers should consider:

- Disclosing the full rate increase amount, how it is spread out across multiple years, and all associated future planned rate increases approved by state insurance regulators.
- Specifying if the premium increase referenced is the first, second, third, last, etc.
- Offering CNF based on the full increase amount and offered with each phase of the rate action.
- Notifying policyholders at least 45 days in advance of each phase of the rate increase, consistent with any applicable state laws and/or regulations.

VII. EXHIBITS

A. EXHIBIT A—SAMPLE MSA ADVISORY REPORT

FROM: Long-Term Care Insurance (LTCI) Multistate Actuarial Rate Review Team
DATE: [Date]
RE: ABC Insurance Company – Block LTC1 – Draft of Initial MSA Advisory Report

Executive Summary

The LTCI Multistate Actuarial Rate Review Team (MSA Team) recommends a rate increase of 35% to be approved for inflation-protected products and 20% to be approved for products with no inflation, related to ABC Company’s block.

Higher rate increases are recommended for states where past cumulative rate increases below 55% have been approved. Reduced benefit options (RBOs) may be selected to help manage the impact of the rate increase.

Analysis by the MSA Team resulted in the recommended rate increase being consistent with that resulting from the actuarially justified Texas and Minnesota approaches. The recommended rate increases are below the increases that would have resulted from the lifetime loss ratio approach and the rate stability rules.

Background

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7 Information contained in this sample report is an example only and is not derived from any actual rate filing.
The MSA Team was formed to assist the Long-Term Care Insurance (EX) Task Force in developing a consistent national approach for reviewing LTCI rates, which results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization.

The members are: [List names and state of members]. Starting in the first half of 2020, the MSA Team accepted rate increase proposals as part of a pilot program. The MSA Review became operational on [insert date].

This MSA Advisory Report is related to the rate increase proposal filed by ABC Company for its LTC 1 block sold between 2003 and 2006. The MSA Team’s actuarial analysis is provided below. The intention is that states can utilize this analysis and feel comfortable accepting the MSA Advisory Report recommendation when taking action on the upcoming ABC filings that will be made to the states.

The MSA Review and findings shall not be considered an approval of the rate schedule increase filing, nor shall it be binding on the states or the insurer. As this is a state-approved product, each state will ultimately be responsible for approving, partially approving, or disapproving the rate increase. A goal of the Task Force is for as much consistency as possible to occur between states in the rate increase approvals.

Insurer’s Proposal

ABC Company requests a rate increase of 60% to be approved for inflation-protected products and 40% to be approved for products with no inflation.

In addition, ABC Company is requesting higher rate increases for states that did not grant full approval of prior rate increase requests.

Workstream-Related Review Aspects

Actuarial Review

At the direction of the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup, the MSA Team applied the Minnesota and Texas approaches to calculate the recommended, approvable rate increases. Aspects of the Minnesota approach that result in lower rate increases than those resulting from loss ratio-based approaches contained in many states’ laws and rules include:

- Reduction in rate increases at later policy durations to address shrinking block issues.
- Elimination of rate increases related to inappropriate recovery of past losses.

Minnesota also has additional unique aspects: 1) consideration of adverse investment expectations related to the decline in market interest rates, 2) adjustments to projected claim costs to ensure the impact of uncertainty is adequately borne by the insurer; and 3) a cost-sharing formula applied in typical circumstances.

Even though these additional aspects are outside the pure loss-ratio requirements, they fall in line with legal provisions that rates shall be fair, reasonable, and not misleading.

The Minnesota approach, including application of the typical-circumstance cost-sharing formula, results in an approvable rate increase of 35% for inflation-protected products and 20% for products with no inflation protection.

The Texas approach results in an approvable rate increase of 29% in aggregate.

The MSA Team’s recommendation, in consideration of the Minnesota and Texas approaches, is to approve a rate increase of 35% for inflation-protected products and 20% for products with no inflation protection.
Higher rate increases are recommended for states where past cumulative rate increases below 55% have been approved.

The MSA Team reviewed support for the assumptions, experience, and projections provided by the insurer and performed validation steps to review the insurer-provided information for reasonableness. Details regarding the actuarial review are provided in Appendix 1. Also, the initial submission and subsequent correspondence between the insurer and the MSA Team are available on SERFF. The SERFF tracking number is ABCC-123456789.

Consideration of Differences in Histories of States’ Rate Increase Approvals

According to the Historical Rate Level Summary, Appendix D in the insurer proposal, past rate increase approvals by state have varied and can be categorized as follows:

- 25 states have granted full or near-full approval of ABC Company’s past requests (at or near 55%, cumulative).
- 18 states have granted cumulative approvals averaging 45%.
- Five states have granted cumulative approvals averaging 27%.
- Two states have granted cumulative approvals averaging 15%.

The insurer’s stated goal is to bring rates in all states up to an equivalent rate level. Currently, the average annual premium rates for a policyholder range from below $1,700 in some states (with the lowest past approvals) to over $2,200 in other states (with the highest past approvals).

The MSA Team’s recommendation is based on a goal of rates per benefit unit being uniform between states going forward.

A table of examples of recommended rate increases based on past cumulative approval history is provided in Appendix 2.

Non-actuarial & Valuation/Solvency Considerations

Non-actuarial considerations, including flexibility regarding the phase-in of rate increases, waiting periods between rate increases being coordinated with phase-in periods, and other issues are being discussed at the Task Force and the Subgroup.

Even with future claims potentially being reduced due to COVID-19-related behavioral impact, ABC Company will continue to experience substantial losses on this block.

Regarding coordination of rate and reserving reviews, the insurer states that assumptions underlying the rate increase proposal are consistent with assumptions underlying the reserve adequacy testing.

RBOs – Review for Reasonableness

Unless a rider was purchased, ABC Company policyholders facing a rate increase will be offered the following applicable options in lieu of a rate increase:

1) Extending the elimination period.
2) Decreasing the benefit period.
3) Reducing future inflation accumulation.

The insurer produced rate tables which demonstrate that the RBOs provide reasonable value in relation to a case of a policyholder retaining full benefits and paying the full rate increase.
Financial Impact for Insurer
The requested rate increase associated with recent adverse development would result in around $50 million of reduced losses for this block according to information contained in the actuarial memorandum.

Mix of Business
From the insurer’s actuarial memorandum:

Enrollees:
- Total enrollees as of date of proposal: 15,000
- Inflation protection: 9,000 (inflation protection) and 6,000 (no inflation)
- Benefit period: 8,500 (lifetime benefits) and 6,500 (limited benefits)

Product type: Expense reimbursement:
- Average issue age: 58
- Average attained age: 75
- Annualized premium: $30 million; $2,000 average per policyholder

Appendix 1
Drivers of Rate Increase Proposal – Summary
The primary drivers, summarized in the insurer actuarial memorandum, were lower lapses and longer average claim length. The insurer assumptions were based on actual-to-expected adjustments, based in part by insurer experience that has become more credible in recent years. The assumptions were determined to be reasonable and in line with industry and actuarial averages.

Details Regarding Minnesota Approach
For an average (in terms of benefit period and issue age), 5% compound inflation-protected cell:
- Makeup cumulative rate increase: 177% (the increase from original rates needed going forward to get the block to the financial position contemplated at original pricing)
  - This increase is equal to the increase that would result from a pure loss ratio approach.
- If-knew cumulative rate increase: 36% (the increase from original rates needed if the insurer could go back to the past and reprice the product given information it knows now)
- Proportion of original policyholders remaining in force, based on insurer original and updated assumptions: 62%
- Blended if-knew / makeup rate cumulative rate increase since issue: 123%
  - $0.62 * 177% + (1 - 0.62) * 36%, adjusted for rounding
- Insurer cost share based on Minnesota formula (see Appendix 3): 12%
- Recommended cumulative rate increase since issue: 109%
  - $(1 - 0.12) * 1.23$, adjusted for rounding
- Past cumulative rate increases: 55%
- Actuarial recommended rate increase from current rates: 35%
  - $(1 - 0.55) = 1$, adjusted for rounding
- Final actuarial recommended rate increase from current rates (for the inflation-protected cell): 35%
  - Minimum of calculated approval rate of 35% and insurer proposal of 60%.
- Using the same methodology, the final actuarial recommended rate increase from current rates (for the non-inflation-protected cell): 20%
Note that the Minnesota approach includes the reflection of declining interest rates which tends to lead to adverse investment returns compared to expectations in original pricing. Also, where applicable, insurer morbidity assumptions are adjusted downward due to a lack of credible support at extremely high ages, and a general lack of complete support for aspects of morbidity assumptions, including uncertainty regarding future benefit utilization.

Details Regarding Texas Approach
- Insurer Calculation (aggregate): 52%

PPV calculations
- Texas Life & Health Actuarial Office (LHAO) PPV Calculation (aggregate): 29%

LHAO Comments
- For the purposes of the MSA report, and as a component of the calculation of the approvable rate increase, Texas recommends an actuarially justified PPV calculated amount of 29%.

Texas rate stabilized PPV Formula:
\[
\text{rate increase} \% = \frac{\Delta PT'(future incurred claims) - \left( \frac{.58 + .85C}{1+C} \right) \Delta PT'(future earned premiums)}{.85 PT'_{current}(future earned premiums)}
\]

Reconciliation of Minnesota and Texas Approaches

The Texas PPV calculated amount of 29% aligns well with the Minnesota approach’s recommended rate increase of 35% for inflation-protected policies and 20% for non-inflation-protected policies when the distribution of inflation-protected vs. non-inflation-protected cells is applied. The MSA Team’s recommended rate increase is 35% for inflation-protected policies and 20% for non-inflation-protected policies.

Recommended rate increases by state, in consideration of various histories of rate increase approvals, are listed in Appendix 2.

Correspondence Summary
- Template information request for multi-state rate increase filings, based on the list adopted by the Health Actuarial (B) Task Force on March 23, 2018.
- New premium rate schedule, percentage increase for each rating scenario such as issue age, benefit period, elimination period, etc., from the existing and original rates.
- Rate increase history that reflects the filed increase.
- Actuarial Memorandum justifying the new rate schedule, which includes:
  - Lifetime loss ratio projection, with earned premiums and incurred claims discounted at the maximum valuation interest rate.
  - Reasons for the rate increase, including which pricing assumptions were not realized and why.
  - Statement that policy design, underwriting, and claims handling practices were considered.
  - A demonstration that actual and projected costs exceed anticipated costs and the margin.
  - The method and assumptions used in determining projected values should be reviewed in light of reported experience and compared to the original pricing assumptions and current assumptions.
  - Combined morbidity experience from different forms with similar benefits, whether from inside or outside the insurer, where appropriate to result in more credible historical claims as the basis for future claim costs.
  - Comparison with asset adequacy testing reserve assumptions.
• Provide actuarial assumptions from original pricing and most recent rate increase filing, and, have the original actuarial memorandum available upon request.
  o Guidance Manual Checklist items: summaries, including past rate adjustments; average premium; distribution of business, including rate increases by state; underwriting; policy design and margins; actuarial assumptions; experience data; loss ratios; rationale for increase; and reserve description.
  o Assert that analysis complies with Actuarial Standards of Practice, including No. 18 and No. 41.
  o Numerical exhibits should be provided in Microsoft Excel spreadsheets with active formulas maintained, where possible.

• Rate Comparison Statement of renewal premiums with new business premiums, if applicable.

• Policyholder notification letter – should be clear and accurate.
  o Provide a description of options for policyholders in lieu of or to reduce the increase.
  o If inflation protection is removed or reduced, is accumulated inflation protection vested?
  o Explain the comparison of value between the rate increase and policyholder options.
  o Are future rate increases expected if the rate increase is approved in full? If so, how is this communicated to policyholders?
  o How are partnership policies addressed?

• Supplementary information, based on a list developed by the MSA Team following the review of initial pilot program proposals:
  o Information on benefit utilization.
  o Attribution of rate increase by factor.
  o RBO history and reasonability analysis.
  o Investment returns.
  o Expected loss ratio.
  o Shock lapse history.
  o Waiver of premium handling.
  o Actual-to-expected differences.
  o Assumption consistency with Actuarial Guideline 51 asset adequacy testing.

• Following initial review of the proposal, additional information was requested by the MSA Team related to:
  o Original pricing assumptions.
  o Lapse assumption by duration.
  o Premiums and incurred claims by calendar year based on original assumptions.
  o Distribution of in force by inflation protection.
  o Loss ratios by lifetime/non-lifetime benefit period and with/without inflation protection.
  o Description of waiver of premium handling in premium and claim projections.
  o Commentary on COVID-19 short-term and long-term LTC impact.

Appendix 2

Examples of Rate Increases If an RBO is Not Selected
Appendix 3

Potential Cost-Sharing Formula for Typical Circumstance

Cumulative rate increase since issue date is haircut by:

- No haircut for the first 15%.
- 10% for the portion of cumulative rate increase between 15% and 50%.
- 25% for the portion of cumulative rate increase between 50% and 100%.
- 35% for the portion of cumulative rate increase between 100% and 150%.
- 50% for the portion of cumulative rate increase in excess of 150%.

Example: if the pre-cost sharing Minnesota approach results in a cumulative 210% rate increase since issue:

- Break 210% into the following components: 15%, 35%, 50%, 50%, 60%
- Post haircut approval is 100% of 15% + 90% of 35% + 75% of 50% + 65% of 50% + 50% of 60%
- = 15% + 32% + 38% + 33% + 30%
- = 147%

Justification for the cost-sharing formula is that the insurer should have had more information about the possibility of triple-digit rate increases than the consumer had.

Adjustments to the formula may be desired when an insurer’s solvency position is dependent on a certain level of rate increase approval. That is not the case with this insurer or proposal.
The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

For more information, visit www.naic.org.
The Long-Term Care Insurance (EX) Task Force conducted an e-vote that concluded Oct. 29, 2021. The following Task Force members participated: Michael Conway, Vice Chair (CO); Jim L. Ridling represented by Mark Fowler (AL); Alan McClain (AR); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Philip Barlow (DC); Trinidad Navarro represented by Frank Pyle (DE); David Altmaier represented by Christina Huff (FL); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dana Popish Severinghaus represented by Shannon Whalen (IL); Amy L. Beard represented by Dawn Bopp (IN); Anita G. Fox represented by Karen Dennis (MI); Grace Arnold (MN); Chlora Lindley-Myers (MO); Mike Chaney represented by Bob Williams (MS); Troy Downing represented by Bob Biskupiak (MT); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning (NE); Russell Toal (NM); Barbara D. Richardson represented by Jack Childress (NV); Glen Mulready represented by Andrew Schallhorn (OK); Andrew Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Mike Kreidler represented by Molly Nollette (WA); Mark Afable (WI); Allan L. McVey (WV); and Jeff Rude (WY).

1. **Adopted the 2022 Proposed Charges**

The Task Force conducted an e-vote to consider adoption of the 2022 proposed charges of the Task Force and its Subgroups. A majority of the members voted in favor of adopting the 2022 proposed charges (Attachment Six-A). The motion passed.

Having no further business, the Long-Term Care Insurance (EX) Task Force adjourned.

[06_LTCI(EX)TaskForce_102921_Minutes.docx]
**2022 Proposed Charges**

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

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

A. The Long-Term Care Insurance (EX) Task Force will:

Recognizing the gravity of the threat posed by the current long-term care insurance (LTCI) environment both to consumers and our state-based system of insurance regulation, this Task Force is charged to:

- further develop and implement a coordinated national approach for reviewing LTCI rates;
- monitor and evaluate the rate review process;
- evaluate and recommend options to help consumers manage the impact of rate increases; and
- monitor work performed by other NAIC groups to review the financial solvency of long-term care (LTC) insurers.

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

1. The Long-Term Care Insurance (EX) Task Force will:

A. Once adopted by the NAIC Executive (EX) Committee and Plenary, monitor, and evaluate the progress of the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document. Monitor state insurance department rate review actions subsequent to implementation of the MSA Framework and MSA rate review recommendations.

   A. Develop a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. Deliver such a proposal to the Executive (EX) Committee by the 2021 Summer National Meeting.

   B. Complete an evaluation and further evaluate and recommend options to provide consumers with choices regarding modifications to LTCI contract benefits where policies are no longer affordable due to rate increases.

   C. Monitor the work performed by other NAIC solvency working groups and assist in the timely multi-state coordination and communication of the review of the financial condition of LTC insurers. Deliver such a proposal to the Executive (EX) Committee by the 2021 Summer National Meeting.

**Staff Support:** Jeff Johnston, Jane Koenigsman

4. The Long-Term Care Insurance Financial Solvency (EX) Subgroup will:

1. Explore restructuring options and techniques to address potential inequities between policyholders in different states and techniques to mitigate policyholders’ risk to state guaranty fund benefit limits, including states’ pre-rehabilitation planning options. Evaluate the work of the consultant and report on the work to the Task Force.

2. Monitor the work performed by other NAIC solvency working groups and assist in the timely multi-state coordination and communication of the review of the financial condition of LTC insurers.

3. Complete its charges by the 2021 Summer National Meeting.

**The Long-Term Care Insurance Multistate Rate Review (EX) Subgroup will:**

A. Develop and finalize the development of the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document which outlines a consistent national approach for reviewing LTCI rates that results in actuarially appropriate increases being granted by the states in a timely manner and eliminates cross-state rate subsidization. Implement the MSA rate review process once adopted by the NAIC Executive (EX) Committee and Plenary.

B. Evaluate the progress of the MSA rate review process and provide ongoing maintenance and enhancements, as deemed necessary.

C. The Subgroup should complete its charges by the 2022 Summer National Meeting.

**Staff Support:** Eric King
6.3. The Long-Term Care Reduced Benefit Options (EX) Subgroup will:
   A. Further Complete an evaluation and/or recommendation of options to help consumers manage the impact of rate increases. This includes:
      1. The potential Finalizing development of a process to evaluate innovative options that allow for insurers to offer benefits that lessen the likelihood of an insured needing long-term care services, including evaluation of the suitability of and regulatory barriers to proposed options.
      2. The potential development of mechanisms to help regulators and consumers objectively compare reduced benefit options (RBOs), including comparison of accepting a rate increase and retaining current benefits to electing an offered RBOs.
      3. The further exploration of pursuing more uniformity in Finalizing the Consumer Notices Checklist for RBOs.
   B. Support and provide expertise to the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup regarding evaluation of RBOs.
   C. The Subgroup should Complete its charges by the 2021 Summer Fall National Meeting.

Staff Support: Eric King
The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Dec. 7, 2021. The following Subgroup members participated: Jessica K. Altman, Chair (PA); Lori K. Wing-Heier (AK); Jimmy Harris (AR); Emily Smith (CA); Frank Pyle (DE); Andria Seip (IA); Eric Anderson (IL); Karen Dennis (MI); Fred Andersen (MN); Jill Kruger (SD); Michael Markham (TX); Tomasz Serbinowski (UT); Anna Van Fleet (VT); Lichiou Lee (WA); and Joylynn Fix (WV).

1. **Adopted a Draft LTC Wellness Program Issues Document**

Mr. Andersen gave an overview of the draft long-term care (LTC) wellness program issues document and provided a summary of comments and edits made to the draft exposure.

Mr. Andersen made a motion, seconded by Director Wing-Heir, to adopt the document (Attachment Seven-A) that reflects edits made in response to comments received (Attachment Seven-B) during its second public exposure for comment. The motion passed unanimously.

Commissioner Altman said the document will be forwarded to the Long-Term Care Insurance (EX) Task Force for its consideration.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.
Issues related to LTC wellness benefits

7/22/2021 exposed draft with 10/04/21 edits

Objective:
The objective of this paper is to increase clarity to regulators, insurance companies, and interested parties regarding issues related to innovative long-term care wellness programs.

Background:
Stand-alone long-term care insurance is a unique industry, in that higher-than-expected claims’ costs have resulted in substantial rate increases for consumers and financial losses and in some cases solvency concerns for insurance companies.

Technology firms are developing technological and other approaches that could be used by insurance companies to potentially prevent, delay, or lower the severity of LTC claims and improve health outcomes in a space called “LTC wellness”. Examples of these early, pre-insurance-claim interventions include:

- Fall prevention programs;
- Home modification consultations, analysis and implementation to facilitate aging in place;
- Caregiver support programs for both formal and informal caregivers;
- Next generation care coordination services;
- Technological solutions aimed at improvements in cognitive impairment prevention and early diagnosis, potentially involving technology supplemented by a physician’s cognitive risk evaluation.

In light of systemic, LTC-related financial challenges, insurance companies, insurance regulators, and tech firms are interested in working together to explore some of these claim cost-reducing innovations. Here are some potential barriers to increased adoption of these new approaches and how those barriers could potentially be addressed, with details provided below the list:

1. Analysis of effectiveness
2. Unfair discrimination
3. Consumer confusion
4. Rebating
5. Tax considerations
6. Regulatory role in approving or evaluating LTC wellness approaches
7. Actuarial considerations
8. Data privacy
9. Other considerations
Details:

1. Analysis of effectiveness
   a. Issue: in light of the lag time between policyholder age during LTC wellness efforts and policyholder age when claim incidence becomes more common, what issues arise from insurers' lack of knowledge of effectiveness of LTC wellness programs in reducing claim costs, and how can those issues be addressed?
      i. The cost of innovation efforts, with no guarantee of any returns, may dissuade some insurance companies from pursuing these programs.
         1. Expenses vary - in many cases are typically upfront and significant.
         2. The financial impact on claims cost is typically unknown and down the road.
      ii. Designing pilot programs is difficult because there is such a variety of programs available, and each block of LTC insurance policies has unique characteristics that might influence the effectiveness of a given program.
      iii. Some companies are concerned about regulatory reaction to these changes.
   b. Current observations
      i. Industry representatives described some current or likely upcoming LTC wellness efforts at the May 4, 2021 NAIC Reduced Benefit Option Subgroup meeting. A theme was that there is great supply and demand for LTC wellness innovation efforts.
      ii. Some insurance companies are exploring or implementing pilot programs. Very early signs on the effectiveness of interventions on impact on policyholder health and claim costs are promising, but data development is slow and it is difficult to implement control trials.
         1. Insurance companies are eager for data and for ways to effectively share data within the legal and regulatory framework so that the industry can effectively respond to positive policyholder experiences and discontinue any programs that fail to make an impact.
      iii. Because there is little competition in the stand-alone LTC insurance market, due to the financial losses accumulated and many insurance companies exiting the actively selling market, sharing of ideas between companies on management of active policies may be possible, although care should be taken regarding anti-trust issues.
      iv. Effectiveness may increase or decrease if targeting certain policyholders.
      iii. Development of experience showing effectiveness will be a work in progress.
   c. Addressing of Issues
      i. Lack of data: With most LTC wellness programs being under-developed or being implemented recently, data is lacking on the extent to which resulting claim cost decreases offset the costs of the programs.
      ii. How to measure health impact: Whether an LTC wellness program effectively reduces claim costs or not, will there be approaches established to measure health benefits to policyholders?
i. Data sharing: Facilitating the sharing of data, between vendors and insurance companies, and perhaps involving public programs such as Medicaid, is a key element of analyzing effectiveness.

d. Next steps
   i. Regulators engage with insurance companies to learn of recent developments.
   ii. Research public programs’ data on effectiveness of LTC wellness programs to see if Medicare Advantage, Med Supp, or Medicaid / PACE data is available, relevant, and used. Also, look into potential independent living / senior facility wellness experience as well as health and life insurance wellness experience.
   iii. Determine an approach to monitor success of programs. For example, if 3 to 4 companies are applying 3 to 4 pilot programs and finding success, it would be good news regarding broader, future efforts.
      1. Facilitate the sharing of general results (i.e., not individual policyholder data) among those insurance companies in a way that is within the legal and regulatory boundaries.
   iv. Regulators ensure capital supporting LTC liabilities is adequate under a range of scenarios, including one where claims costs continue to increase.

2. Prevention of unfair discrimination related to extra-contractual benefits and costs
   a. Issue: how does an insurer offer a wellness initiative that is not unfairly discriminatory to discrete populations within the broader group of policyholders?
   b. Current observations
      i. There may be state anti-discrimination and bias-related legal issues to address if certain policyholders are targeted, including through Big Data, to receive extra benefits.
         1. For instance, if older policyholders have less of an online footprint than younger policyholders, how would this impact the accuracy of the targeting of LTC wellness benefits or otherwise introduce bias?
         2. [Birny Birnbaum May 4 comment]: If wellness or other efforts to address specific conditions are based on age or the health of the policyholder, this seems like normal value-added products and services for loss prevention and not an example of unfair discrimination.
            a. Issues to address are likely related to creating a clear framework for compliance related to the use of data analytics and artificial intelligence.
   c. Addressing of issues
      i. Equality: How policyholders are offered wellness initiatives could be unfairly discriminatory.
         1. Policyholders of “the same class and of essentially the same hazard” must be treated equally. See NAIC Model Unfair Trade Practices Act (#880) (“Model Law”).
2. How may an insurer “classify” policyholders post underwriting? Regulators may need to provide guidance on how to classify policyholders.
   a. What is fair? The insurers will need to provide justification.
      i. For example, under the Model Law the availability of the value-added product or service must be based on documented objective criteria and offered in a manner that is not unfairly discriminatory.
   b. May classification be made by jurisdiction? Does that impact the LTC Multi-State Actuarial Rate Review (MSA) program’s overarching goals?
   c. May classification be made by product form?

ii. Selection: How policyholders are selected for wellness initiatives could be unfairly discriminatory.
   1. Wellness initiatives may be costly to the insurer. How can an insurer test it to validate the benefits before rolling it out more broadly?
      a. Under the Model Act, the insurer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no more than one year.
      a.b. Initial selection of participants may be the most important for antidiscrimination. That selection for pilots should consider including a wide range of individuals from various geographic, economic, social, marital, age, racial, and ethnic populations to ensure meaningful data is collected.
   2. Would a random selection of policyholders be unfair?
   3. Should policyholders be given the option to participate in a wellness initiative?
      a. Must all policyholders be given the option to participate?
   4. How much time/data is needed to prove the initiative is valuable?

5. Prior to offering a wellness program, an insurer should have a logical hypothesis of what benefits could be derived from the program.
   a. Even if benefits are available to all those who utilize, the initiatives may be limited in application depending on a policyholder’s specific circumstances.

iii. Accessibility: How a wellness initiative operates could be unfairly discriminatory.
   1. Does it limit who can participate based on the medium and cost of the equipment or technology? For example:
      a. Does it require access to a computer or internet for online participation?
      b. Does it require access to a smart phone, texting minutes, etc., to use an app?
      c. Does it require access to roads, pools, sidewalks?
      d. Does it require technical skills to use software or hardware?
      e.e. Will insurers utilize different communication methods, such as phone, text, e-mail, or mail?
2. Does any such limitation require alternatives for those unable to participate in the initiative?

iv. Uniformity: If guidance is issued on wellness initiatives, how would states adopt the guidance, especially if states have different standards for allowing wellness programs in LTC insurance?

1. Have all states adopted the Model Law? If not, what have hurdles been for states that have not adopted the model? Will states adopt updates to the Model Law?

2. Standards for unfair discrimination, including in the specific context of wellness initiatives, may vary by state requiring insurers and regulators to be aware of the specific requirements of the jurisdiction in question.
   a. For example, Alaska permits rewards under wellness programs but requires that the reward be available for “all similarly situated individuals.” See AK Stat § 21.36.110.

3. If some states allowed wellness initiatives and not others, would this conflict with other initiatives, such as the MSA?

d. Dependencies
   i. Unfair discrimination guidance needs to consider other wellness initiative issues that include:
      1. Analyzing Effectiveness
      2. Actuarial Impacts
      3. Rebate Standards and Limitations
         a. What if an insurer offers the service at a cost (full or portion) for the policyholder(s) after the pilot?

3.4. Regulatory Evaluation

e. Next steps
   i. Regulators and interested parties discuss the issues noted above, including whether the use of Big Data to predict risks (of e.g., falls or dementia) and offering benefits and services only to those targeted as high risk would cause concerns regarding discrimination.

3. Consumer confusion
   a. Issue: potential consumer confusion concerning LTC wellness programs will be highly variable dependent upon factors such as the nature of the program, the consumers involved, and the complexity of regulatory issues.

b. Addressing of issues:
   i. Wellness programs with simple to understand direct connections to prevention of common medical issues (e.g., installing a grab bar) will provoke far less confusion than more esoteric programs based on new technological services (e.g., data collection/monitoring of insured activities) with not yet proven results. Simpler programs may also trigger fewer and less complex regulatory/statutory requirements related to privacy, consent, disclosure, etc. resulting in programs...
that will be more easily understood and documented. Programs with newer technology, more data collection and manipulation, and which are connected to more complex care issues will be more confusing and will trigger more complicated regulatory/statutory requirements.

1. In these scenarios, there may be a need to first educate consumers on the technology and the data collection/usage and then the program and its potential benefits before disclosure and informed consent can occur. The ability to prevent confusion and achieve adequate education and understanding may be further impacted by the level of technological sophistication and mental acuity of the consumer, factors which often decline with age.

ii. Designing effective communication regarding insurer LTC wellness programs will require in-depth engagement with LTC consumers, policyholders, family members, eldercare subject matter experts, and NAIC consumer representatives. When the vetting group engages with Medicaid programs, PACE, etc. to learn about best practices in wellness programming, the vetting group should take the opportunity to learn about the successes and failures in communication used in implementing these programs, including any relevant focus group data available.

iii. In addition to engaging with Medicaid and PACE, the following organizations may have valuable insights: National Council on Aging (www.ncoa.org), AARP (www.aarp.org), and the National Institute on Aging (www.nia.nih.gov). In addition to engaging with NAIC representatives and these national organizations, the Vermont team would also propose to reach out to Vermont’s sister agencies in state government (The Agency of Disabilities, Aging, and Independent Living (DAIL), and the Agency of Human Services, (AHS)). Lastly, Emily Brown serves on the board of directors for Central Vermont Home Health and Hospice. Engagement with this local group may provide rural eldercare perspectives missing at the national level.

iv. Focus groups designed to elicit feedback on communication style are most helpful when the programming has been determined. In the alternative, guidelines for communication and disclosure designed to minimize confusion and maximize understanding would need to be developed along a spectrum of wellness programs of increasing complexity. The results of vetting group work around rebating, program effectiveness, data privacy, loss of tax-preferred status, and discrimination concerns will determine components of what needs to be tested in focus groups. For instance, if the loss of tax-preferred status is something the vetting group can address at the federal level, it will not need to be considered when determining barriers to effective communication.
v. Building consensus around terminology and building trust are essential to effective communication. In a Medicaid setting, the PACE program (Programs for All Inclusive Care for the Elderly), wellness efforts include a multidisciplinary team of health professionals coordinating care and no cost share on services. (Source: https://www.medicaid.gov/medicaid/long-term-services-supports/pace/programs-all-inclusive-care-elderly-benefits/index.html). This builds trust through human contact with medical professionals.

1. This type of communication is vastly different than the communication between an insurer and a long-term care policyholder facing a rate increase, where participation may have some impact on the premium rate increase the consumer must pay. As a result, extra care will need to be taken to ensure policyholders truly understand the offer and the level of participation required and that they do not acquiesce based on confusion or because they feel they have no other choice.

vi. As the wellness vetting subgroup works through the issues (program effectiveness, discrimination, data privacy, and tax considerations), the Vermont team hopes to build on the conversations planned with subject matter experts in eldercare programming. The vetting group should plan to add time at the end of the process to explore and understand the vetted programs with consumers via focus group(s) to best anticipate and mitigate consumer confusion.

4. Rebating

a. Issue: whether some long-term care wellness benefits for policyholders run afoul of the NAIC Model anti-rebating laws or are otherwise prohibited. Those wellness plans may be designed to prevent or lower the severity of LTC insurance claims or to improve health outcomes (“Wellness Initiative”).

b. Addressing issues:

i. **NAIC Model Law.** The recently amended version of the NAIC Model Unfair Trade Practices Act (#880) (“Model Law”) explicitly exempts the type of Wellness Initiatives currently being considered from the prohibition on rebates as an unfair trade practice. Specifically, § 4 (H)(2)(e) of the Model Law excludes from “the definition of discrimination or rebates . . . [t]he offer or provision . . . of value-added products or services at no or reduced cost,” even “when such products or services are not specified in the policy of insurance,” if the product or service meets certain requirements. Amongst procedural requirements, the Model Law requires that the product or service (a) relate to the insurance coverage, (b) be “primarily designed to satisfy” one of nine functions, including providing loss mitigation, reducing claim costs, enhancing health, and incentivizing behavioral changes, and (c) cost a reasonable amount in comparison to premiums or coverage. As the Wellness Initiatives in question would be designed to prevent or
lower the severity of LTC insurance claims and improve health outcomes, as long as their cost is reasonably related to the premiums or coverage, then they should not be considered rebates under the recently amended Unfair Trade Practice Act.

ii. Variations in State Law. The above cited language from the Unfair Trade Practices Act, § 4 (H)(2)(e), however, is a recent December 2020 addition to the Model Law. As such, most states have yet to specifically address that update and have only enacted a prior version of the Unfair Trade Practices Act. Unfortunately, the old language of the Model Law was less flexible on this point, which led a number of states to carve out exceptions by individual amendments, regulations, bulletins or desk drawer rules. And the Unfair Trade Practices Act is not the only model law with language prohibiting rebates in the business of insurance. As such, it is much less certain whether the Wellness Initiatives at issue would trigger the law’s anti-rebating provision. And the many state initiatives in this area do not permit a uniform analysis of rebating in each adopting jurisdiction as the precise language, interpretation, and application of the law varies by state.

1. As a result, whether Wellness Initiatives could arguably be considered a rebate remains a question subject to the specifics of each individual state’s rebating law and how each jurisdiction has interpreted and applied that law. To provide a few examples of the variations in state law, even amongst states that have adopted the prior Model Law:

   a. Alaska: Statutorily excludes “a reward under a wellness program established under a health care plan that favors an individual” from the definition of rebates so long as seven requirements, including the program being designed to promote health or prevent disease, are met. See AK Stat § 21.36.110.

   b. Maine: Statutorily permits provision of a value-added service that is related to the coverage provided by an insurance contract, without fee or at a reduced fee, if it is (a) included within the insurance contract, (b) directly related to the servicing of the insurance contract, or (c) offered to provide risk control for the benefit of a client. See Me. Stat. tit. 24-A, § 2163-A.

2. Thus, under the current legal landscape, those seeking to introduce Wellness Initiatives would need to confirm whether such an initiative would be permissible under each relevant jurisdiction’s rebating law and if there are any state specific requirements for offering such an initiative.

iii. Trends in State Law. Notwithstanding the variation in individual state’s laws and if and how they have been amended or interpreted, there does appear to be a general trend that “services are not prohibited if they are directly related to the
insurance product sold, are intended to reduce claims, and are provided in a fair and nondiscriminatory manner.”  J. Parson, D. Marlett, S. Powell, Time to Dust Off the Anti-Rebate Laws, 36 J. Ins. Reg. 7, at 8 (2017).  Under this general approach, which aligns with the substantive result of the language in the current Model Law, a Wellness Initiative should not be prohibited as impermissible rebating.

iv. Policy Considerations. The exemptions in the current Model Law and the trend amongst states to permit certain services even if they are not contained within the insurance contract appear to be logical limitations on the scope of anti-rebating statutes. In short, Wellness Initiatives are not the type of conduct that anti-rebating statutes were originally designed to protect consumers against. This is particularly true in the context of LTC insurance where consideration of these initiatives only began significantly after the policies were initially sold, where the initiatives do not begin at the moment the policy is issued, and moreover where the policies have proven to be unprofitable for the insurers. In other words, it is fair to assume that Wellness Initiatives in this context are not being used to either induce the policyholder to enter into the insurance contract, nor to expand the insurer’s share of the LTC insurance market. Rather, they are targeted at improving policyholder health and reducing the frequency and severity of claims.

v. Conclusion. Given the current legal landscape with respect to rebating, to facilitate the success of Wellness Initiatives jurisdictions could either (a) adopt the recently added rebating exemptions found in the current version of the Model Law, which would explicitly permit such initiatives, or (b) take action to interpret and apply their existing laws in a manner that would allow the provision of products or services that are directly related to the insurance policy in question and designed to reduce claims or improve health. Absent adoption of the current version of the Model Law, however, insurers would need to conduct a state-by-state evaluation of rebating laws in all relevant jurisdictions before implementing a Wellness Initiative.

5. Tax considerations
   a. Issue: will non-ADL / non-cognitive benefits cause tax issues for policyholders?
   b. Current observations
      i. There may be tax consequences for consumers if benefits outside the federal definition of LTC benefits are provided, but this may depend on whether initial investment in programs is paid for out of general company expenses or from the benefit pool.
   c. Addressing issues: [section to be drafted]
   d. Next steps:
      i. Engage with the federal government and insurance industry tax experts to work out potential IRS/tax issues.
6. **Regulatory role in approving or evaluating LTC wellness approaches**
   
a. **Issue:** there is question as to whether LTC wellness approaches need to be approved by regulators or will be implemented by companies and later evaluated by regulators.
   
b. **Current observations:**
   
i. There is little regulatory clarity or uniformity regarding LTC wellness programs.
   
c. **Addressing issues**
   
i. **Idea:**
   
   1. Provide guidance that companies should have available, upon request, documentation of their programs and documentation that key issues our group identified have been addressed.
      
      a. These issues include company plans to accumulate data on programs’ effectiveness, avoiding unfair discrimination, preventing consumer confusion, their take on rebating, avoiding unfavorable consumer tax issues, and data privacy.
   
   2. States retain the right to conduct back-end reviews, targeting any critical areas of regulatory focus.
   
   3. Companies and regulators need to ensure that this approach is in compliance with existing state laws.
      
      a. The NAIC Model Unfair Trade Practices Law appears to contemplate either a “provide notice and opportunity for objection” approach or a “documented criteria must be maintained by the insurer and produced to the regulator upon request” approach, depending on the circumstances.
   
ii. **Considerations:**
   
   1. Balance between holding companies accountable while not creating a burden that could prevent or slow up companies from pursuing beneficial programs.
   
   2. There may be mixed policies regarding pre-approval or filing of documentation by state. An effort to make any filing process as efficient as possible for regulators and companies should be pursued to avoid any unconstructive burdens.
   
   3. Companies being alerted that documentation must be available would likely ensure they at least attempt to address each of the issues prior to implementing a program.
   
   4. Would states be interested in being provided notice of development of a new wellness program? Would states want to be notified of every change in or addition to a program? In what form would the notification occur?
   
   5. Would a state have a right to object to an aspect of a program? If the objection leads to elimination of the program in that state, would that lead to other concerns, e.g., discrimination?
6. Would development of a uniform LTC wellness template help creating uniformity in how states interact with companies offering programs?

7. Need to determine consequences for a company that does not maintain the required documentation.

i. After experiencing several companies’ pilot programs and identifying actual problem areas (as opposed to hypothetical issues), it is possible regulators will want to pursue a targeted pre-approval process or up-front receipt of documentation. That could be decided at a later date.

Next steps

i. Analyze flexibility in existing laws that would allow for innovation that could potentially result in better health for policyholders and lower claims costs for insurance companies.

ii. Consider developing a template that a company could fill in with narrative explanation of how they have considered identified issues in development of a LTC wellness program. An efficient manner to have this information received by interested regulators resulting from a single company filing (perhaps through SERFF or an NAIC portal) can be pursued.

ii. Because LTC insurance is in a desperate situation in some cases regarding solvency and rate increases, explore a regulatory sandbox approach regarding LTC wellness innovations.

iii. Explore whether a company’s commitment towards innovation efforts could be a contingency to receiving a fully actuarially justified rate increase.

7. Actuarial considerations

a. Issue: how are actuarial issues such as valuation, rate increase reviews, and reasonable value of benefits and options impacted by LTC wellness benefits?

b. Current observations

i. Although health outcomes can be expected to improve, to some extent, with LTC wellness programs, it is unclear how future claim costs will be impacted in comparison to the investment in the programs.

ii. As data emerges, actuarial issues related to the impact of LTC wellness benefits on future claim incidence and severity, could impact rate increases and reserves.

C. Addressing of Issues

i. Valuation: Under moderately adverse conditions, as data emerges, future cash flows associated with LTC wellness programs and potential claim cost reductions resulting from the programs may be incorporated into reserve adequacy testing, including Actuarial Guideline 51 stand-alone long-term care analysis, per actuarial standards of practice.

ii. Rates: As data emerges, future cash flows associated with LTC wellness programs and potential claim cost reductions resulting from the programs may be incorporated into lifetime loss ratio projections associated with rate-increase filings, per actuarial standards of practice.
iii. The NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation and NAIC Health Actuarial Task Force-adopted Consolidated, Most Commonly Asked Questions - States’ LTC Rate Increase Reviews document suggest that consistency between rate increase assumptions and reserve adequacy assumptions (noting reserve adequacy assumptions may include a margin to account for moderately adverse conditions) may be expected by some regulators.

iv. Reasonable value: The Long-term Care (EX) Task Force has tentatively established guidance that reduced benefit options in lieu of rate increases should provide reasonable value in comparison to the economic value of maintaining benefits and paying the increased premium. To the extent that LTC wellness benefits are tied into reduced benefit options, the holistic concept of reasonable value will likely be a consideration.

d. Next steps
   i. Determine the NAIC venue to work through LTC wellness actuarial issues.

8. Data privacy

   a. Issue: utilization of consumers’ data for wellness initiatives can be used to develop the marketing strategy and a specific wellness initiative, as well as to analyze the impact or effects of a wellness initiative. The use of Big data Data or artificial intelligence to develop the target demographic for new sales, the selection of the existing consumers for wellness initiatives, or to determine the results of the initiative, could result in an insurer or third party data vendor using the data in a way that could be unethical, discriminatory, confusing, or otherwise problematic.

   i. With many of the tech advancements, data on the policyholder would be accessed to, e.g., help identify warning signs of risks such as falls and early-stage dementia.

   b. Current observations
      i. The standards applied by insurance companies and tech firm vendors to ensure certain levels of privacy are generally unknown.

   c. Addressing of issues
      i. Data Use to Identify Wellness Initiatives:
         1. Policyholders considerations:
            a. Confusion about why they are being solicited for the initiative.
            b. Suspicion about the motivation of the insurer.
c. General lack of awareness that data is being collected, and what data is being collected.

d. General lack of awareness or understanding on how data is collected and used.

e. Will they know if their data was used to determine a specific wellness initiative for them versus being selected as part of a class of policyholders?

f. Will the policyholder know what data is going to be used prior to participation?

g. Should the policyholder have the option to “opt in/out” of their data being used internally for other initiatives or for external sale or use?

h. Should policyholders have the ability to have appropriate control over their information, including the ability to access and correct inaccuracies, consistent with legitimate business purposes and/or legal requirements to retain such information?

2. Insurer considerations:

   a. Should insurer communications include why a wellness initiative is being offered; including what data is being used?

   b. How should insurers use clear and concise notice about the collection, use, and disclosure of personal information?

   c. Should insurers purchase data regarding their policyholders (e.g. data that shows specific policyholders may have a near term claim - purchasing canes, grab bars, electronic fall detectors, etc.)?

   d. How should wellness initiatives be marketed to a policyholder? Insurers may need to limit what is advertised on the envelope, postcard, etc. due to HIPAA concerns.

   e. Should insurers partner with vendors or service providers to supply specific policyholder data to the wellness company? What data should be sent? How will the data be transferred?

   f. Should insurers focus their data on policyholder specific needs and only offer services relevant to the ongoing needs?

   g. How are opt in/out options, disclosures, etc. being shared with the consumer? Email, letter, text, etc. Is it appropriate to the policyholder’s needs or preferences?

   h. When using third party data providers, what screening or data protection programs are in place?

ii. Data Use During Wellness Initiative Development:

   1. Should insurers purchase policyholder specific information from third party data sources?

      a. Data collected during purchases, search history, television programming, etc.

      b. Should it always be headless, anonymized, or deidentified?
2. When considering big data, are there unacceptable “correlations”? How will insurers recognize relevant correlations vs irrelevant statistically significant correlations?
3. Are there data use standards, controls, definitions of personal data, or a data privacy review body in place to ensure the data is used, stored, or shared ethically?
4. When evaluating the data for wellness initiatives, will it focus on policyholder specific information – for example, will the policyholder’s claims detail or demographic factors determine the type of wellness initiative offered to that policyholder?
5. Will the risk of a data breach be assessed and protected against by the insurer as well as all vendors or third-party data suppliers?
6. Does the insurer have procedures in place to notify the policyholders of a potential breach?

iii. Wellness Results Data Use:
   1. Should the results be sold? Aggregate vs specific demographic information?
   2. Should insurers use the results internally for cross marketing other wellness initiatives?
   3. Should the policyholder be notified and have the option to “opt in/out” of letting the insurer use the data?
   4. Should the results be shared with the policyholder, POA, third party notifier? What guardrails should be in place relative to that sharing?
   5. How should the data be shared, if at all, with other vendors or service providers?
   6. How long will the data be retained? Will the data be destroyed or disposed?

d. Dependencies
   i. Unfair Discrimination
      ii. States’ adoption of wellness initiatives could make it difficult to implement a program uniformly.

e. Next steps:
   i. Reach out to experts in the health insurance and Medicare Advantage, Medicare Supplement, or Medicaid / PACE areas to learn from their experiences.
   ii. Identify applicable state privacy laws and HIPAA anti-marketing restrictions.
   iii. Require insurance companies to provide information on privacy protection matters when claims management processes are established.
   iv. Determine if policyholder approval of use of expanded data can be established at certain points in time:
      1. At times of options in lieu of rate increases, can insurance companies get agreement to attain more policyholder data?
   v. Can new contracts be written with evergreen access to some private data?
9. **Other considerations**
   
   a. Issue: other legal or market and administrative issues may come into play as LTC wellness programs are established.

   b. Current observations
      
      i. There are dozens or hundreds of cutting-edge technological advancements being developed to help with aspects of LTC claims management.
         
         1. It is difficult for insurance companies and regulators to determine which tech advancements are most promising in terms of likelihood of success and degree of impact on consumer health and reducing claims cost.

      ii. TPAs or reinsurers used by direct-writing insurance companies may be resistant to administering these additional activities or may be concerned about potential legal ramifications that could impact their firms.

      iii. Insurers could potentially be subject to requirements if a policyholder, e.g., is identified as having cognitive impairment and therefore be a risk related to driving or finances.

   c. **Addressing issues [section to be drafted]**

   d. Next steps
      
      i. Determine if there is objection to an insurance company offering an extra-contractual wellness benefit that is not tied to loss ratio / benefits / contracted obligations, i.e., out of expenses?

      ii. Determine if benefits offered outside the contract could be considered in a similar category as because a reduced benefit option in lieu of a rate increase, which is essentially a mutually-agreed-to restructuring of the insurance contract.

      iii. Either identify or ensure industry members are identifying requirements related to disclosing, e.g., when a policyholder has cognitive impairment and may be a high-risk driver.

      iv. Regulatory guidance may help innovators engage in this space.

10. **Miscellaneous topics**

    a. How will insurers report on issues and learnings?

    b. This document will likely need to be updated with new learnings or issues.

    c. Continuous collaboration with insurers regarding issues or new initiatives will likely be needed.

    d. Note that there are hybrid products that contain wellness benefits. However, the scope of this document is wellness associated with stand-alone LTC insurance policies, which tend to have more volatile financial profiles than hybrid products.
Commissioner Jessica Altman
Chairman, NAIC LTCI Reduced Benefit Options (EX) Subgroup
Pennsylvania Insurance Department

November 4, 2021

Dear Commissioner Altman,

The American Council of Life Insurers (ACLI)\(^1\) and the American Association of Health Insurance Plans (AHIP)\(^2\) appreciate the opportunity to comment on the second draft of the “Issues Related to LTC Wellness Benefits,” exposed by the NAIC Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup on October 5, 2021.

ACLI/AHIP continue to support the Subgroup’s work to explore the offering of innovative wellness benefit programs as part of long-term care insurance (LTCI). By discussing the issues and opportunities associated with wellness programs in LTCI, we learn how these benefits may contribute to policyholder health and strengthen the LTCI market.

**OBJECTIVE**

ACLI/AHIP request that the newly added objective statement be revised to reflect the document’s stated purpose in the Background section to work “together to explore some of these claim cost-reducing innovations.” Thus, we recommend the objective statement read, “The objective of this paper is to foster dialogue amongst regulators, insurance companies, and interested parties regarding issues related to innovative long-term care wellness programs.” Fostering discussion that supports insurance companies in developing pilot wellness programs should be the aim of this document, as opposed to increasing “clarity,” which could stifle innovation. As we have previously asserted, LTCI wellness initiatives are in their infancy and will require significant development and testing. Insurers are encouraged to develop wellness initiatives when the regulatory environment facilitates exploration, innovation, and targeted pilot programs.

With the goal of contributing to the discussion on wellness programs in LTCI, our comments on the second draft are as follows.

**BACKGROUND**

We appreciate the addition of “pre-insurance-claim” to describe the wellness interventions discussed in the document. The true value of wellness interventions comes in providing them pre-claim when they are most effective.

And while we recognize the Subgroup’s stated goal to address rate increases and solvency concerns with wellness programs, we continue to feel it is important that this discussion...
document emphasize what should be wellness programs’ primary goal, and that is the maintained or improved health and independence of policyholders. Whether or not wellness programs affect rate increases or solvency concerns remains to be seen. They are likely to be one of many factors, including necessary and actuarially justified rate increases, that strengthen the LTCI marketplace overall. Wellness programs should not be pursued as a “cure” to industry issues. What we can reasonably pursue, however, is the improved wellness of LTCI policyholders.

PREVENTION OF UNFAIR DISCRIMINATION RELATED TO EXTRA-CONTRACTUAL BENEFITS AND COSTS

ACLI/AHIP affirm the importance of avoiding unfair discrimination when offering LTCI wellness benefits. We also believe it is possible navigate discrimination concerns when targeting wellness programs to cohorts of similarly situated insureds. Our original comments asserted that certain wellness “programs may be most effective and most utilized if focused on those insureds with a particular condition, age range, or sex. Targeted wellness programs could more effectively reduce claims costs and maximize the health of policyholders.” The ability to target wellness programs, while avoiding unfair discrimination, is key to encouraging LTC insurers to implement wellness programs. Insurers are unlikely to attempt a wellness program if they cannot first experiment with a small, targeted pilot program before scaling up.

While we agree with efforts to better support underserved markets, we disagree with the newly added language in this section that suggests “selection for pilots should consider including a wide range of individuals from various geographic, economic, social, marital, age, racial, and ethnic populations to ensure meaningful data is collected.” While a broad range of characteristics might be appropriate for many benefit programs, it is not appropriate in all instances, particularly pilot programs. Often, meaningful data is best collected and analyzed when it is targeted. Certain benefits are also likely to be more effective at improving wellness if targeted.

The LTCI industry needs assurance from regulators that focusing wellness benefits on a cohort of similarly situated policyholders successfully navigates unfair discrimination requirements. Regulatory guidance on how to classify policyholders for a targeted wellness program is unnecessary and would hamper industry efforts to innovate.

REGULATORY ROLE IN APPROVING OR EVALUATING LTC WELLNESS APPROACHES

We welcome the edits made to this section that both express a goal to avoid unconstructive regulatory and filing burdens and, also, remove the suggestion that receiving an actuarially justified rate increase be contingent on an insurer’s innovation efforts.

To reiterate, ACLI/AHIP believe that tying wellness benefit programs to rate increases is inappropriate for a few reasons. First, a rate increase request for an individual block of business may not have an associated wellness program. Second, wellness programs might only be offered to new customers. Third, wellness programs are primarily structured to improve
wellness, not address actuarially justified rate increases. Fourth, it could lead to inequities between companies with varying participation levels in the wellness realm. And fifth, the data needed to justify a correlation between wellness programs and rate increases, will, if such a correlation exists, take time to gather and analyze.

CONCLUSION

ACLI/AHIP affirm their commitment to continuous collaboration with regulators and other interested parties in developing the thinking about wellness programs in LTCI. Thank you for the opportunity to provide these comments. ACLI/AHIP look forward to discussing our comments with you soon.

Sincerely,

Jan M. Graeber   Susan Coronel
Senior Actuary, ACLI  Executive Director, Product Policy, AHIP

i The American Council of Life Insurers advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care (LTC) insurance, disability income insurance, reinsurance, dental, vision, and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States.

ii AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.
The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Nov. 19, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Jimmy Harris (AR); Emily Smith (CA); Susan Jennette (DE); Doug Ommen (IA); Stewart Guerin (LA); Kevin Dyke (MI); Carter Lawrence (TN); R. Michael Markham (TX); Tomasz Serbinowski (UT); Elsie Andy (VA); Anna Van Fleet (VT); and Sharon Daniel (WA).

1. **Adopted the RBO Consumer Notices Checklist.**

Ms. Van Fleet and Ms. Logue presented a version of a draft Reduced Benefit Options (RBO) Consumer Notices Checklist (Checklist) that incorporates comments received on the draft, with notes on the proposed treatment of each comment. The Subgroup, interested state insurance regulators, and interested parties discussed and agreed to changes to items 16, 18, and 42. These changes were incorporated into a final version of the Checklist (Attachment Fourteen).

Mr. Serbinowski made a motion, seconded by Ms. Van Fleet, to adopt the final version of the Checklist (Attachment Eight-A). The motion passed unanimously.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.

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attachment: 08 A LTC(EX)TF RBO Communication Checklist 10.19.2021.docx
Checklist for Premium Increase Communications

AUTHORITY

The Long-Term Care Insurance Reduced Benefit Options (RBO) (EX) Subgroup is composed of regulators from 17 state insurance departments. It has been tasked with assisting the Long-Term Care Insurance (EX) Task Force in completing the following charge:

*Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.*

The Long-Term Care Insurance (EX) Task Force (Task Force) adopted the Long-Term Care Insurance RBO Communication Principles. The Long-Term Care Insurance RBO EX Subgroup has been charged with developing a complementary checklist that can be leveraged by state regulators and Long-Term Care Insurance insurers.

INTRODUCTION

This checklist is intended to establish a consistent approach to drafting and reviewing Long-Term Care Insurance RBO policyholder communications. The checklist can be used as guidance and does not carry the weight of law or impose any legal liability.

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experiences in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.

Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion, complaints, improve the quality of consumer communications, and ensure the information presented. The checklist seeks to ensure that consumer communications:

- Reads in a clear, logical, not overly complex manner.
- Present identifies if the options are presented fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

Suggested Edits from BB & BC:

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.

Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion, and complaints, improve the quality of consumer communications, and to ensure the information presented. The checklist seeks to ensure that consumer communications:

- Reads in a clear, logical, not overly complex manner.
● Identify if the options are presented fairly and without subtle coercion.
● Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

[The LTC Task Force? The RBO[9] Subgroup?] RECOMMENDS that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and adopt use the checklist when reviewing filed Long-Term Care Insurance RBO Communications.

CALLS ON all insurance companies to consider the checklist when developing reduced benefit option policyholder communications in the event of a rate increase.
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### Checklist for Premium Increase Communications

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<td><strong>Notes</strong></td>
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<td>1. Does the filing contain all required materials to include: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (screenshots may be requested if communication refers policyholder to website for more information)?</td>
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<td>2. Has actuarial review of the rate increase been completed?</td>
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<td>3. Will notice of the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)?</td>
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<td>4. Have all new innovative RBO options presented in the communication been mentioned prominently as part of clearly explained information?</td>
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4-278 NAIC Proceedings – Fall 2021
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<td>5.</td>
<td>Are there sample policyholder communications with a statement of variability? Do reviewers understand any variable information that appears in the letter communication?</td>
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<td>6.</td>
<td>Are there insurer rules and training for customer service interactions regarding RBOs?</td>
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<td>7.6.</td>
<td>Were state-specific or contract-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification 45-60 days before effective date. PA posts filed rate increase details on their website.</td>
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**READABILITY AND ACCESSIBILITY**

| 8.7. | Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)? Is the primary message of the communication presented first and clearly worded? |   |
| 9.8. | Are all technical insurance terms clearly explained in the communication? |   |
| 10.9. | Are all technical terms used consistently throughout the communication? |   |
| 11.10. | Is the communication in an easily readable font? For example: Is the type in at least 11-point type? |   |
| 12.11. | Does the communication use headings to help the reader find information easily? |   |

Page Reference and Filing Notes
13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?

14. Are tables, charts, and other graphics easy to read and understand? (See question 18 for reference).

15. Are the grade level and reading ease scores appropriate according to state readability standards? (8th grade or lower; Flesch reading ease score 60 or higher).

16. Are there side-by-side illustrations of options compared with current benefits? Are reduced benefit options clear and not misleading? For example: Are there side-by-side illustrations of options compared with current benefits?

   - Use of Italics
   - Narrow margins (top and bottom less than 1.5 inches)
   - All caps (all bold is acceptable)
   - Difficult to read text (fonts other than Sans Serif or Courier)
   - Glossy paper
   - Different colors throughout (print to test)
   - Small font

17. If FAQs are included, are they succinct and easy to understand?

18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language? For example: Accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or
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<td>19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language?</td>
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<td>21. Does the communication answer why the consumer is receiving a rate increase?</td>
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<td>22. Does the communication indicate when the rate increase will be effective?</td>
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<td>23. Does the communication clearly indicate they policyholder has the option to elect an option? Does the election documentation allow the consumer to clearly indicate his or her choice? Does the election form description of options match the description of options found earlier in the communication, such that consumers will not be confused looking at the election form? For example, when check boxes are used to indicate a choice, there should be some way to verify the consumer’s choice.</td>
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</table>

macular degeneration, low vision, deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.

19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language?

20. Does the communication answer what is happening?

21. Does the communication answer why the consumer is receiving a rate increase?

22. Does the communication indicate when the rate increase will be effective?

23. Does the communication clearly indicate they policyholder has the option to elect an option? Does the election documentation allow the consumer to clearly indicate his or her choice? Does the election form description of options match the description of options found earlier in the communication, such that consumers will not be confused looking at the election form? For example, when check boxes are used to indicate a choice, there should be some way to verify the consumer’s choice.
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<tbody>
<tr>
<td>25.</td>
<td>Does the communication clearly explain that the consumer is not being singled out for the increase?</td>
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<td></td>
<td>26.</td>
<td>Does the communication clearly describe “class basis”?</td>
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<td>Are consumers being singled out for the increase?</td>
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<td>Suggested text: “Overall experience of all contracts in your class...”</td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td><strong>COMMUNICATION TOUCH AND TONE</strong></td>
<td>Page Reference and Filing Notes</td>
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<td>27.</td>
<td>Does the communication remind consumers to reflect on why they may have purchased the original reason they bought the policy?</td>
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<td>28.</td>
<td>Does the communication express empathy and understanding of the difficulty of evaluating choices?</td>
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<td>29.</td>
<td>Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?</td>
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<td></td>
<td>30.</td>
<td>Are the options represented fairly? Options are not presented fairly if one option is emphasized, mentioned multiple times or bolded whereas the others' options are not.</td>
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<td></td>
<td>31.</td>
<td>Are the words used that could influence a policyholder's decision, such as must or avoid? For instance, consider demonstrating immediacy by using the word “now,” instead of and avoiding words like “must” and “avoid.” Consider “mitigation options,” “offset premium impact,” “manage an increase” instead of “avoid an increase.”</td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>CONSULTATION AND CONTACT INFORMATION</td>
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<td>☐</td>
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<td>32.31. Is the insurer’s consumer service number easy to find? Is it clear what hours and days consumer service is open? Regulators may consider testing the phone number to ensure it connects easily to live company representatives without long wait times rather than a phone tree.</td>
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<tr>
<td>☐</td>
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<td>33.32. Are website links and phone numbers accurate and functional?</td>
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<td>☐</td>
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<td>34.33. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial planner, advisor, producer, state SHIP program (where applicable), with the state-specific name of the program, or trusted family member? Is that information communicated clearly?</td>
</tr>
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<td>☐</td>
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<td>35.34. Does the Insurer encourage consumers to consult the Department of Insurance? Does it specify the Department can only give general information?</td>
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<td>☐</td>
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<td>36.35. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss of Partnership status?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>UNDERSTANDING OPTIONS - PRESENTATION</th>
<th>Page Reference and Filing Notes</th>
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<tbody>
<tr>
<td></td>
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<td>37.36. Does the communication have a clearly worded, descriptive title or subject line? For example: Your Long-Term Care Premiums Are Increasing.</td>
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<td>38.37. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?</td>
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<td>39.38. Are the number of options presented reasonable but no more than 5-7 options? If there are less than 3, but more than 5-7, engage with insurer to understand what is being presented.</td>
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<td>40.39. Is the Right to Reduce Coverage at Any Time at any time of a policyholder’s choosing clear? Are the instructions about how to do that clear?</td>
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<td>41.40. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to decide on choose an option?</td>
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<td>Yes No N/A UNDERSTANDING OPTIONS – PAST RATE ACTIONS</td>
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<td>42.41. Does the communication include a statement that premiums may increase in the future? Is it clear that any future increase will include RBOs? Is the plan for filing future rate increases disclosed and clear? Is a date shown when an insurer plans to file within a known time period, or when an insurer has already submitted a rate filing?</td>
<td></td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT</td>
<td>Page Reference and Filing Notes</td>
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<td>43.42. Does the communication include a 10-year nationwide rate increase history for this and similar forms? (if not in the model for policy increases, okay to remove)</td>
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<td>44.43. Does the communication disclose the policy is guaranteed renewable and clearly explain guaranteed renewable?</td>
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<td>UNDERSTANDING OPTIONS – CURRENT BENEFITS</td>
<td>Page Reference and Filing Notes</td>
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<td>45.44. Does the communication indicate what the reader must do to elect an option and provide a deadline to do it?</td>
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<td>46.45. For options that are only available during the decision window, is the limitation clear to consumers?</td>
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<td>47.46. Does the communication indicate what happens if the policyholder does not send payment? For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable? For example, if no payment is received within 120 days, does the communication explain that it advise Contingent Non-Forfeiture will apply and what that means?</td>
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<td>48.47. Does the communication include all relevant applicable information? Current policy benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) in list form?</td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td><strong>49.48.</strong> If current benefits have an inflation option, does the communication clearly explain that changes to this inflation option may have on benefits now and in the future?</td>
<td><strong>Page Reference and Filing Notes</strong></td>
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<td><strong>UNDERSTANDING OPTIONS – PERSONAL DECISION</strong></td>
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<td><strong>50.49.</strong> Can the insurer confirm policyholders will see only those options that are available to them (and not be shown options that are not available to them)? Are the options presented available to the policyholder?</td>
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<td>☐</td>
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<td><strong>51.</strong> Does the communication contain descriptions of the consumer’s options (including changes in the daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?</td>
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<td>☐</td>
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<td><strong>52.50.</strong> Does the communication prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for and cost of for institutionalized care?</td>
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<td><strong>53.</strong> Does the communication provide an unbiased resource(s) for policyholders to research the cost of care?</td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td><strong>UNDERSTANDING OPTIONS – VALUE OF OPTIONS</strong></td>
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<td>54.51. Do options clearly indicate value for consumers? Does the narrative describing the Contingent Nonforfeiture (CNF) and other limited benefit options clearly indicate that there is a reduction in the current policy’s LTC benefits? Availablely describe if there is a reduction in available current policy’s LTC benefits? value (benefit period)? Does the description narrative of the CNF reduce the need to include quantitative dollar value for CNF’s information in the communication, such as the specific benefit amount reduced with each option?</td>
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<td>55. Is there a statement telling consumers how to contact the insurer for more information, to request the full list of options, or help understand their options?</td>
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<td>Yes</td>
<td>No</td>
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<td>56.52.</td>
<td>Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?</td>
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<td>57.53.</td>
<td>Do the options reflect the impact of removing or reducing the inflation option in terms of growth or reduction if the option is to remove or reduce inflation of future benefits?</td>
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<td>58.54.</td>
<td>If dropping inflation protection results in the loss of accumulated benefit amount, is that clearly explained?</td>
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<td>59.55.</td>
<td>For phased-in increases: Is there a table with all phase-in dates and premium amounts if no RBO is selected? Does the communication clearly state if RBO(s) are limited to only the first</td>
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<td>Rate increase or will only be available during each phase of the rate increase?</td>
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<td>☐ ☐ ☐ 60.56. For phased-in increases, are there communications sent at least 45–60 days before each phase of the increase?</td>
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<tr>
<td>☐ ☐ ☐ 61.57. Does the communication disclose that not all reduction options are require careful consideration and may not be of equal in value?</td>
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</tbody>
</table>

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Attachment Eight-A

Long-Term Care Insurance (EX) Task Force

12/12/21

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NAIC Proceedings – Fall 2021

Attachment Eight-A

Long-Term Care Insurance (EX) Task Force

12/12/21

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4-288
The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Oct. 19, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Emily Smith (CA); Frank Pyle (DE); Doug Ommen (IA); Eric Anderson (IL); Karen Dennis (MI); Fred Andersen (MN); Gretchen Brodkorb (SD); Carter Lawrence (TN); Tomasz Serbinowski (UT); Bob Grissom (VA); Anna Van Fleet (VT); and Melanie Anderson (WA).

1. **Discussed Comments Received on a Draft RBO Consumer Notices Checklist.**

Ms. Van Fleet presented a version of a draft Reduced Benefit Options (RBO) Consumer Notices Checklist (Checklist) (Attachment Nine-A) that incorporates comments received on the draft, with notes on the proposed treatment of each comment.

Ms. Van Fleet said discussion at the next meeting will focus on questions 16 and 42. Commissioner Altman said the Subgroup will schedule another meeting to continue discussion of the comments on the Checklist using the version that reflects revisions made today.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.
Comments as of 7-21-21 Noted

Checklist for Premium Increase Communications

AUTHORITY

The Long-Term Care Insurance Reduced Benefit Options (RBO) (EX) Subgroup is composed of regulators from 17 state insurance departments. It has been tasked with assisting the Long-Term Care Insurance (EX) Task Force in completing the following charge:

Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.

The Long-Term Care Insurance (EX) Task Force adopted the Long-Term Care Insurance RBO Communication Principles. The Long-Term Care Insurance RBO EX Subgroup has been charged with developing a complementary checklist that can be leveraged by state regulators and Long-Term Care Insurance insurers.

INTRODUCTION

This checklist is intended to establish a consistent approach to drafting and reviewing Long-Term Care Insurance RBO policyholder communications. The checklist can be used as guidance and does not carry the weight of law or impose any legal liability.

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in their state. State regulators are encouraged to modify the checklist to suit the needs of the Department.

Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion, complaints, improve the quality of consumer communications, and ensure the information presented. The checklist seeks to:

- Reads in a clear, logical, not overly complex manner.
- Identify if the options are presented fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

Suggested Edits from BB & BC:

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.
Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion, and complaints, improve the quality of the consumer communications, and to ensure the information presented. The checklist seeks to ensure that consumer communications:

- Reads in a clear, logical, not overly complex manner.
- Identifies if the options are presented fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

[The LTC Task Force? The RBO Subgroup?] RECOMMENDS that state regulators adopt the checklist to reflect their state regulations, laws, or statutes and when reviewing filed Long-Term Care Insurance RBO Communications.

CALLS ON all insurance companies to consider the checklist when developing reduced benefit option policyholder communications in the event of a rate increase.
# Checklist for Premium Increase Communications

<table>
<thead>
<tr>
<th>Insurer name:</th>
<th>Date of filing:</th>
<th>Product form:</th>
<th>Tracking number(s) SERFF rate filing:</th>
<th>Tracking number(s) SERFF form filing:</th>
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<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th><strong>SERFF FILING</strong></th>
<th><strong>Page Reference and Filing Notes</strong></th>
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<tbody>
<tr>
<td></td>
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<td>1. Does the filing contain all required materials to including: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (screenshots may be requested-expected if communication refers policyholder to website for more information)? [A15][A16][A17][A18]</td>
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<td>2. Has actuarial review of the rate increase been completed?</td>
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<td>3. Will notice of the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)? [A21][A22][A23][A24]</td>
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<td>4. Have all new innovative RBO options presented in the communication been mentioned prominently as part of clearly explained in the filing? Have they been vetted by policy and actuarial staff? [A25][A26][A27][A28][A29][A30][A31]</td>
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</table>
| Question                                                                 | Yes | No | N/A
|-------------------------------------------------------------------------|-----|----|-----
| 5. Are there sample policyholder communications with a statement of variability? |     |    |     
| Do reviewers understand any variable information that appears in the letter communication? |     |    |     
| 6. Are there insurer rules and training for customer service interactions regarding RBOs? |     |    |     
| Were state-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification 45-60 days before effective date. PA posts rate increase details on their website. |     |    |     
| 7. Were state-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification 45-60 days before effective date. PA posts rate increase details on their website. |     |    |     
| 8. Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)? |     |    |     
| 9. Are all technical insurance terms clearly explained in the communication? |     |    |     
| 10. Are all technical terms used consistently throughout the communication? |     |    |     
| 11. Is the communication in an easily readable font? For example: Is the typeface at least 11 point? |     |    |     
| 12. Does the communication use headings to help the reader find information easily? |     |    |     

*READABILITY AND ACCESSIBILITY*
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<th>13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?</th>
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<td>14. Are tables, charts, and other graphics easy to read and understand? (See question 18 for reference)</td>
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<td>15. Are the grade level and reading ease scores appropriate according to state readability standards? D (8th grade) or lower; Flesch reading ease score [60] or higher?</td>
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<td>16. Are there side-by-side illustrations of options compared with current benefits? Are reduced benefit options clear and not misleading? For example: Are there side-by-side illustrations of options compared with current benefits?</td>
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<td>17. If FAQs are included, are they succinct and easy to understand?</td>
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<td>18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language? For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or macular degeneration, low vision, deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.</td>
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<td>19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language?</td>
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<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>IDENTIFICATION</td>
<td>Page Reference and Filing Notes</td>
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<td>20. Does the communication answer what is happening?</td>
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<td>Question</td>
<td>Communication</td>
<td>Policyholder Options</td>
<td>Election Documentation</td>
<td>Class Basis</td>
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<td>21. Does the communication answer why the consumer is receiving a rate increase?</td>
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<td>22. Does the communication reflect negatively on the Department of Insurance?</td>
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<td>23. Does the communication indicate when the rate increase will be effective?</td>
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<td>24. Does the communication clearly indicate the policyholder has options?</td>
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<td>25. Does the communication clearly indicate how the consumer may elect an option? Does the election documentation allow the consumer to clearly indicate his or her choice? For example, when check boxes are used to indicate a choice, there may be some way to verify that choice on the form returned to the insurer to avoid mistakes?</td>
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<td>26. Does the communication clearly explain that the consumer is not being singled out for the increase?</td>
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<td>27. Does the communication remind consumers to reflect on why they may have purchased the original reason why they purchased the policy?</td>
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<td>28. Does the communication express empathy and understanding of the difficulty of evaluating choices?</td>
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<td>29. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?</td>
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<td>30. Are the options represented fairly? Options are not presented fairly if one option is emphasized, mentioned multiple times or bolded whereas the others options are not.</td>
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<td>31. Are the words used that could influence a policyholder’s decision, such as must or avoid? For instance, consider demonstrating immediacy by using the word “now,” instead of and avoiding words like “must.” Consider “mitigation options,” “offset premium impact,” “manage an increase” instead of “avoid an increase.”</td>
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<td>Yes</td>
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<td>N/A</td>
<td>CONSULTATION AND CONTACT INFORMATION</td>
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<td>32. Is the insurer’s consumer service number easy to find? Is it clear what hours and days consumer service is open? Regulators may consider testing the phone number to ensure it connects easily to live company representatives without long wait times rather than a phone tree.</td>
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<td>33. Are website links and phone numbers accurate and functional?</td>
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<td>34. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial planner, advisor, producer, state SHIP program (where applicable) with the state-specific name of the program, or...</td>
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<td>Yes</td>
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<td>N/A</td>
<td>UNDERSTANDING OPTIONS - PRESENTATION</td>
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<td>35. Does the Insurer encourage consumers to consult the Department of Insurance? Does it specify the Departments can only give general information?</td>
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<td>36. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss of Partnership status?</td>
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<td>37. Does the communication have a clearly worded, descriptive title or subject line? For example: Your Long-Term Care Premiums Are Increasing.</td>
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<td>38. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?</td>
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<td>39. Are the number of options presented reasonable but no more than 5-7? If there are less than 3, or more than 5-7, engage with insurer to understand what is being presented.</td>
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<td>40. Is the Right to Reduce Coverage at Any Time at any time of a policyholder’s choosing clear? Are the instructions about how to do that clear?</td>
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<td>41. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education measures?</td>
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<td><strong>UNDERSTANDING OPTIONS – PAST RATE ACTIONS</strong></td>
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<td>42. Does the communication include a statement that premiums may increase in the future? Is it clear that any future increase will include RBOs? Is the plan for filing future rate increases disclosed and clear? Is a date shown when an insurer plans to file within a known time period, or when an insurer has already submitted a rate filing?</td>
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<td>43. Does the communication include a 10-year nationwide rate increase history for this and similar forms? (if not in the model for policy increases, okay to remove)</td>
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<td>44. Does the communication disclose the policy is guaranteed renewable and clearly explain guaranteed renewable?</td>
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<td><strong>UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT</strong></td>
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<td>45. Does the communication indicate what the reader must do to elect an option and provide a and the deadline to do it?</td>
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<td>46. For options that are only available during the decision window, is that limitation clear to consumers?</td>
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| 47. Does the communication answer what happens if the policyholder does not send payment? For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable? For example, if...
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<tr>
<th>Yes</th>
<th>No</th>
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<th>UNDERSTANDING OPTIONS – CURRENT BENEFITS</th>
<th>Page Reference and Filing Notes</th>
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<td>48. Does the communication include all relevant information? Current policy benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) in list form?</td>
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<td>49. If current benefits have an inflation option, does the communication include the lifetime maximum benefit in dollars illustrated both five and fifteen years into the future?</td>
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<td>Yes</td>
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<td>UNDERSTANDING OPTIONS – PERSONAL DECISION</td>
<td>Page Reference and Filing Notes</td>
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<td>50. Can the insurer confirm policyholders will see only those options that are available to them (and not be shown options that are not available to them)? Are the options presented available to the policyholder?</td>
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<td>51. Does the communication contain descriptions of the consumer’s options (including changes in the daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?</td>
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<td>52. Does the communication prompt the policyholder to consider their personal situation, such as: current age, health</td>
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<td>conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for and cost of institutionalized care?</td>
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<td>53. Does the communication provide an unbiased resource(s) for policyholders to research the cost of care?</td>
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<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>UNDERSTANDING OPTIONS – VALUE OF OPTIONS</td>
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<td>54. Do options clearly indicate value for consumers? Does Does the narrative describing the Contingent Nonforfeiture (CNF) and other limited benefit options clear that there is a reduction in the current policy’s LTC benefits? Does the narrative clearly describe if there is a reduction in the current policy’s LTC benefits?</td>
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<td>Is there a statement telling consumers how to contact the insurer for more information, to request the full list of options, or help understand their options?</td>
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<td>Yes</td>
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<td>UNDERSTANDING OPTIONS – IMPACT OF DECISION</td>
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<td>56. Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?</td>
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<td>57. Do the options reflect the impact of <strong>removing or reducing</strong> the inflation option in terms of on the growth or reduction if the option is to remove or reduce inflation of future benefits? [A237][A238]</td>
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<td>58. If dropping inflation protection results in the loss of accumulated benefit amount, is that clearly explained disclosed? [A239][A240][A241]</td>
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<td>59. For phased-in increases [A242][A243][A244][A245][A246]: Is there a table with all phase-in dates and premium amounts if no RBO is selected? Does the communication clearly state if RBO(s) are limited to only the first rate increase or will only be available during each phase of the rate increase?</td>
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<td>60. For phased-in increases [A247][A248][A249], are there communications sent at least 45–60 days before each phase of the increase?</td>
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<td>61. Does the communication [A250][A251][A252] disclose that not all reduction options are require careful consideration and may are not be of equal in value? [A253][A254]</td>
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The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Oct. 4, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Emily Smith (CA); Frank Pyle (DE); Doug Ommen (IA); Eric Anderson (IL); Stewart Guerin (LA); Karen Dennis (MI); Fred Andersen (MN); Carter Lawrence (TN); Barbara Snyder (TX); Tomasz Serbinowski (UT); Scott A. White (VA); Anna Van Fleet (VT); Melanie Anderson (WA); and Joylynn Fix (WV).

1. **Discussed Comments Received on a Draft LTC Wellness Program Issues Document**

Commissioner Altman presented a version of a draft Long-Term Care (LTC) Wellness Program Issues document (Attachment Ten-A) that reflects edits made in response to comments received (Attachment Ten-B) during its public exposure for comment. She also presented a summary (Attachment Ten-C) of the comments received. Mr. Andersen gave an overview of the document and the summary of comments.

Bonnie Burns (California Health Advocates—CHA) asked how wellness program benefits will be offered to policyholders. Mr. Andersen said the benefits are likely not included in the original policy contract, and they will likely be offered through a mutual agreement between the insurer and policyholder to new contract terms. He said this will be like how reduced benefit options (RBO) are made available to policyholders.

Birny Birnbaum (Center for Economic Justice—CEJ) suggested that a standardized template be used for collection of data needed for wellness program implementation and the data collection be facilitated using a national statistical agent.

Anitha Rao (Neurocern) said she is concerned that the standards of care used by insurers offering wellness programs for providing care to policyholders may not be the same as those used by the medical community.

Commissioner Altman said the document will be re-exposed for an additional public comment ending Nov.4.

2. **Responded to a Referral from the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup**

Mr. Andersen presented a comment (Attachment Ten-D) submitted by the Vermont Department of Financial Regulation in response to an exposure for public comment by the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup of Operational sections of a Long-Term Care Insurance (LTCI) Multi-State Rate Review Framework (MSA Framework). He said the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup referred the comment to the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup for a recommendation on whether to include the additional language proposed in the MSA Framework.

The Subgroup determined that it will recommend that the proposed language not be added to the MSA Framework at this time. However, if the Multistate Actuarial LTCI Rate Review Team (MSA Team) is presented with a rate increase filing that includes the issue addressed in the comment, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup requests that the Long-Term Care Insurance Multistate Rate Review (EX) Subgroup make a referral that includes details of the offering’s connection to the rate increase request.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.

10 10-04-21 LTCI RBO min.docx
Issues related to LTC wellness benefits

7/22/2021 exposed draft with 10/04/21 edits

Objective:

The objective of this paper is to increase clarity to regulators, insurance companies, and interested parties regarding issues related to innovative long-term care wellness programs.

Background:

Stand-alone long-term care insurance is a unique industry, in that higher-than-expected claims’ costs have resulted in substantial rate increases for consumers and financial losses and in some cases solvency concerns for insurance companies.

Technology firms are developing technological and other approaches that could be used by insurance companies to potentially prevent, delay, or lower the severity of LTC claims and improve health outcomes in a space called “LTC wellness”. Examples of these early pre-insurance-claim interventions include:

- Fall prevention programs;
- Home modification consultations, analysis and implementation to facilitate aging in place;
- Caregiver support programs for both formal and informal caregivers;
- Next generation care coordination services;
- Technological solutions aimed at improvements in cognitive impairment prevention and early diagnosis, potentially involving technology supplemented by a physician’s cognitive risk evaluation.

In light of systemic, LTC-related financial challenges, insurance companies, insurance regulators, and tech firms are interested in working together to explore some of these claim cost-reducing innovations. Here are some potential barriers to increased adoption of these new approaches and how those barriers could potentially be addressed, with details provided below the list:

1. Analysis of effectiveness
2. Unfair discrimination
3. Consumer confusion
4. Rebating
5. Tax considerations
6. Regulatory role in approving or evaluating LTC wellness approaches
7. Actuarial considerations
8. Data privacy
9. Other considerations
Details:

1. Analysis of effectiveness
   a. Issue: in light of the lag time between policyholder age during LTC wellness efforts and policyholder age when claim incidence becomes more common, what issues arise from insurers’ lack of knowledge of effectiveness of LTC wellness programs in reducing claim costs, and how can those issues be addressed?
      i. The cost of innovation efforts, with no guarantee of any returns, may dissuade some insurance companies from pursuing these programs.
         1. Expenses vary - in many cases are typically-upfront and significant.
         2. The financial impact on claims cost is typically unknown and down the road.
      ii. Designing pilot programs is difficult because there is such a variety of programs available, and each block of LTC insurance policies has unique characteristics that might influence the effectiveness of a given program.
      iii. Some companies are concerned about regulatory reaction to these changes.
   b. Current observations
      i. Industry representatives described some current or likely upcoming LTC wellness efforts at the May 4, 2021 NAIC Reduced Benefit Option Subgroup meeting. A theme was that there is great supply and demand for LTC wellness innovation efforts.
      ii. Some insurance companies are exploring or implementing pilot programs. Very early signs on the effectiveness of interventions on impact on policyholder health and claim costs are promising, but data development is slow and it is difficult to implement control trials.
         1. Insurance companies are eager for data and for ways to effectively share data within the legal and regulatory framework so that the industry can effectively respond to positive policyholder experiences and discontinue any programs that fail to make an impact.
      iii. Because there is little competition in the stand-alone LTC insurance market, due to the financial losses accumulated and many insurance companies exiting the actively selling market, sharing of ideas between companies on management of active policies may be possible, although care should be taken regarding anti-trust issues.
      iv. Effectiveness may increase or decrease if targeting certain policyholders.
      v. Development of experience showing effectiveness will be a work in progress.
   c. Addressing of issues
      i. Lack of data: With most LTC wellness programs being under-developed or being implemented recently, data is lacking on the extent to which resulting claim cost decreases offset the costs of the programs.
      ii. How to measure health impact: Whether an LTC wellness program effectively reduces claim costs or not, will there be approaches established to measure health benefits to policyholders?
iii. Data sharing: Facilitating the sharing of data, between vendors and insurance companies, and perhaps involving public programs such as Medicaid, is a key element of analyzing effectiveness.

d. Next steps
i. Regulators engage with insurance companies to learn of recent developments.
ii. Research public programs’ data on effectiveness of LTC wellness programs to see if Medicare Advantage, Med Supp, or Medicaid / PACE data is available, relevant, and used. Also, look into potential independent living / senior facility wellness experience as well as health and life insurance wellness experience.
iii. Determine an approach to monitor success of programs. For example, if 3 to 4 companies are applying 3 to 4 pilot programs and finding success, it would be good news regarding broader, future efforts.
   1. Facilitate the sharing of general results (i.e., not individual policyholder data) among those insurance companies in a way that is within the legal and regulatory boundaries.
iv. Regulators ensure capital supporting LTC liabilities is adequate under a range of scenarios, including where claims costs continue to increase.

2. Prevention of unfair discrimination related to extra-contractual benefits and costs
   a. Issue: how does an insurer offer a wellness initiative that is not unfairly discriminatory to discrete populations within the broader group of policyholders?
   b. Current observations
      i. There may be state anti-discrimination and bias-related legal issues to address if certain policyholders are targeted, including through Big Data, to receive extra benefits.
         1. For instance, if older policyholders have less of an online footprint than younger policyholders, how would this impact the accuracy of the targeting of LTC wellness benefits or otherwise introduce bias?
         2. [Birny Birnbaum May 4 comment]: If wellness or other efforts to address specific conditions are based on age or the health of the policyholder, this seems like normal value-added products and services for loss prevention and not an example of unfair discrimination.
            a. Issues to address are likely related to creating a clear framework for compliance related to the use of data analytics and artificial intelligence.
   c. Addressing of issues
      i. Equality: How policyholders are offered wellness initiatives could be unfairly discriminatory.
         1. Policyholders of “the same class and of essentially the same hazard” must be treated equally. See NAIC Model Unfair Trade Practices Act (#880) (“Model Law”).
2. How may an insurer “classify” policyholders post underwriting? Regulators may need to provide guidance on how to classify policyholders.
   a. What is fair? The insurers will need to provide justification.
      i. For example, under the Model Law the availability of the value-added product or service must be based on documented objective criteria and offered in a manner that is not unfairly discriminatory.
   b. May classification be made by jurisdiction? Does that impact the LTC Multi-State Actuarial Rate Review (MSA) program’s overarching goals?
   c. May classification be made by product form?

ii. Selection: How policyholders are selected for wellness initiatives could be unfairly discriminatory.
   1. Wellness initiatives may be costly to the insurer. How can an insurer test it to validate the benefits before rolling it out more broadly?
      a. Under the Model Act, the insurer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no more than one year.
      b. Initial selection of participants may be the most important for antidiscrimination. That selection for pilots should consider including a wide range of individuals from various geographic, economic, social, marital, age, racial, and ethnic populations to ensure meaningful data is collected.
   2. Would a random selection of policyholders be unfair?
   3. Should policyholders be given the option to participate in a wellness initiative?
      a. Must all policyholders be given the option to participate?
   4. How much time/data is needed to prove the initiative is valuable?
      a. Even if benefits are available to all those who utilize, the initiatives may be limited in application depending on a policyholder’s specific circumstances.

iii. Accessibility: How a wellness initiative operates could be unfairly discriminatory.
   1. Does it limit who can participate based on the medium and cost of the equipment or technology? For example:
      a. Does it require access to a computer or internet for online participation?
      b. Does it require access to a smart phone, texting minutes, etc., to use an app?
      c. Does it require access to roads, pools, sidewalks?
      d. Does it require technical skills to use software or hardware?
      e. Will insurers utilize different communication methods, such as phone, text, e-mail, or mail?
2. Does any such limitation require alternatives for those unable to participate in the initiative?

iv. **Uniformity:** If guidance is issued on wellness initiatives, how would states adopt the guidance, especially if states have different standards for allowing wellness programs in LTC insurance?

1. Have all states adopted the Model Law? If not, what have hurdles been for states that have not adopted the model? Will states adopt updates to the Model Law?
2. Standards for unfair discrimination, including in the specific context of wellness initiatives, may vary by state. Requesting insurers and regulators to be aware of the specific requirements of the jurisdiction in question.
   a. For example, Alaska permits rewards under wellness programs but requires that the reward be available for “all similarly situated individuals.” See AK Stat § 21.36.110.

3. If some states allowed wellness initiatives and not others, would this conflict with other initiatives, such as the MSA?

d. Dependencies
   i. Unfair discrimination guidance needs to consider other wellness initiative issues that include:
      1. Analyzing Effectiveness
      2. Actuarial Impacts
      3. Rebate Standards and Limitations
         a. What if an insurer offers the service at a cost (full or portion) for the policyholder(s) after the pilot?
      4. Regulatory Evaluation

e. Next steps
   i. Regulators and interested parties discuss the issues noted above, including whether the use of Big Data to predict risks (of e.g., falls or dementia) and offering benefits and services only to those targeted as high risk would cause concerns regarding discrimination.

3. **Consumer confusion**
   a. Issue: Potential consumer confusion concerning LTC wellness programs will be highly variable dependent upon factors such as the nature of the program, the consumers involved, and the complexity of regulatory issues.

   b. Addressing of issues:
      i. Wellness programs with simple to understand direct connections to prevention of common medical issues (e.g., installing a grab bar) will provoke far less confusion than more esoteric programs based on new technological services (e.g., data collection/monitoring of insured activities) with not yet proven results. Simpler programs may also trigger fewer and less complex regulatory/statutory requirements related to privacy, consent, disclosure, etc. resulting in programs
that will be more easily understood and documented. Programs with newer technology, more data collection and manipulation, and which are connected to more complex care issues will be more confusing and will trigger more complicated regulatory/statutory requirements.

1. In these scenarios, there may be a need to first educate consumers on the technology and the data collection/usage and then the program and its potential benefits before disclosure and informed consent can occur. The ability to prevent confusion and achieve adequate education and understanding may be further impacted by the level of technological sophistication and mental acuity of the consumer, factors which often decline with age.

ii. Designing effective communication regarding insurer LTC wellness programs will require in-depth engagement with LTC consumers, policyholders, family members, eldercare subject matter experts, and NAIC consumer representatives. When the vetting group engages with Medicaid programs, PACE, etc. to learn about best practices in wellness programming, the vetting group should take the opportunity to learn about the successes and failures in communication used in implementing these programs, including any relevant focus group data available.

iii. In addition to engaging with Medicaid and PACE, the following organizations may have valuable insights: National Council on Aging (www.ncoa.org), AARP (www.aarp.org), and the National Institute on Aging (www.nia.nih.gov). In addition to engaging with NAIC representatives and these national organizations, the Vermont team would also propose to reach out to Vermont’s sister agencies in state government (The Agency of Disabilities, Aging, and Independent Living (DAIL), and the Agency of Human Services, (AHS)). Lastly, Emily Brown serves on the board of directors for Central Vermont Home Health and Hospice. Engagement with this local group may provide rural eldercare perspectives missing at the national level.

iv. Focus groups designed to elicit feedback on communication style are most helpful when the programming has been determined. In the alternative, guidelines for communication and disclosure designed to minimize confusion and maximize understanding would need to be developed along a spectrum of wellness programs of increasing complexity. The results of vetting group work around rebating, program effectiveness, data privacy, loss of tax-preferred status, and discrimination concerns will determine components of what needs to be tested in focus groups. For instance, if the loss of tax-preferred status is something the vetting group can address at the federal level, it will not need to be considered when determining barriers to effective communication.
v. Building consensus around terminology and building trust are essential to effective communication. In a Medicaid setting, the PACE program (Programs for All Inclusive Care for the Elderly), wellness efforts include a multidisciplinary team of health professionals coordinating care and no cost share on services. (Source: https://www.medicaid.gov/medicaid/long-term-services-supports/pace/programs-all-inclusive-care-elderly-benefits/index.html). This builds trust through human contact with medical professionals.

1. This type of communication is vastly different than the communication between an insurer and a long-term care policyholder facing a rate increase, where participation may have some impact on the premium rate increase the consumer must pay. As a result, extra care will need to be taken to ensure policyholders truly understand the offer and the level of participation required and that they do not acquiesce based on confusion or because they feel they have no other choice.

vi. As the wellness vetting subgroup works through the issues (program effectiveness, discrimination, data privacy, and tax considerations), the Vermont team hopes to build on the conversations planned with subject matter experts in eldercare programming. The vetting group should plan to add time at the end of the process to explore and understand the vetted programs with consumers via focus group(s) to best anticipate and mitigate consumer confusion.

4. Rebating
   a. Issue: whether some long-term care wellness benefits for policyholders run afoul of the NAIC Model anti-rebating laws or are otherwise prohibited. Those wellness plans may be designed to prevent or lower the severity of LTC insurance claims or to improve health outcomes (“Wellness Initiative”).
   b. Addressing issues:
      i. **NAIC Model Law.** The recently amended version of the NAIC Model Unfair Trade Practices Act (#880) (“Model Law”) explicitly exempts the type of Wellness Initiatives currently being considered from the prohibition on rebates as an unfair trade practice. Specifically, § 4 (H)(2)(e) of the Model Law excludes from “the definition of discrimination or rebates . . . [t]he offer or provision . . . of value-added products or services at no or reduced cost,” even “when such products or services are not specified in the policy of insurance,” if the product or service meets certain requirements. Amongst procedural requirements, the Model Law requires that the product or service (a) relate to the insurance coverage, (b) be “primarily designed to satisfy” one of nine functions, including providing loss mitigation, reducing claim costs, enhancing health, and incentivizing behavioral changes, and (c) cost a reasonable amount in comparison to premiums or coverage. As the Wellness Initiatives in question would be designed to prevent or
lower the severity of LTC insurance claims and improve health outcomes, as long as their cost is reasonably related to the premiums or coverage, then they should not be considered rebates under the recently amended Unfair Trade Practice Act.

ii. Variations in State Law. The above cited language from the Unfair Trade Practices Act, § 4 (H)(2)(e), however, is a recent December 2020 addition to the Model Law. As such, most states have yet to specifically address that update and have only enacted a prior version of the Unfair Trade Practices Act. Unfortunately, the old language of the Model Law was less flexible on this point, which led a number of states to carve out exceptions by individual amendments, regulations, bulletins or desk drawer rules. And the Unfair Trade Practices Act is not the only model law with language prohibiting rebates in the business of insurance. As such, it is much less certain whether the Wellness Initiatives at issue would trigger the law’s anti-rebating provision. And the many state initiatives in this area do not permit a uniform analysis of rebating in each adopting jurisdiction as the precise language, interpretation, and application of the law varies by state.

1. As a result, whether Wellness Initiatives could arguably be considered a rebate remains a question subject to the specifics of each individual state’s rebating law and how each jurisdiction has interpreted and applied that law. To provide a few examples of the variations in state law, even amongst states that have adopted the prior Model Law:
   a. Alaska: Statutorily excludes “a reward under a wellness program established under a health care plan that favors an individual” from the definition of rebates so long as seven requirements, including the program being designed to promote health or prevent disease, are met. See AK Stat § 21.36.110.
   b. Maine: Statutorily permits provision of a value-added service that is related to the coverage provided by an insurance contract, without fee or at a reduced fee, if it is (a) included within the insurance contract, (b) directly related to the servicing of the insurance contract, or (c) offered to provide risk control for the benefit of a client. See Me. Stat. tit. 24-A, § 2163-A.

2. Thus, under the current legal landscape, those seeking to introduce Wellness Initiatives would need to confirm whether such an initiative would be permissible under each relevant jurisdiction’s rebating law and if there are any state specific requirements for offering such an initiative.

iii. Trends in State Law. Notwithstanding the variation in individual state’s laws and if and how they have been amended or interpreted, there does appear to be a general trend that “services are not prohibited if they are directly related to the

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insurance product sold, are intended to reduce claims, and are provided in a fair and nondiscriminatory manner.” J. Parson, D. Marlett, S. Powell, *Time to Dust Off the Anti-Rebate Laws*, 36 J. Ins. Reg. 7, at 8 (2017). Under this general approach, which aligns with the substantive result of the language in the current Model Law, a Wellness Initiative should not be prohibited as impermissible rebating.

iv. **Policy Considerations.** The exemptions in the current Model Law and the trend amongst states to permit certain services even if they are not contained within the insurance contract appear to be logical limitations on the scope of anti-rebating statutes. In short, Wellness Initiatives are not the type of conduct that anti-rebating statutes were originally designed to protect consumers against. This is particularly true in the context of LTC insurance where consideration of these initiatives only began significantly after the policies were initially sold, **where the initiatives do not begin at the moment the policy is issued**, and **moreover** where the policies have proven to be unprofitable for the insurers. In other words, it is fair to assume that Wellness Initiatives in this context are not being used to either induce the policyholder to enter into the insurance contract, nor to expand the insurer’s share of the LTC insurance market. Rather, they are targeted at improving policyholder health and reducing the frequency and severity of claims.

v. **Conclusion.** Given the current legal landscape with respect to rebating, to facilitate the success of Wellness Initiatives jurisdictions could either (a) adopt the recently added rebating exemptions found in the current version of the Model Law, which would explicitly permit such initiatives, or (b) take action to interpret and apply their existing laws in a manner that would allow the provision of products or services that are directly related to the insurance policy in question and designed to reduce claims or improve health. Absent adoption of the current version of the Model Law, however, insurers would need to conduct a state-by-state evaluation of rebating laws in all relevant jurisdictions before implementing a Wellness Initiative.

5. **Tax considerations**
   a. Issue: will non-ADL / non-cognitive benefits cause tax issues for policyholders?
   b. Current observations
      i. There may be tax consequences for consumers if benefits outside the federal definition of LTC benefits are provided, but this may depend on whether initial investment in programs is paid for out of general company expenses or from the benefit pool.
   c. Addressing issues: *[section to be drafted]*
   d. Next steps:
      i. Engage with the federal government and insurance industry tax experts to work out potential IRS/tax issues.
6. **Regulatory role in approving or evaluating LTC wellness approaches**
   
a. **Issue:** there is question as to whether LTC wellness approaches need to be approved by regulators or will be implemented by companies and later evaluated by regulators.
   
b. **Current observations:**
   i. There is little regulatory clarity or uniformity regarding LTC wellness programs.
   
c. **Addressing issues**
   i. **Idea:**
   1. Provide guidance that companies should have available, upon request, documentation of their programs and documentation that key issues our group identified have been addressed.
      a. These issues include company plans to accumulate data on programs’ effectiveness, avoiding unfair discrimination, preventing consumer confusion, their take on rebating, avoiding unfavorable consumer tax issues, and data privacy.
   2. States retain the right to conduct back-end reviews, targeting any critical areas of regulatory focus.
   3. Companies and regulators need to ensure that this approach is in compliance with existing state laws.
      a. The NAIC Model Unfair Trade Practices Law appears to contemplate either a “provide notice and opportunity for objection” approach or a “documented criteria must be maintained by the insurer and produced to the regulator upon request” approach, depending on the circumstances.
   
   ii. **Considerations:**
   1. Balance between holding companies accountable while not creating a burden that could prevent or slow up companies from pursuing beneficial programs.
   2. **There may be mixed policies regarding pre-approval or filing of documentation by state.** An effort to make any filing process as efficient as possible for regulators and companies should be pursued to avoid any unconstructive burdens.
   3. Companies being alerted that documentation must be available would likely ensure they at least attempt to address each of the issues prior to implementing a program.
   4. Would states be interested in being provided notice of development of a new wellness program? Would states want to be notified of every change in or addition to a program? In what form would the notification occur?
   5. Would a state have a right to object to an aspect of a program? If the objection leads to elimination of the program in that state, would that lead to other concerns, e.g., discrimination?
6. Would development of a uniform LTC wellness template help creating uniformity in how states interact with companies offering programs?

7. Need to determine consequences for a company that does not maintain the required documentation.

- After experiencing several companies’ pilot programs and identifying actual problem areas (as opposed to hypothetical issues), it is possible regulators will want to pursue a targeted pre-approval process or up-front receipt of documentation. That could be decided at a later date.

Next steps

- Analyze flexibility in existing laws that would allow for innovation that could potentially result in better health for policyholders and lower claims costs for insurance companies.

- Consider developing a template that a company could fill in with narrative explanation of how they have considered identified issues in development of a LTC wellness program. An efficient manner to have this information received by interested regulators resulting from a single company filing (perhaps through SERFF or an NAIC portal) can be pursued.

- Because LTC insurance is in a desperate situation in some cases regarding solvency and rate increases, explore a regulatory sandbox approach regarding LTC wellness innovations.

- Explore whether a company’s commitment towards innovation efforts could be a contingency to receiving a fully actuarially justified rate increase.

7. Actuarial considerations

a. Issue: how are actuarial issues such as valuation, rate increase reviews, and reasonable value of benefits and options impacted by LTC wellness benefits?

b. Current observations

i. Although health outcomes can be expected to improve, to some extent, with LTC wellness programs, it is unclear how future claim costs will be impacted in comparison to the investment in the programs.

ii. As data emerges, actuarial issues related to the impact of LTC wellness benefits on future claim incidence and severity, could impact rate increases and reserves.

c. Addressing of issues

i. Valuation: Under moderately adverse conditions, as data emerges, future cash flows associated with LTC wellness programs and potential claim cost reductions resulting from the programs may be incorporated into reserve adequacy testing, including Actuarial Guideline 51 stand-alone long-term care analysis, per actuarial standards of practice.

ii. Rates: As data emerges, future cash flows associated with LTC wellness programs and potential claim cost reductions resulting from the programs may be incorporated into lifetime loss ratio projections associated with rate-increase filings, per actuarial standards of practice.
iii. The NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation and NAIC Health Actuarial Task Force-adopted Consolidated, Most Commonly Asked Questions - States' LTC Rate Increase Reviews document suggest that consistency between rate increase assumptions and reserve adequacy assumptions (noting reserve adequacy assumptions may include a margin to account for moderately adverse conditions) may be expected by some regulators.

iv. Reasonable value: The Long-term Care (EX) Task Force has tentatively established guidance that reduced benefit options in lieu of rate increases should provide reasonable value in comparison to the economic value of maintaining benefits and paying the increased premium. To the extent that LTC wellness benefits are tied into reduced benefit options, the holistic concept of reasonable value will likely be a consideration.

d. Next steps
   i. Determine the NAIC venue to work through LTC wellness actuarial issues.

8. Data privacy
   a. Issue: utilization of consumers’ data for wellness initiatives can be used to develop the marketing strategy and a specific wellness initiative, as well as to analyze the impact or effects of a wellness initiative. The use of **Big data** [Data or artificial intelligence] to develop the target demographic for new sales, the selection of the existing consumers for wellness initiatives, or to determine the results of the initiative, could result in an insurer or third party data vendor using the data in a way that could be unethical, discriminatory, confusing, or otherwise problematic.

   i. With many of the tech advancements, data on the policyholder would be accessed to, e.g., help identify warning signs of risks such as falls and early-stage dementia.

   b. Current observations
      i. The standards applied by insurance companies and tech firm vendors to ensure certain levels of privacy are generally unknown.
      ii. There are lessons from other types of insurance on the types of privacy-related issues that may develop.

      iii. There are cases, and perhaps a trend, of programs/interventions being implemented without utilizing significant amounts of policyholder personally identifiable information.

      iv. States’ continuous adoption of data and privacy regulations will need to be available for insurers to assess the compliance of their wellness initiatives.

   c. Addressing of issues
      i. **Data Use to Identify Wellness Initiatives:**
         1. Policyholders considerations:
            a. Confusion about why they are being solicited for the initiative.
            b. Suspicion about the motivation of the insurer.
c. General lack of awareness that data is being collected, and what data is being collected.
d. General lack the awareness or understanding on how data is collected and used.
e. Will they know if their data was used to determine a specific wellness initiative for them versus being selected as part of a class of policyholders?
f. Will the policyholder know what data is going to be used prior to participation?
g. Should the policyholder have the option to “opt in/out” of their data being used internally for other initiatives or for external sale or use?
h. **Should policyholders have the ability to have appropriate control over their information, including the ability to access and correct inaccuracies, consistent with legitimate business purposes and/or legal requirements to retain such information?**

2. **Insurer considerations:**
   a. Should insurer communications include why a wellness initiative is being offered; including what data is being used?
   b. **How should insurers use clear and concise notice about the collection, use, and disclosure of personal information?**
   c. Should insurers purchase data regarding their policyholders (e.g. data that shows specific policyholders may have a near term claim - purchasing canes, grab bars, electronic fall detectors, etc.)?
   d. **How should wellness initiatives be marketed to a policyholder? Insurers may need to limit what is advertised on the envelope, postcard, etc. due to HIPAA concerns.**
   e. Should insurers partner with vendors or service providers to supply specific policyholder data to the wellness company? What data should be sent? How will the data be transferred?
   f. Should insurers focus their data on policyholder specific needs and only offer services relevant to the ongoing needs?
   g. **How are opt in/out options, disclosures, etc. being shared with the consumer? Email, letter, text, etc. Is it appropriate to the policyholder’s needs or preferences?**
   h. When using third party data providers, what screening or data protection programs are in place?

ii. **Data Use During Wellness Initiative Development:**
   1. Should insurers purchase policyholder specific information from third party data sources?
      a. Data collected during purchases, search history, television programming, etc.
      b. Should it always be headless, anonymized, or deidentified?
2. When considering big data, are there unacceptable “correlations”? How will insurers recognize relevant correlations vs irrelevant statistically significant correlations?
3. Are there data use standards, controls, definitions of personal data, or a data privacy review body in place to ensure the data is used, stored, or shared ethically?
4. When evaluating the data for wellness initiatives, will it focus on policyholder specific information – for example, will the policyholder’s claims detail or demographic factors determine the type of wellness initiative offered to that policyholder?
5. Will the risk of a data breach be assessed and protected against by the insurer as well as all vendors or third-party data suppliers?
6. Does the insurer have procedures in place to notify the policyholders of a potential breach?

iii. **Wellness Results Data Use:**
   1. Should the results be sold? Aggregate vs specific demographic information?
   2. Should insurers use the results internally for cross marketing other wellness initiatives?
   3. Should the policyholder be notified and have the option to “opt in/out” of letting the insurer use the data?
   4. Should the results be shared with the policyholder, POA, third party notifier? What guardrails should be in place relative to that sharing?
   5. How should the data be shared, if at all, with other vendors or service providers?
   6. How long will the data be retained? Will the data be destroyed or disposed?

d. **Dependencies**
   i. Unfair Discrimination
   ii. States’ adoption of wellness initiatives could make it difficult to implement a program uniformly.

e. **Next steps:**
   i. Reach out to experts in the health insurance and Medicare Advantage, Medicare Supplement, or Medicaid / PACE areas to learn from their experiences.
   ii. Identify applicable state privacy laws and HIPAA anti-marketing restrictions.
   iii. Require insurance companies to provide information on privacy protection matters when claims management processes are established.
   iv. Determine if policyholder approval of use of expanded data can be established at certain points in time:
      1. At times of options in lieu of rate increases, can insurance companies get agreement to attain more policyholder data?
   v. Can new contracts be written with evergreen access to some private data?
9. **Other considerations**
   a. Issue: other legal or market and administrative issues may come into play as LTC wellness programs are established.
   b. Current observations
      i. There are dozens or hundreds of cutting-edge technological advancements being developed to help with aspects of LTC claims management.
         1. It is difficult for insurance companies and regulators to determine which tech advancements are most promising in terms of likelihood of success and degree of impact on consumer health and reducing claims cost.
      ii. TPAs or reinsurers used by direct-writing insurance companies may be resistant to administering these additional activities or may be concerned about potential legal ramifications that could impact their firms.
      iii. Insurers could potentially be subject to requirements if a policyholder, e.g., is identified as having cognitive impairment and therefore be a risk related to driving or finances.
   c. Addressing issues [section to be drafted]
   d. Next steps
      i. Determine if there is objection to an insurance company offering an extra-contractual wellness benefit that is not tied to loss ratio / benefits / contracted obligations, i.e., out of expenses?
      ii. Determine if benefits offered outside the contract could be considered in a similar category as because a reduced benefit option in lieu of a rate increase, which is essentially a mutually-agreed-to restructuring of the insurance contract.
      iii. Either identify or ensure industry members are identifying requirements related to disclosing, e.g., when a policyholder has cognitive impairment and may be a high-risk driver.
      iv. Regulatory guidance may help innovators engage in this space.

10. **Miscellaneous topics**
   a. How will insurers report on issues and learnings?
   b. This document will likely need to be updated with new learnings or issues.
   c. Continuous collaboration with insurers regarding issues or new initiatives will likely be needed.
   d. Note that there are hybrid products that contain wellness benefits. However, the scope of this document is wellness associated with stand-alone LTC insurance policies, which tend to have more volatile financial profiles than hybrid products.
September 1, 2021

Dear Interested NAIC Regulators, the Long-Term Care Insurance (LTCI) Reduced Benefit Options (EX) Subgroup, Senior Issues (B) Task Force, Health Actuarial (B) Task Force, and Interested Parties:

This letter is in response to the draft long term care insurance (LTCI) wellness program document circulated on 7/22/2021. We are a group of physicians who specialize in cognitive and neurological issues in adults. Many of our patients require home care, assisted living, or long-term care eventually in their lifetime. LTCI has been beneficial for our patients that need custodial care.

Regarding the cognitive wellness initiatives specifically related to “Technological solutions aimed at improvements in cognitive impairment prevention and early diagnosis”, we have the following concerns:

- Insurance carriers are implementing various digital technologies such as wearables, eye-tracking, and other digital biomarkers as the sole means to flag patients with cognitive risk. These technologies are rapidly evolving, experimental and, at most, should be considered data points that are used for decision support. We highly recommend that insurance carriers urge their members to see their physician for a proper cognitive risk evaluation.

- Research from the Alzheimer’s Association has demonstrated approximately 50% of cognitive impairment cases are undiagnosed. New cognitive wellness programs in LTCI that identify patients for cognitive risk could potentially do so before a physician has diagnosed or disclosed the medical condition to the patient. This brings up a variety of legal risks to both the insurance carrier, cognitive wellness coaches, and for the patient.

- As part of cognitive impairment guidelines from the American Academy of Neurology, there is bloodwork and imaging to do as part of the medical workup, as well as ruling out common conditions that “mimic” cognitive impairment (i.e., delirium, vitamin deficiencies, depression). This process is not being verified by insurance carriers or cognitive wellness programs. This gap in care may result in a high number of patients incorrectly flagged as having cognitive risk (false positives). This may also have downstream financial implications for patients through increased insurance premiums.
- Social workers and nurses should not be flagging, diagnosing, or telling patients they have cognitive impairment without a proper medical evaluation and workup by their physician using evidence-based clinical practice guidelines. This gap in care is currently underway at LTCI third-party administrators (during face-to-face assessments) and in internal claims processing workflows during chronic illness verification and the adjudication process. In 2020, an independent external medical advisory task force found 20-30% of potential claims to have a possible 'treatable' condition to their cognitive impairment (delirium, depression, vitamin deficiencies etc.). These patients may have received an incorrect label of irreversible cognitive impairment.

- There are ethical and legal consequences to consider in telling someone they are at risk for dementia or have cognitive impairment before a physician does so. Some states require clinicians to report the patient’s medical condition to the DMV or alert banks regarding mental capacity.

As advocates for patient safety and care representing several U.S territories, we are concerned that these issues will put our patients in harm rather than benefiting them. We suggest to the committee that they seek the advice from an external independent medical advisory board before implementing any nationally approved cognitive wellness programs.

Yours respectfully,

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Eric, here are some comments I received on the LTC Wellness exposure. The submitter (for some reason) wanted to be anonymous.

- Clarify definition of wellness benefits by calling them pre-claim wellness initiatives.
- Perhaps define pre-claim wellness initiatives as providing pre-claim support to assist regarding the declining independence of the insured.
- Wellness benefits (home modification, caregiver training, care management) are often available in today’s LTC products but are not available until the insured is benefit eligible, which is too late to benefit the insured or their family. It should be offered when there’s an initial need.
- Pre-claim (pre-2 ADL) access to caregiver training and home modifications can delay the need for formal care and may provide fairly reliable claim cost savings.
- Rebating would tend to come into play if extra benefits were available day 1, not “later on but pre-claim”.
- Supplement or replace reliance on technology to identify high risk policyholders by having insureds self-identify or opt in.
- If the initiative is one of early support, broad communication and outreach is key. If the initiative is age- or condition-based, it should be offered consistently.
- Health plans already offer caregiver training, home modifications, or wellness programs without tax consequences – what’s different about LTC?

Another issue brought up is whether hybrid products should be brought into the conversation. I think, considering LTC TF is focused on standalone LTC, focus there for now and don’t enter life insurance policy issues into the conversation when standalone LTC is the focus. Do you have thoughts on this?

Thanks.
Larry Nisenson  
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To the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup, Senior Issues (B) Task Force,  
Health Actuarial (B) Task Force, Interested Regulators, and Interested Parties:

Assured Allies mission is to transform the aging process and improve lives for every American as they age. We aspire to do this by reinventing the aging experience for the estimated 20+ million US consumers the vast majority of which are unprepared to finance their long term care costs.

While the precise number of Americans that need assistance as they age is debatable, there is no question that we need a creative and modern approach to solve this societal problem. Assured allies may be new to the long term care space, but our team is rich and deep in experience solving issues for health care and aging. Our products are built with the consumer in mind and thereby use a data driven engagement approach with the singular aim of helping our consumers live healthier lives and age in place.

While our programs fall under the heading of “wellness programs”, we believe our science based wellness solutions provide much more. In fact, we are the first company to take longstanding solutions in the healthcare space, modernize them and apply them to aging and long term care. We build trusted relationships with our consumers and engage and coach them on their respective aging journey. We partner with trusted vendors across the nation to offer meaningful value added discounts to help the consumer as they age and reward the policyholder for healthy decisions. We look to change the trajectory of aging and demonstrate to our consumers that they personally can impact how they age and even where they age. We look to deliver these services, tied to the insurable risk of needing long term care services and partner with insurance carriers to offer new insurance products and help manage current legacy blocks of business. Our new approach and product design will change how long term care is financed and even the aging process.

Insurance regulators are rightly concerned with data use, sources and protections/privacy. We appreciate the data concerns expressed by state regulators and believe through positive consumer consent and transparency we can strike the right balance of protection and innovation that will ultimately benefit our policyholders. We also appreciate the rebating concerns highlighted in the document and believe that our program, which is designed to benefit all policyholders navigates through this complex issue as well. Our program, services and benefits are all tied directly the underlying insurable risk in the insurance contract. We believe it is important to look holistically at how we finance long term care and move beyond premium increases, cutting benefits and try to improve peoples’ lives.

As a new emerging technology company focused on helping older adults age with dignity and independence, we’d appreciate an opportunity to discuss the data privacy and rebating concerns and why we believe our innovative approach to aging is good for consumers, carriers and state insurance departments.

Thank you for your consideration.

Larry Nisenson  
Chief Growth Officer
Issues related to LTC wellness benefits
First draft, work in progress – 7/22/2021

Background:
Stand-alone long-term care insurance is a unique industry, in that higher-than-expected claims’ costs have resulted in substantial rate increases for consumers and financial losses and in some cases solvency concerns for insurance companies.

Technology firms are developing approaches that could be used by insurance companies to potentially prevent or lower the severity of LTC claims and improve health outcomes in a space called “LTC wellness”. Examples of these early interventions include:

- Fall prevention programs;
- Home modification consultations, analysis and implementation to facilitate aging in place;
- Caregiver support programs for both formal and informal caregivers;
- Next generation care coordination services;
- Technological solutions aimed at improvements in cognitive impairment prevention and early diagnosis.

In light of systemic, LTC-related financial challenges, insurance companies, insurance regulators, and tech firms are interested in working together to explore some of these claim cost-reducing innovations. Here are some potential barriers to increased adoption of these new approaches and how those barriers could potentially be addressed, with details provided below the list:

1. Analysis of effectiveness
2. Unfair discrimination
3. Consumer confusion
4. Rebating
5. Tax considerations
6. Regulatory role in approving or evaluating LTC wellness approaches
7. Actuarial considerations
8. Data privacy
9. Other considerations
Details:

1. Analysis of effectiveness

   a. Issue: in light of the lag time between policyholder age during LTC wellness efforts and policyholder age when claim incidence becomes more common, what issues arise from insurers’ lack of knowledge of effectiveness of LTC wellness programs in reducing claim costs, and how can those issues be addressed?

   i. The cost of innovation efforts, with no guarantee of any returns, may dissuade some insurance companies from pursuing these programs.

      1. Expenses are typically upfront and significant.

      2. The financial impact on claims cost is typically unknown and down the road.

   ii. Designing pilot programs is difficult because there is such a variety of programs available, and each block of LTC insurance policies has unique characteristics that might influence the effectiveness of a given program.

   iii. Some companies are concerned about regulatory reaction to these changes.

   b. Current observations

   i. Industry representatives described some current or likely upcoming LTC wellness efforts at the May 4, 2021 NAIC Reduced Benefit Option Subgroup meeting. A theme was that there is great supply and demand for LTC wellness innovation efforts.

   ii. Some insurance companies are exploring or implementing pilot programs. Very early signs on the effectiveness of interventions on impact on policyholder health and claim costs are promising, but data development is slow and it is difficult to implement control trials.

      1. Insurance companies are eager for data and for ways to effectively share data within the legal and regulatory framework so that the industry can effectively respond to positive policyholder experiences and discontinue any programs that fail to make an impact.

   iii. Because there is little competition in the stand-alone LTC insurance market, due to the financial losses accumulated and many insurance companies exiting the actively selling market, sharing of ideas between companies on management of active policies may be possible, although care should be taken regarding anti-trust issues.

   c. Addressing of Issues

   i. Lack of data: With most LTC wellness programs being under-developed or being implemented recently, data is lacking on the extent to which resulting claim cost decreases offset the costs of the programs.

   ii. How to measure health impact: Whether an LTC wellness program effectively reduces claim costs or not, will there be approaches established to measure health benefits to policyholders?
iii. Data sharing: Facilitating the sharing of data, between vendors and insurance companies, and perhaps involving public programs such as Medicaid, is a key element of analyzing effectiveness.

d. Next steps
   i. Regulators engage with insurance companies to learn of recent developments.
   ii. Research public programs’ data on effectiveness of LTC wellness programs to see if Medicare Advantage, Med Supp, or Medicaid / PACE data is available, relevant, and used.
   iii. Determine an approach to monitor success of programs. For example, if 3 to 4 companies are applying 3 to 4 pilot programs and finding success, it would be good news regarding broader, future efforts.
      1. Facilitate the sharing of general results (i.e., not individual policyholder data) among those insurance companies in a way that is within the legal and regulatory boundaries.
   iv. Regulators ensure capital supporting LTC liabilities is adequate under a range of scenarios, including one where claims costs continue to increase.

We suggest another next step would be to explore the potential effect of wellness programs offered at independent living/senior facilities and identification of programs that delay or reduce the length of stays in long-term care facilities. We also support the use of pilot programs to help identify successful programs.

2. Prevention of unfair discrimination related to extra-contractual benefits and costs
   a. Issue: how does an insurer offer a wellness initiative that is not unfairly discriminatory to discrete populations within the broader group of policyholders?
   b. Current observations
      i. There may be state anti-discrimination and bias-related legal issues to address if certain policyholders are targeted, including through Big Data, to receive extra benefits.
         1. For instance, if older policyholders have less of an online footprint than younger policyholders, how would this impact the accuracy of the targeting of LTC wellness benefits or otherwise introduce bias?
         2. [Birny Birnbaum May 4 comment]: If wellness or other efforts to address specific conditions are based on age or the health of the policyholder, this seems like normal value-added products and services for loss prevention and not an example of unfair discrimination.
            a. Issues to address are likely related to creating a clear framework for compliance related to the use of data analytics and artificial intelligence.
   c. Addressing of issues
      i. Equality: How policyholders are offered wellness initiatives could be unfairly discriminatory.
1. Policyholders of “the same class and of essentially the same hazard” must be treated equally. See NAIC Model Unfair Trade Practices Act (#880) (“Model Law”).

2. How may an insurer “classify” policyholders post-underwriting?
   a. What is fair? The insurers will need to provide justification.
      i. For example, under the Model Law the availability of the value-added product or service must be based on documented objective criteria and offered in a manner that is not unfairly discriminatory.
   b. May classification be made by jurisdiction? Does that impact the LTC Multi-State Actuarial Rate Review (MSA) program’s overarching goals?
   c. May classification be made by product form?

ii. Selection: How policyholders are selected for wellness initiatives could be unfairly discriminatory.
   1. Wellness initiatives may be costly to the insurer. How can an insurer test it to validate the benefits before rolling it out more broadly?
      a. Under the Model Act, the insurer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no more than one year.
   2. Would a random selection of policyholders be unfair?
   3. Should policyholders be given the option to participate in a wellness initiative?
      a. Must all policyholders be given the option to participate?
   4. How much time/data is needed to prove the initiative is valuable?
   5. Prior to offering a wellness program, an insurer should have a logical hypothesis of what benefits could be derived from the program.

iii. Accessibility: How a wellness initiative operates could be unfairly discriminatory.
   1. Does it limit who can participate based on the medium? For example:
      a. Does it require access to a computer or internet for online participation?
      b. Does it require access to a smart phone, texting minutes, etc., to use an app?
      c. Does it require access to roads, pools, sidewalks?
   2. Does any such limitation require alternatives for those unable to participate in the initiative?

iv. Uniformity: If guidance is issued on wellness initiatives, how would states adopt the guidance, especially if states have different standards for allowing wellness programs in LTC insurance?
   1. Have all states adopted the Model Law? If not, what have hurdles been for states that have not adopted the model? Will states adopt updates to the Model Law?
   2. Standards for unfair discrimination, including in the specific context of wellness initiatives, may vary by state requiring insurers and regulators to be aware of the specific requirements of the jurisdiction in question.
a. For example, Alaska permits rewards under wellness programs but requires that the reward be available for “all similarly situated individuals.” See AK Stat § 21.36.110.

3. If some states allowed wellness initiatives and not others, would this conflict with other initiatives, such as the MSA?

d. Dependencies
   i. Unfair discrimination guidance needs to consider other wellness initiative issues that include:
      1. Analyzing Effectiveness
      2. Actuarial Impacts
      3. Rebate Standards and Limitations
      4. Regulatory Evaluation

e. Next steps
   i. Regulators and interested parties discuss the issues noted above, including whether the use of Big Data to predict risks (of e.g., falls or dementia) and offering benefits and services only to those targeted as high risk would cause concerns regarding discrimination.

We agree that a determination must be made regarding to whom any pilot or permanent program is offered to ensure no unfair discrimination. Including a wide range of individuals from various geographic, economic, social, age, racial, and ethnic populations is necessary to determine the usefulness of such a program, the credibility of data collected, and whether the program is valuable for all or some.

Additionally, to ensure no unfair discrimination, consideration regarding the availability of internet and smart devices, as well as the technical skills needed to use any devices will be necessary. This includes consideration that aging may impact/change a person’s previous tech skills. Also, a person’s financial position may change, limiting the ability to purchase current/up-to-date technology devices or equipment.

Consideration in selecting pilot participants should also include younger consumers; those who purchase LTC coverage long before their senior years.

3. Consumer confusion
   a. Issue: potential consumer confusion concerning LTC wellness programs will be highly variable dependent upon factors such as the nature of the program, the consumers involved, and the complexity of regulatory issues.

   b. Addressing of issues:
      i. Wellness programs with simple to understand direct connections to prevention of common medical issues (e.g., installing a grab bar) will provoke far less confusion than more esoteric programs based on new technological services (e.g., data collection/monitoring of insured activities) with not yet proven results. Simpler programs may also trigger fewer and less complex regulatory/statutory requirements related to privacy, consent, disclosure, etc. resulting in programs
that will be more easily understood and documented. Programs with newer technology, more data collection and manipulation, and which are connected to more complex care issues will be more confusing and will trigger more complicated regulatory/statutory requirements.

1. In these scenarios, there may be a need to first educate consumers on the technology and the data collection/usage and then the program and its potential benefits before disclosure and informed consent can occur. The ability to prevent confusion and achieve adequate education and understanding may be further impacted by the level of technological sophistication and mental acuity of the consumer, factors which often decline with age.

ii. Designing effective communication regarding insurer LTC wellness programs will require in-depth engagement with LTC consumers, policyholders, family members, eldercare subject matter experts, and NAIC consumer representatives. When the vetting group engages with Medicaid programs, PACE, etc. to learn about best practices in wellness programming, the vetting group should take the opportunity to learn about the successes and failures in communication used in implementing these programs, including any relevant focus group data available.

iii. In addition to engaging with Medicaid and PACE, the following organizations may have valuable insights: National Council on Aging (www.ncoa.org), AARP (www.aarp.org), and the National Institute on Aging (www.nia.nih.gov). In addition to engaging with NAIC representatives and these national organizations, the Vermont team would also propose to reach out to Vermont’s sister agencies in state government (The Agency of Disabilities, Aging, and Independent Living (DAIL), and the Agency of Human Services, (AHS)). Lastly, Emily Brown serves on the board of directors for Central Vermont Home Health and Hospice. Engagement with this local group may provide rural eldercare perspectives missing at the national level.

iv. Focus groups designed to elicit feedback on communication style are most helpful when the programming has been determined. In the alternative, guidelines for communication and disclosure designed to minimize confusion and maximize understanding would need to be developed along a spectrum of wellness programs of increasing complexity. The results of vetting group work around rebating, program effectiveness, data privacy, loss of tax-preferred status, and discrimination concerns will determine components of what needs to be tested in focus groups. For instance, if the loss of tax-preferred status is something the vetting group can address at the federal level, it will not need to be considered when determining barriers to effective communication.
v. Building consensus around terminology and building trust are essential to effective communication. In a Medicaid setting, the PACE program (Programs for All Inclusive Care for the Elderly), wellness efforts include a multidisciplinary team of health professionals coordinating care and no cost share on services. (Source: https://www.medicaid.gov/medicaid/long-term-services-supports/pace/programs-all-inclusive-care-elderly-benefits/index.html). This builds trust through human contact with medical professionals.

1. This type of communication is vastly different than the communication between an insurer and a long-term care policyholder facing a rate increase, where participation may have some impact on the premium rate increase the consumer must pay. As a result, extra care will need to be taken to ensure policyholders truly understand the offer and the level of participation required and that they do not acquiesce based on confusion or because they feel they have no other choice.

vi. As the wellness vetting subgroup works through the issues (program effectiveness, discrimination, data privacy, and tax considerations), the Vermont team hopes to build on the conversations planned with subject matter experts in eldercare programming. The vetting group should plan to add time at the end of the process to explore and understand the vetted programs with consumers via focus group(s) to best anticipate and mitigate consumer confusion.

We agree significant consumer education must be done to ensure understanding of the product, the wellness benefit and any associated technology, and the intent of the wellness benefit and its potential impact on future rate changes. A variety of education methods should be developed and utilized; consumer outreach will be critical.

4. Rebating

a. Issue: whether some long-term care wellness benefits for policyholders run afoul of the NAIC Model anti-rebating laws or are otherwise prohibited. Those wellness plans may be designed to prevent or lower the severity of LTC insurance claims or to improve health outcomes (“Wellness Initiative”).

b. Addressing issues:

i. **NAIC Model Law.** The recently amended version of the NAIC Model Unfair Trade Practices Act (#880) (“Model Law”) explicitly exempts the type of Wellness Initiatives currently being considered from the prohibition on rebates as an unfair trade practice. Specifically, § 4 (H)(2)(e) of the Model Law excludes from “the definition of discrimination or rebates . . . [t]he offer or provision . . . of value-added products or services at no or reduced cost,” even “when such products or services are not specified in the policy of insurance,” if the product or service meets certain requirements. Amongst procedural requirements, the Model Law
requires that the product or service (a) relate to the insurance coverage, (b) be “primarily designed to satisfy” one of nine functions, including providing loss mitigation, reducing claim costs, enhancing health, and incentivizing behavioral changes, and (c) cost a reasonable amount in comparison to premiums or coverage. As the Wellness Initiatives in question would be designed to prevent or lower the severity of LTC insurance claims and improve health outcomes, as long as their cost is reasonably related to the premiums or coverage, then they should not be considered rebates under the recently amended Unfair Trade Practice Act.

ii. Variations in State Law. The above cited language from the Unfair Trade Practices Act, § 4 (H)(2)(e), however, is a recent December 2020 addition to the Model Law. As such, most states have yet to specifically address that update and have only enacted a prior version of the Unfair Trade Practices Act. Unfortunately, the old language of the Model Law was less flexible on this point, which led a number of states to carve out exceptions by individual amendments, regulations, bulletins or desk drawer rules. And the Unfair Trade Practices Act is not the only model law with language prohibiting rebates in the business of insurance. As such, it is much less certain whether the Wellness Initiatives at issue would trigger the law’s anti-rebating provision. And the many state initiatives in this area do not permit a uniform analysis of rebating in each adopting jurisdiction as the precise language, interpretation, and application of the law varies by state.

1. As a result, whether Wellness Initiatives could arguably be considered a rebate remains a question subject to the specifics of each individual state’s rebating law and how each jurisdiction has interpreted and applied that law. To provide a few examples of the variations in state law, even amongst states that have adopted the prior Model Law:

a. Alaska: Statutorily excludes “a reward under a wellness program established under a health care plan that favors an individual” from the definition of rebates so long as seven requirements, including the program being designed to promote health or prevent disease, are met. See AK Stat § 21.36.110.

b. California: Repealed certain anti-rebating provisions via Proposition 103 in 1988.2

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1 A variety of states have other prohibitions on rebates, gifts, and inducements. Trade association ACLI had cataloged a list that the authors found online from 2015 here. https://cdn2.hubspot.net/hubfs/193810/documents/producer/2018/ACLI_Inducements_Gifts_Rebates.pdf.

2 But note that one California attorney warned that recent actions by the CA DOI reflect the state’s still existing anti-rebating statutes in specific areas, like title insurance and home protection contracts. See https://www.insurereinsure.com/2021/03/24/warning-shot-across-the-bow-the-ca-dept-of-insurance-and-rebating/.
c. **Maine:** Statutorily permits provision of a value-added service that is related to the coverage provided by an insurance contract, without fee or at a reduced fee, if it is (a) included within the insurance contract, (b) directly related to the servicing of the insurance contract, or (c) offered to provide risk control for the benefit of a client. See Me. Stat. tit. 24-A, § 2163-A.

2. Thus, under the current legal landscape, those seeking to introduce Wellness Initiatives would need to confirm whether such an initiative would be permissible under each relevant jurisdiction’s rebating law and if there are any state specific requirements for offering such an initiative.

iii. **Trends in State Law.** Notwithstanding the variation in individual state’s laws and if and how they have been amended or interpreted, there does appear to be a general trend that “services are not prohibited if they are directly related to the insurance product sold, are intended to reduce claims, and are provided in a fair and nondiscriminatory manner.” J. Parson, D. Marlett, S. Powell, *Time to Dust Off the Anti-Rebate Laws*, 36 J. Ins. Reg. 7, at 8 (2017). Under this general approach, which aligns with the substantive result of the language in the current Model Law, a Wellness Initiative should not be prohibited as impermissible rebating.

iv. **Policy Considerations.** The exemptions in the current Model Law and the trend amongst states to permit certain services even if they are not contained within the insurance contract appear to be logical limitations on the scope of anti-rebating statutes. In short, Wellness Initiatives are not the type of conduct that anti-rebating statutes were originally designed to protect consumers against. This is particularly true in the context of LTC insurance where consideration of these initiatives only began significantly after the policies were initially sold, and moreover where the policies have proven to be unprofitable for the insurers. In other words, it is fair to assume that Wellness Initiatives in this context are not being used to either induce the policyholder to enter into the insurance contract, nor to expand the insurer’s share of the LTC insurance market. Rather, they are targeted at improving policyholder health and reducing the frequency and severity of claims.

v. **Conclusion.** Given the current legal landscape with respect to rebating, to facilitate the success of Wellness Initiatives jurisdictions could either (a) adopt the recently added rebating exemptions found in the current version of the Model Law, which would explicitly permit such initiatives, or (b) take action to interpret and apply their existing laws in a manner that would allow the provision of products or services that are directly related to the insurance policy in question and designed to reduce claims or improve health. Absent adoption of the current version of the Model Law, however, insurers would need to conduct a state-by-
state evaluation of rebating laws in all relevant jurisdictions before implementing a Wellness Initiative.

We agree it must be determined if offering a benefit requiring a device or app violates anti-rebating or uniform trade practices statutes.

5. Tax considerations
   a. Issue: will non-ADL / non-cognitive benefits cause tax issues for policyholders?
   b. Current observations
      i. There may be tax consequences for consumers if benefits outside the federal definition of LTC benefits are provided, but this may depend on whether initial investment in programs is paid for out of general company expenses or from the benefit pool.
   c. Addressing issues: [section to be drafted]
   d. Next steps:
      i. Engage with the federal government and insurance industry tax experts to work out potential IRS/tax issues.

We agree that understanding the tax consequences of new benefits will be critical to the success of any pilot or permanent wellness program.

6. Regulatory role in approving or evaluating LTC wellness approaches
   a. Issue: there is question as to whether LTC wellness approaches need to be approved by regulators or will be implemented by companies and later evaluated by regulators.
   b. Current observations:
      i. There is little regulatory clarity or uniformity regarding LTC wellness programs.
   c. Addressing issues [section to be drafted]
   d. Next steps
      i. Analyze flexibility in existing laws that would allow for innovation that could potentially result in better health for policyholders and lower claims costs for insurance companies.
      ii. Because LTC insurance is in a desperate situation in some cases regarding solvency and rate increases, explore a regulatory sandbox approach regarding LTC wellness innovations.
      iii. Explore whether a company’s commitment towards innovation efforts could be a contingency to receiving a fully actuarially justified rate increase.

Uniformity on prior approval of LTC wellness benefits would be helpful.
7. Actuarial considerations
   a. Issue: how are actuarial issues such as valuation, rate increase reviews, and reasonable value of benefits and options impacted by LTC wellness benefits?
   b. Current observations
      i. Although health outcomes can be expected to improve, to some extent, with LTC wellness programs, it is unclear how future claim costs will be impacted in comparison to the investment in the programs.
      ii. As data emerges, actuarial issues related to the impact of LTC wellness benefits on future claim incidence and severity, could impact rate increases and reserves.
   c. Addressing of Issues
      i. Valuation: Under moderately adverse conditions, as data emerges, future cash flows associated with LTC wellness programs and potential claim cost reductions resulting from the programs may be incorporated into reserve adequacy testing, including Actuarial Guideline 51 stand-alone long-term care analysis, per actuarial standards of practice.
      ii. Rates: As data emerges, future cash flows associated with LTC wellness programs and potential claim cost reductions resulting from the programs may be incorporated into lifetime loss ratio projections associated with rate-increase filings, per actuarial standards of practice.
      iii. The NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation and NAIC Health Actuarial Task Force-adopted Consolidated, Most Commonly Asked Questions - States' LTC Rate Increase Reviews document suggest that consistency between rate increase assumptions and reserve adequacy assumptions (noting reserve adequacy assumptions may include a margin to account for moderately adverse conditions) may be expected by some regulators.
      iv. Reasonable value: The Long-term Care (EX) Task Force has tentatively established guidance that reduced benefit options in lieu of rate increases should provide reasonable value in comparison to the economic value of maintaining benefits and paying the increased premium. To the extent that LTC wellness benefits are tied into reduced benefit options, the holistic concept of reasonable value will likely be a consideration.
   d. Next steps
      i. Determine the NAIC venue to work through LTC wellness actuarial issues.

As noted under Section 1, we suggest some data might or could be available from independent living/senior communities related to classes or programs offered that may help improve or stabilize health issues resulting in mitigation of loss or severity of loss.

Consideration should be given to both the cost of developing and implementing wellness programs and the value of wellness programs related to premium/rates.
8. Data privacy

a. Issue: utilization of consumers’ data for wellness initiatives can be used to develop the marketing strategy and a specific wellness initiative, as well as to analyze the impact or effects of a wellness initiative. The use of data to develop the target demographic for new sales, the selection of the existing consumers for wellness initiatives, or to determine the results of the initiative, could result in an insurer or third party data vendor using the data in a way that could be unethical, discriminatory, confusing, or otherwise problematic.
   i. With many of the tech advancements, data on the policyholder would be accessed to, e.g., help identify warning signs of risks such as falls and early-stage dementia.

b. Current observations
   i. The standards applied by insurance companies and tech firm vendors to ensure certain levels of privacy are generally unknown.
   ii. There are lessons from other types of insurance on the types of privacy-related issues that may develop.
   iii. There are cases, and perhaps a trend, of programs/interventions being implemented without utilizing significant amounts of policyholder personally identifiable information.

c. Addressing of issues
   i. Data Use to Identify Wellness Initiatives:
      1. Policyholders considerations:
         a. Confusion about why they are being solicited for the initiative.
         b. Suspicion about the motivation of the insurer.
         c. General lack of awareness that data is being collected, and what data is being collected.
         d. General lack the awareness or understanding on how data is collected and used.
         e. Will they know if their data was used to determine a specific wellness initiative for them versus being selected as part of a class of policyholders?
         f. Will the policyholder know what data is going to be used prior to participation?
         g. Should the policyholder have the option to “opt in/out” of their data being used internally for other initiatives or for external sale or use?
      2. Insurer considerations:
         a. Should insurer communications include why a wellness initiative is being offered; including what data is being used?
         b. Should insurers purchase data regarding their policyholders (e.g. data that shows specific policyholders may have a near term claim - purchasing canes, grab bars, electronic fall detectors, etc.)?
c. How should wellness initiatives be marketed to a policyholder? Insurers may need to limit what is advertised on the envelope, postcard, etc. due to HIPAA concerns.
d. Should insurers partner with vendors or service providers to supply specific policyholder data to the wellness company? What data should be sent? How will the data be transferred?
e. Should insurers focus their data on policyholder specific needs and only offer services relevant to the ongoing needs?
f. How are opt in/out options, disclosures, etc. being shared with the consumer? Email, letter, text, etc. Is it appropriate to the policyholder’s needs or preferences?
g. When using third party data providers, what screening or data protection programs are in place?

ii. Data Use During Wellness Initiative Development:
1. Should insurers purchase policyholder specific information from third party data sources?
   a. Data collected during purchases, search history, television programming, etc.
   b. Should it always be headless, anonymized, or deidentified?
2. When considering big data, are there unacceptable “correlations”? How will insurers recognize relevant correlations vs irrelevant statistically significant correlations?
3. Are there data use standards, controls, definitions of personal data, or a data privacy review body in place to ensure the data is used, stored, or shared ethically?
4. When evaluating the data for wellness initiatives, will it focus on policyholder specific information – for example, will the policyholder’s claims detail or demographic factors determine the type of wellness initiative offered to that policyholder?
5. Will the risk of a data breach be assessed and protected against by the insurer as well as all vendors or third-party data suppliers?
6. Does the insurer have procedures in place to notify the policyholders of a potential breach?

iii. Wellness Results Data Use:
1. Should the results be sold? Aggregate vs specific demographic information?
2. Should insurers use the results internally for cross marketing other wellness initiatives?
3. Should the policyholder be notified and have the option to “opt in/out” of letting the insurer use the data?
4. Should the results be shared with the policyholder, POA, third party notifier? What guardrails should be in place relative to that sharing?
5. How should the data be shared, if at all, with other vendors or service providers?
6. How long will the data be retained? Will the data be destroyed or disposed?

d. Dependencies
   i. Unfair Discrimination

e. Next steps:
   i. Reach out to experts in the health insurance and Medicare Advantage, Medicare Supplement, or Medicaid / PACE areas to learn from their experiences.
   ii. Identify applicable state privacy laws and HIPAA anti-marketing restrictions.
   iii. Require insurance companies to provide information on privacy protection matters when claims management processes are established.
   iv. Determine if policyholder approval of use of expanded data can be established at certain points in time:
      1. At times of options in lieu of rate increases, can insurance companies get agreement to attain more policyholder data?
   v. Can new contracts be written with evergreen access to some private data?

We recognize the trend toward use of technology but are concerned with wellness programs reliance on technology and AI. Seniors must be comfortable with the use of and security of their personal data for these programs to succeed.

9. Other considerations
   a. Issue: other legal or market and administrative issues may come into play as LTC wellness programs are established.
   b. Current observations
      i. There are dozens or hundreds of cutting-edge technological advancements being developed to help with aspects of LTC claims management.
         1. It is difficult for insurance companies and regulators to determine which tech advancements are most promising in terms of likelihood of success and degree of impact on consumer health and reducing claims cost.
      ii. TPAs or reinsurers used by direct-writing insurance companies may be resistant to administering these additional activities or may be concerned about potential legal ramifications that could impact their firms.
      iii. Insurers could potentially be subject to requirements if a policyholder, e.g., is identified as having cognitive impairment and therefore be a risk related to driving or finances.
   c. Addressing issues [section to be drafted]
   d. Next steps
      i. Determine if there is objection to an insurance company offering an extra-contractual wellness benefit that is not tied to loss ratio / benefits / contracted obligations, i.e., out of expenses?
ii. Determine if benefits offered outside the contract could be considered in a similar category as because a reduced benefit option in lieu of a rate increase, which is essentially a mutually-agreed-to restructuring of the insurance contract.

iii. Either identify or ensure industry members are identifying requirements related to disclosing, e.g., when a policyholder has cognitive impairment and may be a high-risk driver.

iv. Regulatory guidance may help innovators engage in this space.
Commissioner Jessica Altman
Chairman, NAIC LTCI Reduced Benefit Options (EX) Subgroup
Pennsylvania Insurance Department

November 4, 2021

Dear Commissioner Altman,

The American Council of Life Insurers (ACLI)\(^1\) and the American Association of Health Insurance Plans (AHIP)\(^2\) appreciate the opportunity to comment on the second draft of the “Issues Related to LTC Wellness Benefits,” exposed by the NAIC Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup on October 5, 2021.

ACLI/AHIP continue to support the Subgroup’s work to explore the offering of innovative wellness benefit programs as part of long-term care insurance (LTCI). By discussing the issues and opportunities associated with wellness programs in LTCI, we learn how these benefits may contribute to policyholder health and strengthen the LTCI market.

**OBJECTIVE**

ACLI/AHIP request that the newly added objective statement be revised to reflect the document’s stated purpose in the Background section to work “together to explore some of these claim cost-reducing innovations.” Thus, we recommend the objective statement read, “The objective of this paper is to foster dialogue amongst regulators, insurance companies, and interested parties regarding issues related to innovative long-term care wellness programs.”

Fostering discussion that supports insurance companies in developing pilot wellness programs should be the aim of this document, as opposed to increasing “clarity,” which could stifle innovation. As we have previously asserted, LTCI wellness initiatives are in their infancy and will require significant development and testing. Insurers are encouraged to develop wellness initiatives when the regulatory environment facilitates exploration, innovation, and targeted pilot programs.

With the goal of contributing to the discussion on wellness programs in LTCI, our comments on the second draft are as follows.

**BACKGROUND**

We appreciate the addition of “pre-insurance-claim” to describe the wellness interventions discussed in the document. The true value of wellness interventions comes in providing them pre-claim when they are most effective.

And while we recognize the Subgroup’s stated goal to address rate increases and solvency concerns with wellness programs, we continue to feel it is important that this discussion
document emphasize what should be wellness programs’ primary goal, and that is the maintained or improved health and independence of policyholders. Whether or not wellness programs affect rate increases or solvency concerns remains to be seen. They are likely to be one of many factors, including necessary and actuarially justified rate increases, that strengthen the LTCI marketplace overall. Wellness programs should not be pursued as a “cure” to industry issues. What we can reasonably pursue, however, is the improved wellness of LTCI policyholders.

PREVENTION OF UNFAIR DISCRIMINATION RELATED TO EXTRA-CONTRACTUAL BENEFITS AND COSTS
ACL/HIP affirm the importance of avoiding unfair discrimination when offering LTCI wellness benefits. We also believe it is possible navigate discrimination concerns when targeting wellness programs to cohorts of similarly situated insureds. Our original comments asserted that certain wellness “programs may be most effective and most utilized if focused on those insureds with a particular condition, age range, or sex. Targeted wellness programs could more effectively reduce claims costs and maximize the health of policyholders.” The ability to target wellness programs, while avoiding unfair discrimination, is key to encouraging LTC insurers to implement wellness programs. Insurers are unlikely to attempt a wellness program if they cannot first experiment with a small, targeted pilot program before scaling up.

While we agree with efforts to better support underserved markets, we disagree with the newly added language in this section that suggests “selection for pilots should consider including a wide range of individuals from various geographic, economic, social, marital, age, racial, and ethnic populations to ensure meaningful data is collected.” While a broad range of characteristics might be appropriate for many benefit programs, it is not appropriate in all instances, particularly pilot programs. Often, meaningful data is best collected and analyzed when it is targeted. Certain benefits are also likely to be more effective at improving wellness if targeted.

The LTCI industry needs assurance from regulators that focusing wellness benefits on a cohort of similarly situated policyholders successfully navigates unfair discrimination requirements. Regulatory guidance on how to classify policyholders for a targeted wellness program is unnecessary and would hamper industry efforts to innovate.

REGULATORY ROLE IN APPROVING OR EVALUATING LTC WELLNESS APPROACHES
We welcome the edits made to this section that both express a goal to avoid unconstructive regulatory and filing burdens and, also, remove the suggestion that receiving an actuarially justified rate increase be contingent on an insurer’s innovation efforts.

To reiterate, ACLI/HP believe that tying wellness benefit programs to rate increases is inappropriate for a few reasons. First, a rate increase request for an individual block of business may not have an associated wellness program. Second, wellness programs might only be offered to new customers. Third, wellness programs are primarily structured to improve
wellness, not address actuarially justified rate increases. Fourth, it could lead to inequities between companies with varying participation levels in the wellness realm. And fifth, the data needed to justify a correlation between wellness programs and rate increases, will, if such a correlation exists, take time to gather and analyze.

CONCLUSION
ACLJ/AHIP affirm their commitment to continuous collaboration with regulators and other interested parties in developing the thinking about wellness programs in LTCI. Thank you for the opportunity to provide these comments. ACLI/AHIP look forward to discussing our comments with you soon.

Sincerely,

Jan M. Graeber  
Senior Actuary, ACLI

Susan Coronel  
Executive Director, Product Policy, AHIP

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1 The American Council of Life Insurers advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers' financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care (LTC) insurance, disability income insurance, reinsurance, dental, vision, and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers' products for peace of mind. ACLI members represent 95 percent of industry assets in the United States.

2 AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.
Commissioner Jessica Altman
Chairman, NAIC LTCI Reduced Benefit Options (EX) Subgroup
Pennsylvania Insurance Department

September 7, 2021

Dear Commissioner Altman,

The American Council of Life Insurers (ACLI)\(^1\) and the American Association of Health Insurance Plans (AHIP)\(^2\) appreciate the opportunity to comment on the draft “Issues Related to LTC Wellness Benefits,” exposed by the NAIC Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup on July 22, 2021.

ACLI/AHIP applaud the work of the Subgroup in exploring innovative wellness benefit programs in long-term care insurance. It is our belief that as regulators and industry work together to consider and develop these programs, they will prove beneficial to policyholders and contribute to a strong LTC market.

**GENERAL**

Overall, ACLI/AHIP found the draft to be a balanced and comprehensive outline of issues related to wellness benefit programs in the LTC insurance realm. We do have three general observations about the draft.

First, we wish to reinforce the understanding that many wellness initiatives are in their infancy and will require significant development and testing. Insurers should be allowed to explore and develop these initiatives on a voluntary basis without regulatory mandates if they determine such initiatives are viable and appropriate for their businesses and policyholders.

Second, as the Subgroup’s work on wellness programs continues, we would like to discuss what form the ultimate deliverable will take. Since wellness benefit programs don’t directly correlate with rate actions, tying them together would unnecessarily encumber both. Therefore, we suggest that wellness initiatives not be incorporated into or made dependent on the RBO Checklist or MSSR process. Ideally, the final deliverable encourages uniform state approaches for wellness programs and discourages state-by-state reviews that could stymie uniformity.

And third, because LTC wellness benefit programs are in their infancy, and there is still much to do, we suggest prioritizing the issues explored in the draft. Issues related to the upfront design of programs, such as rebating and discrimination, are a top priority as they are necessary to get started. Those issues related to results, such as actuarial issues and consumer acceptance/confusion, should be a secondary priority because they will be easier to ascertain and address after we have made some progress.
With these general concepts in mind, we offer our analysis of the draft, by section, below.

**BACKGROUND**

Hybrid products constitute 80% of LTC products sold today. Given their key role in the LTC market, we suggest incorporating hybrid products into the background section.

Timing is an important component of wellness benefit programs that should be mentioned in this section. Many LTC policies provide some form of home modification and caregiver training benefits. The true value of these initiatives comes in providing them pre-claim when they are most effective.

This section refers to wellness initiatives as “claim cost-reducing innovation.” In addition to reducing claim costs for insurers, wellness initiatives help policyholders by potentially extending their independence at home and preventing severe impairment. Providing early access to existing benefits, such as caregiver training and home modifications, may postpone the need for formal care and enable insureds to remain in their homes under the care of their families. In addition to maintaining or improving the health and well-being of insureds, wellness initiatives ultimately benefit family members in caring for loved ones.

**ANALYSIS OF EFFECTIVENESS**

A major concern about developing wellness programs is determining how effective they will be. While there are certain desired results that could require years of study and implementation to ascertain whether they can be achieved, other results can be realized quickly. For instance, the affect wellness programs might have on reducing early claims or encouraging cost-effective home care could be known within months of implementation.

Further, the draft refers to upfront, significant costs associated with wellness programs. While this may be true, there are some wellness offerings that are not expensive and can be tested without much financial risk. For example, health education programs or immunization incentives would not cost much. And while individual blocks of LTC insurance policies might be unique, there could be wellness programs that are effective for most, if not all of them, such as stress management and certain medical screenings.

Paragraph (b)(iii) of this section mentions the stand-alone LTC insurance market. As previously mentioned, it’s important to account for the thriving hybrid LTC market. Carriers selling hybrid products can and should contribute to the industry’s wellness initiatives. The flexible design of hybrid products makes them uniquely suited to offer wellness programs that maintain policyholders’ independence at home. For example, the life component of the hybrid product could finance the wellness initiative. Alternatively, additional riders could be added to the hybrid policy to cover wellness programs.
In addition, there is likely much to be learned from wellness programs currently offered under life insurance policies, whether hybrid or not. LTC certainly has components that differentiate it from life and major medical insurance, but to the extent possible, learning from the experience of life and health insurance wellness programs would be advantageous, saving the LTC industry time and money, while expediting health outcomes. In addition to Medicaid and Medicare Advantage mentioned in the draft, there are other products and programs, such as workplace wellness programs and disability income insurance to look to for learning.

We recommend adding another “next step” to this section to better define what is meant by wellness. We need to be clear on what we are hoping to achieve. We are happy to work with the subgroup on a definition.

There are two additional factors to consider when looking at the effectiveness of wellness programs. First, it should be noted that the goal of wellness programs is to improve the health outcomes of policyholders, which could affect loss ratios for insurers. Second, regulators and all participants should be cautious to avoid, even inadvertently, setting overly optimistic expectations as to what the ultimate impacts of any wellness initiatives might be. More innovative wellness programs may take months or years to pilot and assess before any actuarially meaningful results are revealed. They are likely to be one of many factors, in addition to necessary and actuarially justified rate increases, that may ultimately improve the LTC marketplace. However, wellness programs alone should not be considered a “cure” to industry issues.

PREVENTION OF UNFAIR DISCRIMINATION RELATED TO EXTRA-CONTRACTUAL BENEFITS AND COSTS

Unfair discrimination is an important concern to navigate in LTC wellness programs if the same wellness benefits will not be offered to all policyholders. While certain preventative health programs might be offered to all insureds, other programs may be most effective and most utilized if focused on those insureds with a particular condition, age range, or sex. Targeted wellness programs could more effectively reduce claims costs and maximize the health of policyholders. Limiting wellness programs by geographic region, for example, might be necessary to test the effectiveness of programs before scaling up. To do so, insurers would need regulatory support that programs or initiatives focused on similarly situated insureds, for example, those in the “same class,” would not be considered unfair discrimination. Health insurers have a long history of targeting wellness programs aimed at those deemed high risk while avoiding unfair discrimination.

One issue for further study are the characteristics that can rightfully be used to define an acceptable cohort for a wellness initiative. For example, could an insurer only offer certain benefits to insureds without a spouse or other informal caregiver? Would differing methods of contacting policyholders, for example mail vs. email, be considered unfair discrimination? Also, what are the implications if policyholders share the cost of a more expensive wellness
intervention? Similarly, what would the implications be, if, after a pilot program ends, policyholders wish to continue the wellness program by covering the cost themselves?

CONSUMER CONFUSION
Consumer communication and education are vital to precluding confusion. Giving consumers the option to opt-in a program after they fully understand it is one way to ensure consumers are comfortable. Another option is to allow insureds to self-identify their conditions before a wellness initiative begins. An example of self-identification is optional testing for early dementia where early intervention is effective.

Clearly communicating with informal caregivers is also important. Depending on the wellness benefit program and condition of the insured, a caregiver may be the one utilizing the technology and other tools offered by a wellness program. We would suggest consulting caregiving groups, such as the National Alliance for Caregiving, which supports family caregivers, or the Paraprofessional Healthcare Institute, which represents direct care workers, to give stakeholders valuable insight into fostering caregiver engagement in wellness programs.

REBATING
One can make a strong case that the wellness initiatives our industry is currently contemplating do not violate anti-rebating laws. Wellness benefit programs are intended to encourage behavioral changes that improve the insured’s health, thereby reducing the risk the insured will need LTC. Many states allow insurers to provide value-added services and programs for loss mitigation and rate reduction purposes to insureds at no additional charge or a discounted rate under certain conditions. The ACLI maintains a law survey on the subject of rebating that could prove useful to companies with access to the law survey when assessing the different requirements between states. Additionally, as the draft mentions, the NAIC Model Unfair Trade Practices Act explicitly exempts certain wellness benefits.

Another factor to consider is that many, if not most, wellness initiatives would not begin the moment a policy becomes effective. This factor is further evidence that wellness benefits are not rebates.

TAX CONSIDERATIONS
Many wellness and similar initiatives designed to reduce the onset or severity of chronic illness can be undertaken today consistently with federal tax requirements for qualified long-term care insurance, but for others clarifying guidance from the Treasury Department or IRS would be helpful or amendment of tax requirements by Congress may be needed.

As noted, however, certain wellness initiatives are permissible under current tax law. For example, though not considered precedent, PLR 201105026 and PLR 201105027 describe certain wellness benefits as permissible under federal tax law. The IRS Private Letter Rulings both comment, “It would be inconsistent with the stated goal of § 7702B to deny qualification
to a long-term care insurance contract because it provided ancillary mechanisms aimed at minimizing long-term care needs.”

To summarize, we caution the Subgroup to not purport to interpret existing federal tax requirements regarding wellness initiatives, although we think the NAIC and state regulators can perform an important informational role with respect to non-tax aspects of such initiatives in connection with any future efforts to obtain clarifying IRS/Treasury guidance or legislative changes, there may be tax consequences if benefits are provided to an insured who is not chronically ill as defined in 26 U.S.C.A. §7702B(c)(2), that is, outside the federal tax definition of qualified LTC benefits. Federal legislative changes to section 7702B could be required to ensure policyholders can receive wellness benefits without tax consequence.

**REGULATORY ROLE IN APPROVING OR EVALUATING LTC WELLNESS APPROACHES**

Ideally, the effort to incorporate wellness initiatives in LTC results in a process that minimizes or eliminates state-by-state reviews of wellness programs and fosters flexibility for insurers wanting to offer these incentives.

The draft posits the question of whether a company’s commitment towards innovation efforts could be a contingency to receiving a fully actuarially justified rate increase. It may ultimately be just one factor, of many, to consider in a rate decision. And, first, it would be necessary to establish objective criteria to evaluate companies fairly.

The following items should be considered as wellness initiatives are more fully developed:

- Wellness initiatives are designed to improve the health of policyholders and the impact on claims and loss ratios are still unknown. Linking rate increases to wellness offerings will not be appropriate for some time.
- Formal regulator approval of a wellness offering could stifle innovation. Rather than a formal approval process, companies could provide information to regulators on an as needed basis or upon request.
- Because the impact on claims is unknown at this time, there should not be an assumption that wellness programs are available to all or that engagement in the wellness initiative will be high.
- Finally, characterization of LTC insurance in (d)(iii) as being in a “desperate situation” discounts the vibrant hybrid market.

**ACTUARIAL CONSIDERATIONS**

First, as with any other actuarial assumption, actuaries must have a valid justification for the impact of the wellness initiative, especially as it relates to in-force rate increases. As discussed throughout the draft, this will take time to develop.

Second, while a wellness program could be tied to a reduced benefit option, there should not be an expectation that it will be. This determination is best made by the insurer.
DATA PRIVACY
Data privacy is a fundamental and legitimate concern in the development and implementation of wellness benefit programs. Because these programs are an emerging innovation, starting small by allowing insureds to participate at their discretion and/or self-attest to their medical conditions is key.

In this section of the draft, there are multiple questions raised that likely already have adequate regulations in place to address them. (e.g. “Should insurers purchase data regarding their policyholders?” and “Should insurers partner with vendors or service providers to supply specific policyholder data to the wellness company?”) For issues that have already been addressed, we suggest specifying that their inclusion in the draft is to give a comprehensive overview on the topic, alert regulators for oversight focus, or for some other stated purpose.

Along those same lines, the draft would benefit from bifurcation between issues governed by clear regulations vs. those that are not (either because the issue falls within a gray area or no regulation exists). Similarly, if the NAIC has already addressed substantially similar topics, the draft should refer to the NAIC’s work rather than replicate their efforts. (e.g. “When considering big data, are there unacceptable ‘correlations’? “How will insurers recognize relevant correlations vs. irrelevant statistically significant correlations?”)

The ability to collect and analyze data is essential to test pilot programs and eventually implement fully developed wellness initiatives. In data privacy matters that are unsettled, insurers need assurance they can move forward without fear of adverse legal or regulatory action. The ongoing efforts of regulators and industry stakeholders to coordinate and balance the public policies of data privacy, improved health, and lower LTC costs can give that assurance.

As we move forward, guiding principles are vital. ACLI/AHIP are strongly committed to the proper use and protection of consumer data. We encourage clear and concise notice about the collection, use, and disclosure of personal information. We also support the ability for consumers to have appropriate control over their information, including the ability to access and correct inaccuracies, consistent with legitimate business purposes and/or legal requirements to retain such information.

OTHER CONSIDERATIONS
At this time, ACLI/AHIP have no comments on this section of the draft.
CONCLUSION
Thank you for the opportunity to provide these comments. ACLI/AHIP welcome the opportunity to discuss our comments with you soon.

Sincerely,

Jan M. Graeber  
Senior Actuary, ACLI

Susan Coronel  
Executive Director, Product Policy, AHIP

1 The American Council of Life Insurers advocates on behalf of 280 member companies dedicated to providing products and services that promote consumers’ financial and retirement security. Ninety million American families depend on our members for life insurance, annuities, retirement plans, long-term care (LTC) insurance, disability income insurance, reinsurance, dental, vision, and other supplemental benefits. ACLI represents member companies in state, federal and international forums for public policy that supports the industry marketplace and the families that rely on life insurers’ products for peace of mind. ACLI members represent 95 percent of industry assets in the United States.

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September 8, 2021

Commissioner Altman: Chair
Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup
Cc: Eric King

Comments to NAIC Draft- Issued Related to Wellness Benefits In LTCI Contracts

Dear Commissioner Altman:

We appreciate the opportunity to comment on the subgroup’s draft exposure document on issues related to wellness benefits in long-term care insurance policies. We are encouraged that insurers are interested in this issue and that some have already had limited experience with pilot projects. We do think that new ideas and benefits like these need close cooperation between industry and regulators to avoid unintended consequences and to explore and encourage what’s possible. Consumer groups can help industry and regulators understand a wide variety of situations and services that can help policyholders age in place and potentially delay some claims and could perhaps also delay the need for more extensive care or institutional care.

Long-term care imposes a need for care that is not covered as medical care because it deals with disabling conditions that occur with aging, such as breakdowns in functional ability or the onset of dementia. Care needs are supportive in nature and generally require the assistance of another person. The need for institutional care, often delivered in memory care units of assisted living facilities or other institutional settings, is often the result of advancing dementias.

The eventual need for long-term care is personally unpredictable and difficult to plan and prepare for. Federal data shows that 70% of people over the age of 65 will develop severe needs for long-term care services and supports before they die, and 48% will use some paid care over their lifetime. Individuals however cannot accurately predict their own future need for care. For most people this future risk is a frighteningly expensive uncertainty. Insurance to pay for this kind of care has escalated beyond the ability of most middle income Americans to pay for it, and those who have it are challenged to keep it with the rising cost of premiums.

When asked, most people say they intend to remain in their own homes if they need care. However, they have no clear idea if that will be possible, what kind of care they will need, how they will get that care, or more importantly how they will pay for it. Currently, most people with insurance have bought an income stream to pay for care, but their family will have to build out the care system for the impaired family member and bill and distribute any insurance payment. The type and quality of care providers available to them will depend on where they live, their knowledge of long-term care services and supports, and the availability of those services where the impaired person lives.

Early access to home modification and technology can be useful to help people remain in their homes, both before the need for long-term care begins, and later to delay or prevent the need for a greater amount of care or for institutional care. These newer types of services and devices can support
Caregivers and help an impaired person remain in their own home, or delay or prevent further impairment. Services such as fall prevention assessment programs, supportive equipment to prevent falls, electronic monitoring systems, technological alarms and sensors, community services and senior centers that encourage socialization all have the potential to delay, mitigate, or even prevent a later claim for long-term care benefits.

Care coordination is an important component and can help families of an impaired person utilize all the services, equipment, supplies, and benefits that may be available to them through private or public means. Care management and coordination can bring organization and efficiency to finding and utilizing services, constructing and monitoring an individualized system of care. Helping people age in place is an important factor in delaying or keeping people out of more expensive institutional settings.

We are encouraged by the idea of new benefits or services that can support policyholders in their own home, that help them maintain their independence, and that support caregivers who in the majority of families are younger family members often sacrificing their own economic condition to care for an older family member. New technology and devices might help a family caregiver remain at work with the ability to monitor an impaired family member at home. New systems of care such as the Villages movement, paid transportation like Uber and Lyft, and emerging meal delivery systems can all contribute to this expanding discussion of how to help people age in place and how to construct systems that can provide for these new ways of providing care.

We think important issues have been identified in the draft document for industry and regulators. We are however concerned that any new benefits be appropriately described in a contract, and fairly applied and available when needed. We are also concerned about how new enticing benefits are advertised, both by agents and brokers and by companies. As we’ve seen with MA plans, benefits can be portrayed as universally available when in practice those same benefits are limited in application to specific sets of circumstances.

While we understand that some services and benefits are likely to result in increased premium cost and an increase in claims costs, some claims costs might be offset by these newer services by delaying or moderating the need for paid care. Actuarial scrutiny of all these factors and subsequent trends will be an important component of regulatory review. We plan to be an active participant as the subgroup explores these ideas that could become part of pre-claim benefits, or become a common covered benefit in future long-term care insurance contracts.

Sincerely,

Bonnie Burns, Consultant
California Health Advocates
### General Comments on LTC Wellness - Fred lead

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<tr>
<td>1</td>
<td>Bonnie Burns / CA Health Advocates</td>
<td>Encouraged by the idea of new benefits or services that can support policyholders in their own home, help them maintain independence, and support caregivers who in the majority of families are younger family members often sacrificing their own economic condition to care for an older family member.</td>
<td>N</td>
<td>Supports current wording</td>
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<td>2</td>
<td>Bonnie Burns</td>
<td>Early access to home modification and technology can help people remain in their homes (where care is less expensive) before or after a greater need for care begins. Fall prevention assessment or equipment, electronic monitoring, tech alarms/sensore, community services, senior centers encouraging socialization are examples / can delay, mitigate, or prevent later LTC claims.</td>
<td>Y</td>
<td>Added wording on delaying LTC claims</td>
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<td>3</td>
<td>Bonnie Burns</td>
<td>Care coordination helps families utilize all the public &amp; private services, equipment, supplies, &amp; benefits available in an organized &amp; efficient manner, constructing and monitoring an individualized plan.</td>
<td>N</td>
<td>Supports current wording</td>
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<td>4</td>
<td>Bonnie Burns</td>
<td>New technology and devices might help a family caregiver remain at work with the ability to monitor an impaired family member at home.</td>
<td>N</td>
<td>Supports current wording</td>
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<td>5</td>
<td>Bonnie Burns</td>
<td>Important issues have been identified in the draft document for industry and regulators. New benefits be appropriately described in a contract, and fairly applied and available when needed. Concerned about how new enticing benefits are advertised, both by agents and brokers and by companies.</td>
<td>N</td>
<td>Reach out to Bonnie - are these concerns mainly related to additional costs to policyholders?</td>
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<td>6</td>
<td>Assured Allies</td>
<td>A creative and modern approach is needed to solve this societal problem.</td>
<td>N</td>
<td>Supports current wording</td>
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<td>7</td>
<td>Dr. Anitha Rao &amp; physicians specializing in cogn.and neuro. issues</td>
<td>There are ethical and legal consequences to consider in telling someone they are at risk for dementia or have cognitive impairment before a physician does so. Some states require clinicians to report the patient’s medical condition to the DMV or alert banks regarding mental capacity.</td>
<td>See below</td>
<td>Edited wording to mention physician’s role</td>
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<td>8</td>
<td>Dr. Anitha Rao, et al</td>
<td>Recommends re-wording of aspect of cognitive wellness issues related to technological solutions section</td>
<td>Y</td>
<td>Edited wording to mention physician’s role</td>
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<td>9</td>
<td>Dr. Anitha Rao, et al</td>
<td>Recommend that insurance carriers urge their members to see their physician for a cognitive risk evaluation instead of over-reliance on non-fully-tested tech meant to flag cognitive risk</td>
<td>See above</td>
<td>Edited wording to mention physician’s role</td>
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<td>10</td>
<td>Dr. Anitha Rao, et al</td>
<td>Legal risks if the insurer identifies cognitive risk before the policyholder is aware or diagnosed</td>
<td>See above</td>
<td>Edited wording to mention physician’s role</td>
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<td>11</td>
<td>Dr. Anitha Rao, et al</td>
<td>Gap in care may result in a high number of patients incorrectly flagged as having cognitive risk (false positives). Ruling out common conditions that mimic cognitive impairment should be performed thru a proper medical evaluation</td>
<td>See above</td>
<td>Edited wording to mention physician’s role</td>
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<td>12</td>
<td>Dr. Anitha Rao, et al</td>
<td>TPAs and claims processing workflows, using shortcuts, have been found to mislabel a significant number of treatable conditions as irreversible cognitive impairment</td>
<td>See above</td>
<td>Edited wording to mention physician’s role</td>
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<td>13</td>
<td>Dr. Anitha Rao, et al</td>
<td>Recommend that insurers seek advice from an external independent medical advisory board before implementing any nationally approved cognitive wellness programs.</td>
<td>See above</td>
<td>Edited wording to mention physician’s role</td>
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<td>14</td>
<td>ACLI/AHIP</td>
<td>Found the draft to be a balanced and comprehensive outline of issues related to wellness benefit programs in the LTC insurance realm.</td>
<td>N</td>
<td>Supports current wording</td>
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<td>15</td>
<td>ACLI/AHIP</td>
<td>Reinforce the understanding that many wellness initiatives are in their infancy and will require significant development and testing. Insurers should be allowed to explore and develop these initiatives on a voluntary basis without regulatory mandates if they determine such initiatives are viable and appropriate for their businesses and policyholders.</td>
<td>Y</td>
<td>Wording TBD</td>
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<td>16</td>
<td>ACLI/AHIP</td>
<td>Clarity on the ultimate deliverable will be would be helpful</td>
<td>Y</td>
<td>Added an objective paragraph at the beginning of the document</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>ACLI/AHIP</td>
<td>Incorporate hybrid products in the background section</td>
<td>Y</td>
<td>Added wording at the end of the document</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>18</td>
<td>ACLI/AHIP</td>
<td>Emphasize in the background section that the pre-claim timing of wellness benefits are a key aspect</td>
<td>Y</td>
<td>Added wording in the background section</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>ACLI/AHIP</td>
<td>In addition to potentially reducing claim costs, wellness initiatives may extend independence at home, prevent severe impairment, postpone formal care, and benefits family caregivers</td>
<td>Y</td>
<td>Added wording on postponing/delaying care being a potential benefit of wellness</td>
<td></td>
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</tbody>
</table>

Comments on Analysis of Effectiveness - Fred Lead | Edit doc in response? | Where / How Addressed in Framework

**Doc**
<table>
<thead>
<tr>
<th></th>
<th>State</th>
<th>Comment</th>
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<th>Where / How Addressed in Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Michigan</td>
<td>Explore the potential effect of wellness programs offered at independent living/senior facilities and identification of programs that delay or reduce the length of stays in LTC facilities. Michigan supports the use of pilot programs to help identify successful programs.</td>
<td>Y</td>
<td>Added wording re: looking into indep living / senior facility experience</td>
</tr>
<tr>
<td>21</td>
<td>ACLI/AHIP</td>
<td>Costs of wellness initiatives vary, e.g., health education can have low cost</td>
<td>Y</td>
<td>Tweaked wording to mention expenses vary</td>
</tr>
<tr>
<td>22</td>
<td>ACLI/AHIP</td>
<td>Wellness initiatives are applied to hybrid products, too</td>
<td>Y</td>
<td>Added wording in the background section on hybrid products</td>
</tr>
<tr>
<td>23</td>
<td>ACLI/AHIP</td>
<td>Can learn from wellness initiatives in life insurance, health insurance, Medicaid, and Medicare</td>
<td>Y</td>
<td>Added wording re: looking into health &amp; life ins experience</td>
</tr>
<tr>
<td>24</td>
<td>ACLI/AHIP</td>
<td>Clarifying meaning of &quot;wellness&quot; should be included in next steps</td>
<td>Y</td>
<td>Clarify that the initiatives are pre-claim; perhaps mention that they assist regarding the declining independence of the insured</td>
</tr>
<tr>
<td>25</td>
<td>ACLI/AHIP</td>
<td>Development of experience showing effectiveness will be work in progress</td>
<td>Y</td>
<td>Added this wording in a new bullet</td>
</tr>
</tbody>
</table>

Comments on preventing unfair discrimination - Shannen & Tom lead

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<th>State</th>
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<th>Edit doc in response?</th>
<th>Where / How Addressed in Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>Michigan</td>
<td>A determination must be made regarding to whom any pilot or permanent program is offered to ensure no unfair discrimination. Including a wide range of individuals from various geographic, economic, social, age, racial, and ethnic populations is necessary to determine the usefulness of such a program, the credibility of data collected, and whether the program is valuable for all or some.</td>
<td></td>
<td>Added wording to 2(c)(ii)</td>
</tr>
<tr>
<td>27</td>
<td>Michigan</td>
<td>To ensure no unfair discrimination, consideration regarding the availability of internet and smart devices, as well as the technical skills needed to use any devices will be necessary. This includes consideration that aging may impact/change a person's previous tech skills. Also, a person's financial position may change, limiting the ability to purchase current/up-to-date technology devices or equipment.</td>
<td></td>
<td>Added wording to 2(c)(iii)</td>
</tr>
<tr>
<td>28</td>
<td>Michigan</td>
<td>Consideration in selecting pilot participants should also include younger consumers; those who purchase LTC coverage long before their senior years.</td>
<td></td>
<td>Added wording to 2(c)(ii)</td>
</tr>
<tr>
<td></td>
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<td>---</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Bonnie Burns</td>
<td>As seen with MA plans, benefits can be portrayed as universally available when in practice those same benefits are limited in application to specific sets of circumstances.</td>
<td>Added wording to 2(c)(ii)</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>ACLI/AHIP</td>
<td>Addressing preventing unfair discrimination should be a top priority because it is related to upfront design, e.g., when all benefits will not be available to all policyholders</td>
<td>Added wording to 2(c)(ii)</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>ACLI/AHIP</td>
<td>Effectiveness of programs (reducing claim costs / improving health) may increase if targeted to those with particular condition, age range, and gender.</td>
<td>Added wording to 2(d)</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>ACLI/AHIP</td>
<td>Need regulatory help to ensure programs focused on those in &quot;same class&quot; would not be considered unfairly discriminatory - appears to be similar to approved health insurer programs</td>
<td>Added wording to (c)(i)</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>ACLI/AHIP</td>
<td>Characteristics of acceptable cohort? Without spouse?</td>
<td>Added wording to 2(c)(ii)</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>ACLI/AHIP</td>
<td>Differences in contacting policyholders - mail vs. e-mail</td>
<td>Added wording to 2(c)(iii)</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>ACLI/AHIP</td>
<td>Is sharing wellness intervention costs ok, including policyholders taking over the costs after a pilot expires?</td>
<td>Y Added wording to 2(d)</td>
<td></td>
</tr>
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**Comments on preventing consumer confusion - Anna and Emily lead**

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<thead>
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<tbody>
<tr>
<td>36</td>
<td>Michigan</td>
<td>Significant consumer education must be done to ensure understanding of the product, the wellness benefit and any associated technology, and the intent of the wellness benefit. A variety of education methods should be developed and utilized; consumer outreach will be critical.</td>
</tr>
<tr>
<td>37</td>
<td>ACLI/AHIP</td>
<td>Address consumer confusion issues after upfront design issues (anti-discrimination, rebating)</td>
</tr>
<tr>
<td>38</td>
<td>ACLI/AHIP</td>
<td>Opt in, self identify conditions, e.g., early dementia; communicate with informal caregivers; work with caregiver groups such as Paraprofessional Healthcare Institute, so they can engage in wellness efforts</td>
</tr>
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</table>

**Comments on potential rebating issue - Matt and Tom lead**

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</thead>
<tbody>
<tr>
<td>39</td>
<td>Michigan</td>
<td>Must be determined if offering a benefit requiring a device or app violates anti-rebating or uniform trade practices statutes</td>
</tr>
<tr>
<td></td>
<td>Assured Allies</td>
<td>We appreciate the rebating concerns highlighted in the document and believe that our program, which is designed to benefit all policyholders navigates through this complex issue as well.</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
</tr>
<tr>
<td>41</td>
<td>ACLI/AHIP</td>
<td>Addressing any potential rebating issues should be a top priority because it is related to upfront design.</td>
</tr>
<tr>
<td>42</td>
<td>ACLI/AHIP</td>
<td>Strong case that LTC wellness initiatives do not violate anti-rebating laws, including fact that wellness initiatives typically do not begin at moment policy is issued</td>
</tr>
<tr>
<td>43</td>
<td>ACLI/AHIP</td>
<td>Many states allow insurers to provide value-added services and programs for loss mitigation at no or discounted charge</td>
</tr>
</tbody>
</table>

Comments on tax considerations | Edit doc in response? | Where / How Addressed in Framework
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NAIC Proceedings – Fall 2021

Long-Term Care Insurance (EX) Task Force

12/12/21
<table>
<thead>
<tr>
<th></th>
<th>Michigan</th>
<th>Agree that understanding the tax consequences of new benefits will be critical to the success of any pilot or permanent wellness program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>ACLI/AHIP</td>
<td>Many wellness initiatives to reduce onset/severity of chronic illness are consistent with tax-qualified LTC; IRS private letter rulings 201105026 &amp; 201105027 describe certain wellness benefits as permissible under federal tax law - both comment, “It would be inconsistent with the stated goal of § 7702B to deny qualification to a long-term care insurance contract because it provided ancillary mechanisms aimed at minimizing long-term care needs.”</td>
</tr>
<tr>
<td>46</td>
<td>ACLI/AHIP</td>
<td>Some wellness programs would likely require clarifying guidance from Treasury / IRS</td>
</tr>
<tr>
<td>47</td>
<td>ACLI/AHIP</td>
<td>Cautions regulators to not purport to interpret existing federal tax requirements regarding wellness initiatives, although the NAIC and state regulators can perform an important informational role with respect to non-tax aspects of such initiatives in connection with any future efforts to obtain clarifying IRS/Treasury guidance or legislative changes</td>
</tr>
<tr>
<td>48</td>
<td>ACLI/AHIP</td>
<td>There may be tax consequences if benefits are provided to an insured who is not chronically ill as defined in 26 U.S.C.A. §7702B(c)(2), that is, outside the federal tax definition of qualified LTC benefits.</td>
</tr>
<tr>
<td>49</td>
<td>ACLI/AHIP</td>
<td>Federal legislative changes to section 7702B could be required to ensure policyholders can receive wellness benefits without tax consequence.</td>
</tr>
</tbody>
</table>

**Comments on regulatory role in evaluating LTC wellness approaches - Fred lead**

<table>
<thead>
<tr>
<th></th>
<th>Michigan</th>
<th>Uniformity on prior approval of LTC wellness benefits would be helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>51</td>
<td>ACLI/AHIP</td>
<td>Ideally, the final deliverable encourages uniform state approaches for wellness programs and discourages state-by-state reviews that could stymie uniformity.</td>
</tr>
<tr>
<td>52</td>
<td>ACLI/AHIP</td>
<td>Question of contingency to receive full rate increase - could be one factor down the road after experience develops</td>
</tr>
<tr>
<td>53</td>
<td>ACLI/AHIP</td>
<td>Formal regulator approval of a wellness offering could stifle innovation. Rather than a formal approval process, companies could provide information to regulators on an as needed basis or upon request.</td>
</tr>
<tr>
<td></td>
<td>ACLI/AHIP</td>
<td>Because the impact on claims is unknown at this time, there should not be an assumption that wellness programs are available to all or that engagement in the wellness initiative will be high.</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td></td>
<td>Hybrid market is not desperate</td>
<td></td>
</tr>
</tbody>
</table>

**Comments on actuarial considerations - Fred lead**

<table>
<thead>
<tr>
<th></th>
<th>Michigan</th>
<th>Suggest some data could be available from independent living/senior communities related to classes or programs offered that may help improve or stabilize health issues resulting in mitigation of loss or severity of loss.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Michigan</td>
<td>Consideration should be given to both the cost of developing and implementing wellness programs and the value of wellness programs related to premium/rates.</td>
</tr>
<tr>
<td></td>
<td>Michigan</td>
<td>Impacts of various aspects on rate increases should be understood.</td>
</tr>
<tr>
<td></td>
<td>Bonnie Burns</td>
<td>While we understand that some services and benefits are likely to result in increased premium cost and an increase in claims costs, some claims costs might be offset by these newer services by delaying or moderating the need for paid care. Actuarial scrutiny of all these factors and subsequent trends will be an important component of regulatory review.</td>
</tr>
<tr>
<td></td>
<td>ACLI/AHIP</td>
<td>At this time, wellness initiatives should not be tied into rate increases</td>
</tr>
<tr>
<td></td>
<td>ACLI/AHIP</td>
<td>Address actuarial issues after upfront design issues (anti-discrimination, rebating)</td>
</tr>
<tr>
<td></td>
<td>ACLI/AHIP</td>
<td>Must justify impact on rates, but this will take time to develop</td>
</tr>
<tr>
<td></td>
<td>ACLI/AHIP</td>
<td>Should be insurer's choice whether to tie a wellness program to an RBO</td>
</tr>
</tbody>
</table>

**Comments on data privacy - Shannen and Julie lead**

<table>
<thead>
<tr>
<th></th>
<th>Michigan</th>
<th>Recognition of the trend toward use of technology but concern with wellness programs’ reliance on technology and AI. Seniors must be comfortable with the use of and security of their personal data for these programs to succeed.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assured Allies</td>
<td>We appreciate the data concerns expressed by state regulators and believe through positive consumer consent and transparency we can strike the right balance of protection and innovation that will ultimately benefit our policyholders.</td>
</tr>
<tr>
<td></td>
<td>ACLI/AHIP</td>
<td>Fundamental and legitimate concern</td>
</tr>
</tbody>
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**Where / How Addressed in Framework**

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<td></td>
<td>Updated 8a.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agree with comments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agree with comments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ACLI/AHIP</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>67</td>
<td>At early stages of program, allowing insureds to participate at their discretion and/or self-attest to medical conditions is key</td>
<td>Agree with comments</td>
</tr>
<tr>
<td>68</td>
<td>For issues that have already been addressed, suggest specifying that their inclusion in the draft is to give a comprehensive overview on the topic, alert regulators for oversight focus, or for some other stated purpose.</td>
<td>Should we consider adding in a &quot;process&quot; section that talks about how insurers can bring back findings and issues, so we can update the document?</td>
</tr>
<tr>
<td>69</td>
<td>The draft would benefit from bifurcation between issues governed by clear regulations vs. those that are not (either because the issue falls within a gray area or no regulation exists). Also refer to NAIC's other work rather than replicate.</td>
<td>Updated section 8b</td>
</tr>
<tr>
<td>70</td>
<td>In data privacy matters that are unsettled, insurers need assurance they can move forward without fear of adverse legal or regulatory action. The ongoing efforts of regulators and industry stakeholders to coordinate and balance the public policies of data privacy, improved health, and lower LTC costs can give that assurance.</td>
<td>Added a comment to the &quot;process&quot; section</td>
</tr>
<tr>
<td>71</td>
<td>Guiding principles are vital.</td>
<td>Agree with comments</td>
</tr>
<tr>
<td>72</td>
<td>Encourage clear and concise notice about the collection, use, and disclosure of personal information.</td>
<td>Updated 8c.2</td>
</tr>
<tr>
<td>73</td>
<td>Support the ability for consumers to have appropriate control over their information, including the ability to access and correct inaccuracies, consistent with legitimate business purposes and/or legal requirements to retain such information.</td>
<td>Added section to 8c.</td>
</tr>
</tbody>
</table>

**Misc comments - Fred lead**

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<tbody>
<tr>
<td>74</td>
<td>Other comment</td>
<td>Key is to offer the benefits (home modification, caregiver training, care management) when there's an initial need, not when it's too late</td>
</tr>
<tr>
<td>75</td>
<td>Other comment</td>
<td>Pre-claim (pre-2 ADL) access to caregiver training and home modifications can delay the need for formal care and may provide fairly reliable claim cost savings.</td>
</tr>
<tr>
<td>76</td>
<td>Other comment</td>
<td>If the initiative is age- or condition-based, it should be offered consistently.</td>
</tr>
<tr>
<td>77</td>
<td>Other comment</td>
<td>Health plans already offer caregiver training, home modifications, or wellness programs without tax consequences – what’s different about LTC?</td>
</tr>
<tr>
<td>78</td>
<td>Other comment</td>
<td>If the initiative is one of early support, broad communication and outreach is key.</td>
</tr>
</tbody>
</table>
Vermont Comments

LTC (EX) Multi-state Actuarial Rate Review Framework

On p. 14, in appendix D, Principles for Reduced Benefit Options (RBO) Associated with LTCI Rate Increases, it reads:

*Exploration of innovation, particularly where an outcome of improved health and lower claim costs are possible:

- Regulators and interested parties should continue to study the idea of offerings being made by insurers including potentially being tied to rate increases, e.g., providing hand railings for fall prevention in high-risk homes, and identifying the pros and cons of such an approach.

Rate increases for long-term care policies typically add thousands of dollars to the annual premium paid for the policy. These types of rate increases are significant and may be a hardship to elderly consumers on fixed incomes. Consumers may not be able to consider their own best interest in the face of a significant change to annual expenses. Any offer associated with a rate action, and which involves the collection of data through artificial intelligence should clearly explain how information will be collected and used to avoid profiting and potential discriminator actions on behalf of the insurer. Also, any offer to an insured tied to rate increases should be supported with data showing why and how the rate impact is directly correlated to the offer.

Consider this example:

- A consumer on a fixed income receives notice that long-term care premiums will increase by $3,000 annually.
- That consumer now faces $3,000 of new expenses.
- If the consumer checks a box, they will receive a smart device that will collect data from their home and computer.
- If they select this option, they will not have to pay any rate increase.

The consumer may not be in the position to act in their own best interest and may not be able to consider these options carefully for several reasons. First, the consumer may not fully understand the technology proposed, the data to be collected, and the privacy implications. Second, the consumer may not realize that there may be several other options to modify their policy and reduce premiums besides accepting the new technology option. The technology option may seem like the only choice available.

The MSA subgroup should consider keeping the wellness program offers separate from implementation of large rate increases (greater than 10%). Then, there would be no question that the consumer was coerced, rather than persuaded, to take part in any wellness program.
The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Sept. 27, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Emily Smith (CA); Frank Pyle (DE); Doug Ommen (IA); Eric Anderson (IL); Stewart Guerin (LA); Karen Dennis (MI); Fred Andersen (MN); Carter Lawrence (TN); Barbara Snyder (TX); Tomasz Serbinowski (UT); Bob Grissom (VA); Anna Van Fleet (VT); Melanie Anderson (WA); and Joylynn Fix (WV).

1. Discussed Comments Received on a Draft RBO Consumer Notices Checklist.

Ms. Van Fleet presented a version of a draft Reduced Benefit Options (RBO) Consumer Notices Checklist (Checklist) (Attachment Eleven-A) that incorporates comments received on the draft, with notes on the proposed treatment of each comment.

Ms. Van Fleet said discussion at the next meeting will focus on questions 6, 7, 25, and 49. Commissioner Altman said the Subgroup will schedule another meeting to continue discussion of the comments on the Checklist using the version that reflects revisions made today.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.
Comments as of 7-21-21 Noted

Checklist for Premium Increase Communications

AUTHORITY

The Long-Term Care Insurance Reduced Benefit Options (RBO) (EX) Subgroup is composed of regulators from 17 state insurance departments. It has been tasked with assisting the Long-Term Care Insurance (EX) Task Force in completing the following charge:

*Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.*

The Long-Term Care Insurance (EX) Task Force adopted the Long-Term Care Insurance RBO Communication Principles. The Long-Term Care Insurance RBO EX Subgroup has been charged with developing a complementary checklist that can be leveraged by state regulators and Long-Term Care Insurance insurers.

INTRODUCTION

This checklist is intended to establish a consistent approach to drafting and reviewing Long-Term Care Insurance RBO policyholder communications. The checklist can be used as guidance and does not carry the weight of law or impose any legal liability.

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.

Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion, complaints, improve the quality of the communication, and ensure the information presented:

- Reads in a clear, logical, not overly complex manner.
- Identifies if the options are presented fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

*Suggested Edits from BB & BC:

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.
Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion, and complaints, improve the quality of the consumer communications, and to ensure the information presented. The checklist seeks to ensure that consumer communications:

- Reads in a clear, logical, not overly complex manner.
- Identifies if the options are presented fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

[The LTC Task Force? The RBO\[A7\][A8][A9][A10] Subgroup?] RECOMMENDS that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and adopt use the checklist when reviewing filed Long-Term Care Insurance RBO Communications.

CALLS ON all insurance companies to consider the checklist when developing reduced benefit option policyholder communications in the event of a rate increase.
# Checklist for Premium Increase Communications

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tbody>
<tr>
<td>1.</td>
<td>Does the filing contain all <strong>required</strong> materials including: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (screenshots may be requested if communication refers policyholder to website for more information)?</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Has actuarial review of the rate increase been completed?</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Will <strong>notice of</strong> the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)?</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Have all <strong>new innovative</strong> RBO options presented in the communication been mentioned prominently as part of <strong>clearly explained</strong> in the filing? Have they been vetted by policy and actuarial staff?</td>
<td></td>
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</table>

**Page Reference and Filing Notes**

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NAIC Proceedings – Fall 2021

Long-Term Care Insurance (EX) Task Force

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<th></th>
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<th>5. Are there sample policyholder communications with a statement of variability? Do reviewers understand any variable information that appears in the letter?</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>6. Are there insurer rules and training for customer service interactions regarding RBOs?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7. Were state-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification 45-60 days before effective date. PA posts filed rate increase details on their website.</td>
</tr>
</tbody>
</table>
| Yes | No | N/A | **READABILITY AND ACCESSIBILITY**

<p>|   |   |   | 8. Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)? Is the primary message of the communication presented first and clearly worded? |
|   |   |   | 9. Are all technical insurance technical terms clearly explained in the communication? |
|   |   |   | 10. Are all technical terms used consistently throughout the communication? |
|   |   |   | 11. Is the communication in an easily readable font? For example: Is the type in at least 11-point type? |
|   |   |   | 12. Does the communication use headings to help the reader find information easily? |</p>
<table>
<thead>
<tr>
<th>13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>14. Are tables, charts, and other graphics, easy to read and understand?</td>
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<tr>
<td>15. Are the grade level and reading ease scores appropriate according to state readability standards? 8th grade or lower? Flesch reading ease score 60 or higher?</td>
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<td>16. Are the side-by-side illustrations of options compared with current benefits clear and not misleading?</td>
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<td>17. If FAQs are included, are they succinct and easy to understand?</td>
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<td>18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language?</td>
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<tr>
<td>19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language?</td>
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<tr>
<td>20. Does the communication answer what is happening?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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</table>

**Page Reference and Filing Notes**
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<tr>
<th></th>
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<th>21. Does the communication answer why the consumer is receiving a rate increase?</th>
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<tr>
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<td>22. Does the communication reflect negatively on the Department of Insurance?</td>
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<td>23. Does the communication indicate when the rate increase will be effective?</td>
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<td>24. Does the communication clearly indicate the policyholder has options?</td>
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<td>25. Does the communication clearly indicate how the consumer may elect an option? Does the election documentation allow the consumer to clearly indicate his or her choice? For example, when check boxes are used to indicate a choice there should be some way to verify that choice on the form returned to the insurer to avoid mistakes in the consumer's choice?</td>
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<td>26. Does the communication clearly explain that the consumer is not being singled out for the increase?</td>
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<td>27. Does the communication remind consumers to reflect on why they may have purchased the policy?</td>
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**COMMUNICATION TOUCH AND TONE**

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<tr>
<th>Yes</th>
<th>No</th>
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<th>Page Reference and Filing Notes</th>
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<tr>
<td>Question</td>
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<td>28. Does the communication express empathy and understanding of the</td>
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<td>difficulty of evaluating choices?</td>
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<td>29. Is there a statement telling consumers how to contact the insurer for</td>
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<td>more information or help understanding their options?</td>
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<td>30. Are the options represented fairly?</td>
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<td>31. Are the words used that could influence a policyholder's decision,</td>
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<td>such as must or avoid?</td>
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<td>Options are not presented fairly if one option is emphasized, mentioned multiple times or bolded when the others options are not.</td>
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<td>32. Is the insurer's consumer service number easy to find? Is it clear what hours and days consumer service is open?</td>
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<td>33. Are website links and phone numbers accurate and functional?</td>
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<td>34. Does the Insurer encourage consumers to consult with multiple</td>
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<td>sources to include any of the following: Financial planner/advisor,</td>
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<td>producer, state SHIP program (where applicable)</td>
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<td>UNDERSTANDING OPTIONS - PRESENTATION</td>
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<td>35. Does the Insurer encourage consumers to consult the Department of Insurance? Does it specify the Department can only give general information?</td>
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<td>36. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss of Partnership status?</td>
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<td>37. Does the communication have a clearly worded, descriptive title or subject line? For example: Your Long-Term Care Premiums Are Increasing.</td>
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<td>38. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?</td>
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<td>39. Are the number of options presented reasonable but no more than 5-7? If there are less than 3, but more than 5-7, engage with insurer to understand what is being presented.</td>
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<td>40. Is the Right to Reduce Coverage at Any Time of a policyholder's choosing clear? If not, ask clear?</td>
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<td>41. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc., are they supplemental education?</td>
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<th>materials or are they required sources to decide on an option?</th>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>N/A</strong></td>
<td><strong>UNDERSTANDING OPTIONS – PAST RATE ACTIONS</strong></td>
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<td>42. Does the communication include a statement that premiums may increase in the future? Is it clear that any future increase will include RBOs? Is the plan for filing future rate increases disclosed and clear? Is a date shown when an insurer plans to file within a known time period, or when an insurer has already submitted a rate filing?</td>
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<td>43. Does the communication include a 10-year nationwide rate increase history for this and similar forms? (if not in the model for policy increases, okay to remove)</td>
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<td>44. Does the communication disclose the policy is guaranteed renewable and clearly explain guaranteed renewable?</td>
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<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>N/A</strong></td>
<td><strong>UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT</strong></td>
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<td>45. Does the communication indicate what the reader must do and provide a a and the deadline to do it?</td>
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<td>46. For If options that are only available during the decision window, is that limitation clear to consumers?</td>
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| | | | 47. Does the communication answer what happens if the policyholder does not send payment? For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable? For example, if
<table>
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<tr>
<th>UNDERSTANDING OPTIONS – CURRENT BENEFITS</th>
<th>UNDERSTANDING OPTIONS – PERSONAL DECISION</th>
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<tbody>
<tr>
<td>48. Does the communication include all relevant the following applicable information? Current policy benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) in list form?</td>
<td>50. Can the insurer confirm policyholders will see only those options that are available to them and not be shown options that are not available to them? Are the options presented available to the policyholder?</td>
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<tr>
<td>Yes</td>
<td>Yes</td>
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<td>No</td>
<td>No</td>
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<td>N/A</td>
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<tr>
<td>49. If current benefits have an inflation option, does the communication illustrate the lifetime maximum benefit in dollars five and fifteen years into the future?</td>
<td>51. Does the communication include descriptions of the consumer’s options (including changes in the daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?</td>
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<tr>
<td>Yes</td>
<td>Yes</td>
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<td>N/A</td>
<td>N/A</td>
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<th>UNDERSTANDING OPTIONS – PERSONAL DECISION</th>
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</thead>
<tbody>
<tr>
<td>52. Does the communication prompt the policyholder to consider their personal situation, such as current age, health, etc.?</td>
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<tr>
<td>Yes</td>
<td>Are the options presented available to the policyholder?</td>
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<td>No</td>
<td>N/A</td>
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<tr>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need</td>
<td>Page Reference and Filing Notes</td>
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<td>for and cost of for institutionalized care?</td>
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</tbody>
</table>

53. **Does the communication provide an unbiased resource(s) for policyholders to research the cost of care?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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</thead>
</table>

54. **Do options clearly indicate value for consumers?**

- Contingent Nonforfeiture (CNF) and other limited options clearly describe the reduction in available LTC benefits? value (benefit period)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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</thead>
</table>

55. **Is there a statement telling consumers how to contact the insurer for more information, to request the full list of options, or help understand their options?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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</table>

56. **Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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</table>

57. **Do the options reflect the impact of removing or reducing the inflation option in terms of on the growth or reduction if the option is to remove or reduce inflation of future benefits?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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58. **If dropping inflation protection results in the loss of accumulated benefit amount, is that disclosed?**

<table>
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<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tbody>
<tr>
<td></td>
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<td>59. For phased-in increases: Is there a table with all phase-in dates and premium amounts if no RBO is selected? Does the communication clearly state if RBO are limited to the first rate increase or will be available during each phase of the rate increase?</td>
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<td>60. For phased-in increases, are there communications sent 45-60 days before each phase of the increase?</td>
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<td>61. Does the communication disclose that not all reduction options are of equal in value?</td>
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</tbody>
</table>

Attachment Eleven-A
Long-Term Care Insurance (EX) Task Force
12/12/21

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NAIC Proceedings – Fall 2021

4-373
Attachment Eleven-A
Long-Term Care Insurance (EX) Task Force
12/12/21
The Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup of the Long-Term Care Insurance (EX) Task Force met Aug. 23, 2021. The following Subgroup members participated: Jessica K. Altman, Chair, and Shannen Logue (PA); Perry Kupferman (CA); Susan Jennette (DE); Andria Seip (IA); Dana Popish Severinghaus (IL); Stewart Guerin (LA); Karen Dennis (MI); Rhonda Ahrens (NE); Larry D. Deiter (SD); Brian Hoffmeister (TN); Tomasz Serbinowski (UT); Bob Grissom (VA); Anna Van Fleet (VT); Melanie Anderson (WA); and Joylynn Fix (WV).

1. **Discussed Comments Received on a Draft RBO Consumer Notices Checklist.**

Ms. Van Fleet presented a version of a draft Reduced Benefit Options (RBO) Consumer Notices Checklist (Checklist) (Attachment Twelve-A) that incorporates comments received on the draft, with notes on the proposed treatment of each comment.

Commissioner Altman said the Subgroup will schedule another meeting to finish discussion of comments on Checklist questions 6, 7, 25, and 49.

Having no further business, the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup adjourned.
Checklist for Premium Increase Communications

AUTHORITY

The Long-Term Care Insurance Reduced Benefit Options (RBO) (EX) Subgroup is composed of regulators from 17 state insurance departments. It has been tasked with assisting the Long-Term Care Insurance (EX) Task Force in completing the following charge:

Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCI) contract benefits where policies are no longer affordable due to rate increases.

The Long-Term Care Insurance (EX) Task Force adopted the Long-Term Care Insurance RBO Communication Principles. The Long-Term Care Insurance RBO EX Subgroup has been charged with developing a complementary checklist that can be leveraged by state regulators and Long-Term Care Insurance insurers.

INTRODUCTION

This checklist is intended to establish a consistent approach to drafting and reviewing Long-Term Care Insurance RBO policyholder communications. The checklist can be used as guidance and does not carry the weight of law or impose any legal liability.

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.

Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion, and complaints, improve the quality of the communication, and ensure the information presented:

- Reads in a clear, logical, not overly complex manner.
- Identifies if the options are presented fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

Suggested Edits from BB & BC:

State regulators may consider the checklist excessive, deficient, or not focused on issues specific to consumer experience in a particular state. State regulators are encouraged to modify the checklist to suit the needs of the Department.
Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion, and complaints, improve the quality of the consumer communications, and to ensure the information presented: The checklist seeks to ensure that consumer communications:

- Reads in a clear, logical, not overly complex manner.
- Identifies if the options are presented fairly and without subtle coercion.
- Includes appropriate referrals to external resources, definitions, disclosures, and visualization tools.

[The LTC Task Force? The RBO Subgroup?] RECOMMENDS that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and adopt use the checklist when reviewing filed Long-Term Care Insurance RBO Communications.

CALLS ON all insurance companies to consider the checklist when developing reduced benefit option policyholder communications in the event of a rate increase.
Checklist for Premium Increase Communications

<table>
<thead>
<tr>
<th>Insurer name:</th>
<th>Date of filing:</th>
<th>Product form:</th>
<th>Tracking number(s) SERFF rate filing:</th>
<th>Tracking number(s) SERFF form filing:</th>
</tr>
</thead>
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<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th><strong>SERFF FILING</strong></th>
<th><strong>Page Reference and Filing Notes</strong></th>
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<tbody>
<tr>
<td></td>
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<td>1. Does the filing contain all required materials to including: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (screenshots may be requested expected if communication refers policyholder to website for more information) [A13][A14]? [A15][A16]</td>
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<td>2. Has actuarial review of the rate increase been completed?</td>
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<td>3. Will notice of the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)? [A19][A20][A21][A22]</td>
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<td>4. Have all new innovative [A23][A24] RBO options presented in the communication been mentioned prominently as part of clearly explained in [A25][A26] the filing? Have they been vetted by policy and actuarial staff? [A27][A28][A29]</td>
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<td>Yes</td>
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<td><strong>5. Are there sample policyholder communications with a statement of variability?</strong></td>
<td>Do reviewers understand any variable information that appears in the letter communication?</td>
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<td><strong>6. Are there insurer rules and training for customer service interactions regarding RBOs?</strong></td>
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<td><strong>7. Were state-specific pre-rate increase filing notification procedures followed?</strong> For example: VT has insurers notify consumers of rate increases when filed in addition to notification 45-60Y days before effective date. PA posts filed rate increase details on their website.</td>
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<td><strong>10. Are all technical terms used consistently throughout the communication?</strong></td>
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**READABILITY AND ACCESSIBILITY**
13. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?

14. Are tables, charts, and other graphics easy to read and understand? (See question 18 for reference).

15. Are the grade level and reading ease scores appropriate according to state readability standards? - D (8th grade) or lower; Flesch reading ease score [60] or higher?

16. Are there side-by-side illustrations of options compared with current benefits? Are reduced benefit options clear and not misleading?

17. If FAQs are included, are they succinct and easy to understand?

18. Does the insurer provide appropriate accommodations for policyholders with disabilities or for policyholders for whom English is not a first language?

   For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or macular degeneration, low vision, deafness and hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity and combinations of these.

19. Does the insurer provide access to translation services as needed for policyholders for whom English is not a first language?

   Yes No N/A IDENTIFICATION Page Reference and Filing Notes

20. Does the communication answer what is happening?
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<th>21. Does the communication answer why the consumer is receiving a rate increase?</th>
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<td>22. Does the communication reflect negatively on the Department of Insurance?</td>
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<td>23. Does the communication indicate when the rate increase will be effective?</td>
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<td>24. Does the communication clearly indicate the policyholder has options?</td>
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<td>25. Does the communication clearly indicate how the consumer may elect an option? Does the election documentation allow the consumer to clearly indicate his or her choice? For example, when check boxes are used to indicate a choice there may be some way to verify that choice on the form returned to the insurer to avoid mistakes.</td>
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<td>26. Does the communication clearly explain that the consumer is not being singled out for the increase?</td>
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<td>27. Does the communication remind consumers to reflect on why they may have purchased the original reason they bought the policy?</td>
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**Communication Touch and Tone**

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<th>Yes</th>
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6

NAIC Proceedings – Fall 2021

Long-Term Care Insurance (EX) Task Force

12/12/21

Attachment Twelve-A
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<th>CONSULTATION AND CONTACT INFORMATION</th>
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<td>28. Does the communication express empathy and understanding of the difficulty of evaluating choices?</td>
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<td>29. Is there a statement telling consumers how to contact the insurer for more information or help understanding their options?</td>
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<td>30. Are the options represented fairly? Options are not presented fairly. If one option is emphasized, mentioned multiple times or bolded when the others options are not.</td>
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<td>31. Are the words used that could influence a policyholder’s decision, such as must or avoid? For instance, consider demonstrating immediacy by using the word “now,” instead of and avoiding words like “must.” Consider mitigation options, “offset premium impact,” or “manage an increase” instead of “avoid an increase.”</td>
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<td>32. Is the insurer’s consumer service number easy to find? Is it clear what hours and days consumer service is open? Regulators may consider testing the phone number to ensure it connects easily to live company representatives without long wait times rather than a phone tree.</td>
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<td>33. Are website links and phone numbers accurate and functional?</td>
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|     |    |     | 34. Does the Insurer encourage consumers to consult with multiple sources to include any of the following: Financial planner/advisor, producer, state SHIP program (where applicable) with the state-specific name of the program, or
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<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>UNDERSTANDING OPTIONS - PRESENTATION</th>
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<td>35. Does the Insurer encourage consumers to consult the Department of Insurance? Does it specify the Department [A138][A139][A140]—can only give general information? [A141][A142][A143][A144]</td>
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<td>36. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss of [A145][A146] Partnership status? [A147][A148]</td>
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<td>37. Does the communication have a clearly worded, descriptive title or subject line? For example: Your Long-Term Care Premiums Are Increasing.</td>
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<td>38. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?</td>
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<td>39. Are the number of options presented reasonable [A149][A150][A151][A152][A153][A154] but no more than 5-7 options [A155][A156][A157]?</td>
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<td>41. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to decide on an option?</td>
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<td>Yes</td>
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<td>UNDERSTANDING OPTIONS – PAST RATE ACTIONS</td>
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<td>42. Does the communication include a statement that premiums may increase in the future? Is it clear that any future increase will include RBOs? Is a date shown when an insurer plans to file within a known time period, or when an insurer has already submitted a rate filing? [A168][A169]</td>
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<td>43. Does the communication include a 10-year nationwide rate increase history for this and similar forms? [A170][A171][A172][A173][A174][A175]</td>
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<td>44. Does the communication disclose the policy is guaranteed renewable and clearly explain guaranteed renewable? [A176][A177][A178][A179]</td>
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<th>UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT</th>
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<td>45. Does the communication indicate what the reader must do and the deadline to do it? [A180][A181]</td>
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<td>46. For options that are only available during the decision window, is the limitation clear to consumers? [A182][A183]</td>
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<td>47. Does the communication answer what happens if the policyholder does not send payment? For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable? For example, if no payment is received within 120 days, does the communication explain that it advise Contingent Non-Forfeiture will apply and what that means? [A184][A185][A186][A187]</td>
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<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>UNDERSTANDING OPTIONS – CURRENT BENEFITS</td>
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<td>48. Does the communication [A188][A189][A190] include all the following information? Current policy [A191][A192] benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status) in list form?</td>
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<td>49. If current benefits [A193][A194][A195] have an inflation option, does the communication [A196][A197] include the lifetime maximum benefit in dollars illustrated both five and fifteen years into the future? [A200][A201]</td>
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<tr>
<th>Yes</th>
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<th>UNDERSTANDING OPTIONS – PERSONAL DECISION</th>
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<td>☐</td>
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<td>50. Can the insurer confirm policyholders will see only those options that are available to them (and not be shown sent options that are not available to them?) Are the options presented available to the policyholder?</td>
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<td>51. Does the communication [A204][A207] contain descriptions of the consumer’s options (including changes in the daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)? [A208][A211][A212][A213]</td>
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<td>52. Does the communication [A214][A215] prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for institutionalized care?</td>
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<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>53. Does the communication provide an unbiased resource(s) for policyholders to research the cost of care?</td>
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<td><strong>UNDERSTANDING OPTIONS – VALUE OF OPTIONS</strong></td>
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<td>54. Do options clearly indicate value for consumers? Does Contingent Nonforfeiture (CNF) and other limited options clearly describe the reduction in available LTC benefits?</td>
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<td><strong>UNDERSTANDING OPTIONS – IMPACT OF DECISION</strong></td>
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<td>56. Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?</td>
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<td>57. Do the options reflect the impact of removing or reducing the inflation option in terms of the growth or reduction if the option is to remove or reduce inflation of future benefits?</td>
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<td>58. If dropping inflation protection results in the loss of accumulated benefit amount, is that disclosed?</td>
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<td>59. For phased-in increases: Is there a table with all phase-in dates and premium amounts if no RBO is selected? Does the communication clearly state if RBO are limited to the first rate increase or will be available during each phase of the rate increase?</td>
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<td>60. For phased-in increases, are there communications sent 45-60 days before each phase of the increase?</td>
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<td>61. Does the communication disclose that not all reduction options are of equal value?</td>
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Issues related to LTC wellness benefits

Adopted by LTCI Reduced Benefit Options (EX) Subgroup - 12/07/2021

Objective:
The objective of this paper is to increase clarity to regulators, insurance companies, and interested parties regarding issues related to innovative long-term care wellness programs.

Background:
Stand-alone long-term care insurance is a unique industry, in that higher-than-expected claims’ costs have resulted in substantial rate increases for consumers and financial losses and in some cases solvency concerns for insurance companies.

Firms are developing technological and other approaches that could be used by insurance companies to potentially prevent, delay, or lower the severity of LTC claims and improve health outcomes in a space called “LTC wellness”. Examples of these early, pre-insurance-claim interventions include:

- Fall prevention programs;
- Home modification consultations, analysis, and implementation to facilitate aging in place;
- Caregiver support programs for both formal and informal caregivers;
- Next generation care coordination services;
- Improvements in cognitive impairment prevention and early diagnosis, potentially involving technology supplemented by a physician’s cognitive risk evaluation.

In light of systemic, LTC-related financial challenges, insurance companies, insurance regulators, and tech firms are interested in working together to explore some of these claim cost-reducing innovations. Here are some potential barriers to increased adoption of these new approaches and how those barriers could potentially be addressed, with details provided below the list:

1. Analysis of effectiveness
2. Unfair discrimination
3. Consumer confusion
4. Rebating
5. Tax considerations
6. Regulatory role in approving or evaluating LTC wellness approaches
7. Actuarial considerations
8. Data privacy
9. Other considerations
1. Analysis of effectiveness
   a. Issue: In light of the lag time between policyholder age during LTC wellness efforts and policyholder age when claim incidence becomes more common, what issues arise from insurers’ lack of knowledge of effectiveness of LTC wellness programs in reducing claim costs, and how can those issues be addressed?
      i. The cost of innovation efforts, with no guarantee of any returns, may dissuade some insurance companies from pursuing these programs.
         1. Expenses vary - in many cases are upfront and significant.
         2. The financial impact on claims cost is typically unknown and down the road.
      ii. Designing pilot programs is difficult because there is such a variety of programs available, and each block of LTC insurance policies has unique characteristics that might influence the effectiveness of a given program.
      iii. Some companies are concerned about regulatory reaction to these changes.
   b. Current observations
      i. Industry representatives described some current or likely upcoming LTC wellness efforts at the May 4, 2021 NAIC Reduced Benefit Option Subgroup meeting. A theme was that there is great supply and demand for LTC wellness innovation efforts.
      ii. Some insurance companies are exploring or implementing pilot programs. Very early signs on the effectiveness of interventions on impact on policyholder health and claim costs are promising, but data development is slow, and it is difficult to implement control trials.
         1. Insurance companies are eager for data and for ways to effectively share data within the legal and regulatory framework so that the industry can effectively respond to positive policyholder experiences and discontinue any programs that fail to make an impact.
      iii. Because there is little competition in the stand-alone LTC insurance market, due to the financial losses accumulated and many insurance companies exiting the actively selling market, sharing of ideas between companies on management of active policies may be possible, although care should be taken regarding anti-trust issues.
      iv. Effectiveness may increase or decrease if targeting certain policyholders.
      v. Development of experience showing effectiveness will be a work in progress.
   c. Addressing of Issues
      i. Lack of data: With most LTC wellness programs being under-developed or being implemented recently, data is lacking on the extent to which resulting claim cost decreases offset the costs of the programs.
      ii. How to measure health impact: Whether an LTC wellness program effectively reduces claim costs or not, will there be approaches established to measure health benefits to policyholders?
      iii. Data sharing: Facilitating the sharing of data, between vendors and insurance companies, and perhaps involving public programs such as Medicaid, is a key element of analyzing effectiveness.
d. Next steps
   i. Regulators engage with insurance companies to learn of recent developments.
   ii. Research public programs’ data on effectiveness of LTC wellness programs to see if
       Medicare Advantage, Med Supp, or Medicaid / PACE data is available, relevant, and used.
       Also, look into potential independent living / senior facility wellness experience as well as
       health and life insurance wellness experience.
   iii. Determine an approach to monitor success of programs. For example, if 3 to 4 companies
       are applying 3 to 4 pilot programs and finding success, it would be good news regarding
       broader, future efforts.
       1. Facilitate the sharing of general results (i.e., not individual policyholder data)
          among those insurance companies in a way that is within the legal and regulatory
          boundaries.
   iv. Regulators ensure capital supporting LTC liabilities is adequate under a range of scenarios,
       including one where claims costs continue to increase.

2. Prevention of unfair discrimination related to extra-contractual benefits and costs
   a. Issue: how does an insurer offer a wellness initiative that is not unfairly discriminatory to discrete
      populations within the broader group of policyholders?
   b. Current observations
      i. There may be state anti-discrimination and bias-related legal issues to address if certain
         policyholders are targeted, including through Big Data, to receive extra benefits.
         1. For instance, if older policyholders have less of an online footprint than younger
            policyholders, how would this impact the accuracy of the targeting of LTC
            wellness benefits or otherwise introduce bias?
         2. [Birny Birnbaum May 4 comment]: If wellness or other efforts to address specific
            conditions are based on age or the health of the policyholder, this seems like
            normal value-added products and services for loss prevention and not an
            example of unfair discrimination.
            a. Issues to address are likely related to creating a clear framework for
               compliance related to the use of data analytics and artificial intelligence.
   c. Addressing of issues
      i. Equality: How policyholders are offered wellness initiatives could be unfairly
         discriminatory.
         1. Policyholders of “the same class and of essentially the same hazard” must be
         2. How may an insurer “classify” policyholders post underwriting? Regulators may
            need to provide guidance on how to classify policyholders.
            a. What is fair? The insurers will need to provide justification.
            i. For example, under the Model Law the availability of the value-
               added product or service must be based on documented
               objective criteria and offered in a manner that is not unfairly
               discriminatory.
b. May classification be made by jurisdiction? Does that impact the LTC Multi-State Actuarial Rate Review (MSA) program’s overarching goals?
   c. May classification be made by product form?

ii. **Selection:** How policyholders are selected for wellness initiatives could be unfairly discriminatory.
   1. Wellness initiatives may be costly to the insurer. How can an insurer test it to validate the benefits before rolling it out more broadly?
      a. Under the Model Act, the insurer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no more than one year.
      b. Initial selection of participants may be the most important for antidiscrimination. That selection for pilots should consider including, but not limited to, a wide range of individuals from various geographic, economic, social, marital, age, racial, and ethnic populations to ensure meaningful data is collected, as appropriate to the wellness initiative.
   2. Would a random selection of policyholders be unfair?
   3. Should policyholders be given the option to participate in a wellness initiative?
      a. Must all policyholders be given the option to participate?
   4. How much time/data is needed to prove the initiative is valuable?
   5. Prior to offering a wellness program, an insurer should have a logical hypothesis of what benefits could be derived from the program.
      a. Even if benefits are available to all those who utilize, the initiatives may be limited in application depending on a policyholder’s specific circumstances.

iii. **Accessibility:** How a wellness initiative operates could be unfairly discriminatory.
   1. Does it limit who can participate based on the medium and cost of the equipment or technology? For example:
      a. Does it require access to a computer or internet for online participation?
      b. Does it require access to a smart phone, texting minutes, etc., to use an app?
      c. Does it require access to roads, pools, sidewalks?
      d. Does it require technical skills to use software or hardware?
      e. Will insurers utilize different communication methods, such as phone, text, e-mail, or mail?
   2. Does any such limitation require alternatives for those unable to participate in the initiative?

iv. **Uniformity:** If guidance is issued on wellness initiatives, how would states adopt the guidance, especially if states have different standards for allowing wellness programs in LTC insurance?
   1. Have all states adopted the Model Law? If not, what have hurdles been for states that have not adopted the model? Will states adopt updates to the Model Law?
   2. Standards for unfair discrimination, including in the specific context of wellness initiatives, may vary by state requiring insurers and regulators to be aware of the specific requirements of the jurisdiction in question.
a. For example, Alaska permits rewards under wellness programs but requires that the reward be available for “all similarly situated individuals.” See AK Stat § 21.36.110.

3. If some states allowed wellness initiatives and not others, would this conflict with other initiatives, such as the MSA?

d. Dependencies
   i. Unfair discrimination guidance needs to consider other wellness initiative issues that include:
      1. Analyzing Effectiveness
      2. Actuarial Impacts
      3. Rebate Standards and Limitations
         a. What if an insurer offers the service at a cost (full or portion) for the policyholder(s) after the pilot?
      4. Regulatory Evaluation

3. Consumer confusion
   a. Issue: potential consumer confusion concerning LTC wellness programs will be highly variable dependent upon factors such as the nature of the program, the consumers involved, and the complexity of regulatory issues.

   b. Addressing of issues:
      i. Wellness programs with simple to understand direct connections to prevention of common medical issues (e.g., installing a grab bar) will provoke far less confusion than more esoteric programs based on new technological services (e.g., data collection/monitoring of insured activities) with not yet proven results. Simpler programs may also trigger fewer and less complex regulatory/statutory requirements related to privacy, consent, disclosure, etc. resulting in programs that will be more easily understood and documented. Programs with newer technology, more data collection and manipulation, and which are connected to more complex care issues will be more confusing and will trigger more complicated regulatory/statutory requirements.
         1. In these scenarios, there may be a need to first educate consumers on the technology and the data collection/usage and then the program and its potential benefits before disclosure and informed consent can occur. The ability to prevent confusion and achieve adequate education and understanding may be further impacted by the level of technological sophistication and mental acuity of the consumer, factors which often decline with age.
ii. Designing effective communication regarding insurer LTC wellness programs will require in-depth engagement with LTC consumers, policyholders, family members, eldercare subject matter experts, and NAIC consumer representatives. When the vetting group engages with Medicaid programs, PACE, etc. to learn about best practices in wellness programming, the vetting group should take the opportunity to learn about the successes and failures in communication used in implementing these programs, including any relevant focus group data available.

iii. In addition to engaging with Medicaid and PACE, the following organizations may have valuable insights: National Council on Aging (www.ncoa.org), AARP (www.aarp.org), and the National Institute on Aging (www.nia.nih.gov). In addition to engaging with NAIC representatives and these national organizations, the Vermont team would also propose to reach out to Vermont’s sister agencies in state government (The Agency of Disabilities, Aging, and Independent Living (DAIL), and the Agency of Human Services, (AHS)). Lastly, Emily Brown serves on the board of directors for Central Vermont Home Health and Hospice. Engagement with this local group may provide rural eldercare perspectives missing at the national level.

iv. Focus groups designed to elicit feedback on communication style are most helpful when the programming has been determined. In the alternative, guidelines for communication and disclosure designed to minimize confusion and maximize understanding would need to be developed along a spectrum of wellness programs of increasing complexity. The results of vetting group work around rebating, program effectiveness, data privacy, loss of tax-preferred status, and discrimination concerns will determine components of what needs to be tested in focus groups. For instance, if the loss of tax-preferred status is something the vetting group can address at the federal level, it will not need to be considered when determining barriers to effective communication.

v. Building consensus around terminology and building trust are essential to effective communication. In a Medicaid setting, the PACE program (Programs for All Inclusive Care for the Elderly), wellness efforts include a multidisciplinary team of health professionals coordinating care and no cost share on services. (Source: https://www.medicaid.gov/medicaid/long-term-services-supports/pace/programs-all-inclusive-care-elderly-benefits/index.html) . This builds trust through human contact with medical professionals.

1. This type of communication is vastly different than the communication between an insurer and a long-term care policyholder facing a rate increase, where participation may have some impact on the premium rate increase the consumer must pay. As a result, extra care will need to be taken to ensure policyholders truly understand the offer and the level of participation required and that they do not acquiesce based on confusion or because they feel they have no other choice.
vi. As the wellness vetting subgroup works through the issues (program effectiveness, discrimination, data privacy, and tax considerations), the Vermont team hopes to build on the conversations planned with subject matter experts in eldercare programming. The vetting group should plan to add time at the end of the process to explore and understand the vetted programs with consumers via focus group(s) to best anticipate and mitigate consumer confusion.

4. Rebating

a. Issue: whether some long-term care wellness benefits for policyholders run afoul of the NAIC Model anti-rebating laws or are otherwise prohibited. Those wellness plans may be designed to prevent or lower the severity of LTC insurance claims or to improve health outcomes (“Wellness Initiative”).

b. Addressing issues:

i. **NAIC Model Law.** The recently amended version of the NAIC Model Unfair Trade Practices Act (#880) (“Model Law”) explicitly exempts the type of Wellness Initiatives currently being considered from the prohibition on rebates as an unfair trade practice. Specifically, § 4 (H)(2)(e) of the Model Law excludes from “the definition of discrimination or rebates . . . [t]he offer or provision . . . of value-added products or services at no or reduced cost,” even “when such products or services are not specified in the policy of insurance,” if the product or service meets certain requirements. Amongst procedural requirements, the Model Law requires that the product or service (a) relate to the insurance coverage, (b) be “primarily designed to satisfy” one of nine functions, including providing loss mitigation, reducing claim costs, enhancing health, and incentivizing behavioral changes, and (c) cost a reasonable amount in comparison to premiums or coverage. As the Wellness Initiatives in question would be designed to prevent or lower the severity of LTC insurance claims and improve health outcomes, as long as their cost is reasonably related to the premiums or coverage, then they should not be considered rebates under the recently amended Unfair Trade Practice Act.

ii. **Variations in State Law.** The above cited language from the Unfair Trade Practices Act, § 4 (H)(2)(e), however, is a recent December 2020 addition to the Model Law. As such, most states have yet to specifically address that update and have only enacted a prior version of the Unfair Trade Practices Act. Unfortunately, the old language of the Model Law was less flexible on this point, which led a number of states to carve out exceptions by individual amendments, regulations, bulletins, or desk drawer rules. And the Unfair Trade Practices Act is not the only model law with language prohibiting rebates in the business of insurance. As such, it is much less certain whether the Wellness Initiatives at issue would trigger the law’s anti-rebating provision. And the many state initiatives in this area do not permit a uniform analysis of rebating in each adopting jurisdiction as the precise language, interpretation, and application of the law varies by state.
1. As a result, whether Wellness Initiatives could arguably be considered a rebate remains a question subject to the specifics of each individual state’s rebating law and how each jurisdiction has interpreted and applied that law. To provide a few examples of the variations in state law, even amongst states that have adopted the prior Model Law:
   a. **Alaska**: Statutorily excludes “a reward under a wellness program established under a health care plan that favors an individual” from the definition of rebates so long as seven requirements, including the program being designed to promote health or prevent disease, are met. See AK Stat § 21.36.110.
   b. **Maine**: Statutorily permits provision of a value-added service that is related to the coverage provided by an insurance contract, without fee or at a reduced fee, if it is (a) included within the insurance contract, (b) directly related to the servicing of the insurance contract, or (c) offered to provide risk control for the benefit of a client. See Me. Stat. tit. 24-A, § 2163-A.

2. Thus, under the current legal landscape, those seeking to introduce Wellness Initiatives would need to confirm whether such an initiative would be permissible under each relevant jurisdiction’s rebating law and if there are any state specific requirements for offering such an initiative.

iii. **Trends in State Law.** Notwithstanding the variation in individual state’s laws and if and how they have been amended or interpreted, there does appear to be a general trend that “services are not prohibited if they are directly related to the insurance product sold, are intended to reduce claims, and are provided in a fair and nondiscriminatory manner.” J. Parson, D. Marlett, S. Powell, *Time to Dust Off the Anti- Rebate Laws*, 36 J. Ins. Reg. 7, at 8 (2017). Under this general approach, which aligns with the substantive result of the language in the current Model Law, a Wellness Initiative should not be prohibited as impermissible rebating.

iv. **Policy Considerations.** The exemptions in the current Model Law and the trend amongst states to permit certain services even if they are not contained within the insurance contract appear to be logical limitations on the scope of anti-rebating statutes. In short, Wellness Initiatives are not the type of conduct that anti-rebating statutes were originally designed to protect consumers against. This is particularly true in the context of LTC insurance where consideration of these initiatives only began significantly after the policies were initially sold, where the initiatives do not begin at the moment the policy is issued, and where the policies have proven to be unprofitable for the insurers. In other words, it is fair to assume that Wellness Initiatives in this context are not being used to either induce the policyholder to enter into the insurance contract, nor to expand the insurer’s share of the LTC insurance market. Rather, they are targeted at improving policyholder health and reducing the frequency and severity of claims.
c. **Next steps:**
   i. Given the current legal landscape with respect to rebating, to facilitate the success of Wellness Initiatives jurisdictions could either:
      1. adopt the recently added rebating exemptions found in the current version of the Model Law, which would explicitly permit such initiatives, or
      2. take action to interpret and apply their existing laws in a manner that would allow the provision of products or services that are directly related to the insurance policy in question and designed to reduce claims or improve health.
   
   ii. Absent adoption of the current version of the Model Law, however, insurers would need to conduct a state-by-state evaluation of rebating laws in all relevant jurisdictions before implementing a Wellness Initiative.

5. **Tax considerations**
   a. Issue: will non-ADL / non-cognitive benefits cause tax issues for policyholders?
   b. Current observations
      i. In order for a contract to be a “qualified long-term care insurance contract” (QLTCI) as defined in 26 USC 7702B, it must satisfy a number of definitional requirements, including that such a contract must provide insurance coverage only of qualified long-term care services and it generally cannot provide a cash value. There may be adverse tax consequences for consumers if a contract provided benefits that are inconsistent with the definitional requirements.
   c. **Addressing issues:**
      i. If a QLTCI contract meets the statutory definition, it is treated as an accident and health insurance contract. See 26 USC 7702B(a)(1). The NAIC is addressing the addition of wellness benefits to QLTCI contracts, and it is understood that insurers would only offer such benefits where this could be done without forfeiting the contract’s tax qualified status. Wellness benefits may include provision of home assessments to identify risks which could lead to a chronic illness such as tripping hazards, installation of ramps and railings, caregiver training for family members and sharing information regarding local LTC providers to those in need or anticipating assistance.
      
      ii. While not exactly on point, two interpretive letters* from the Internal Revenue Service responded to questions from a taxpayer regarding the inclusion of riders to QLTCI that 1) “allow access to information pertaining to health, wellness and long term care that promotes and encourages a healthy lifestyle,” and 2) allow participation in voluntary incentive programs that are based on periodic health assessments and other medical criteria evidencing health living and could result in premium discounts or increases in benefits.
iii. The interpretive letters observe that 26 USC 7702B was enacted to provide incentive for individuals to take financial responsibility for their long-term needs and therefore generally provides favorable tax treatment with respect to QLTCI and qualified long-term care services meeting the statutory requirements. The Code defines “qualified long-term care services” as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services and maintenance or personal care services which are required by a chronically ill individuals and are pursuant to a plan of care prescribed by a licensed health care practitioner. The IRS further observed that, in essence, the rider allows the contract to be implemented based on the risk profile of the insured. The IRS held that the inclusion of the rider in a QLTCI contract will not cause the contract to be treated as providing insurance coverage other than of qualified long-term care services.

* The guidance contained in the interpretive letters is directed only to the requesting taxpayer(s) and may not be used or cited as precedent.

d. Next steps:
   i. Insurers and policyholders could benefit from federal guidance regarding tax qualification of broad classes of QLTCI, including QLTCI combo products. Such guidance would clearly articulate:
      1. Safe harbor product features that would not be inconsistent with the tax qualification requirements for QLTCI;
      2. That the safe harbors are not exhaustive of permissible wellness and other features for reducing the risk of chronic illness or severity of any future chronic illness; and
      3. That the IRS may supplement safe harbor guidance as appropriate, and that taxpayers may utilize the private letter ruling process of clarifying the treatment of particular features not covered by safe harbors.

6. Regulatory role in approving or evaluating LTC wellness approaches
   a. Issue: there is question as to whether LTC wellness approaches need to be approved by regulators or will be implemented by companies and later evaluated by regulators.
   b. Current observations:
      i. There is little regulatory clarity or uniformity regarding LTC wellness programs.
   c. Addressing issues
      i. Idea:
         1. Provide guidance that companies should have available, upon request, documentation of their programs and documentation that key issues our group identified have been addressed.
            a. These issues include company plans to accumulate data on programs’ effectiveness, avoiding unfair discrimination, preventing consumer confusion, their take on rebating, avoiding unfavorable consumer tax issues, and data privacy.
2. States retain the right to conduct back-end reviews, targeting any critical areas of regulatory focus.
3. Companies and regulators need to ensure that this approach is in compliance with existing state laws.
   a. The NAIC Model Unfair Trade Practices Law appears to contemplate either a “provide notice and opportunity for objection” approach or a “documented criteria must be maintained by the insurer and produced to the regulator upon request” approach, depending on the circumstances.

ii. Considerations:
1. Balance between holding companies accountable while not creating a burden that could prevent or slow up companies from pursuing beneficial programs.
2. There may be mixed policies regarding pre-approval or filing of documentation by state. An effort to make any filing process as efficient as possible for regulators and companies should be pursued to avoid any unconstructive burdens.
3. Companies being alerted that documentation must be available would likely ensure they at least attempt to address each of the issues prior to implementing a program.
4. Would states be interested in being provided notice of development of a new wellness program? Would states want to be notified of every change in or addition to a program? In what form would the notification occur?
5. Would a state have a right to object to an aspect of a program? If the objection leads to elimination of the program in that state, would that lead to other concerns, e.g., discrimination?
6. Would development of a uniform LTC wellness template help creating uniformity in how states interact with companies offering programs?
7. Need to determine consequences for a company that does not maintain the required documentation.

iii. After experiencing several companies’ pilot programs and identifying actual problem areas (as opposed to hypothetical issues), it is possible regulators will want to pursue a targeted pre-approval process or up-front receipt of documentation. That could be decided at a later date.

iv. Next steps
   i. Analyze flexibility in existing laws that would allow for innovation that could potentially result in better health for policyholders and lower costs for insurance companies.
   ii. Consider developing a template that a company could fill in with narrative explanation of how they have considered identified issues in development of a LTC wellness program. An efficient manner to have this information received by interested regulators resulting from a single company filing (perhaps through SERFF or an NAIC portal) can be pursued.
7. Actuarial considerations
   a. Issue: how are actuarial issues such as valuation, rate increase reviews, and reasonable value of benefits and options impacted by LTC wellness benefits?
   b. Current observations
      i. Although health outcomes can be expected to improve, to some extent, with LTC wellness programs, it is unclear how future claim costs will be impacted in comparison to the investment in the programs.
      ii. As data emerges, actuarial issues related to the impact of LTC wellness benefits on future claim incidence and severity, could impact rate increases and reserves.
   c. Addressing of Issues
      i. Valuation: Under moderately adverse conditions, as data emerges, future cash flows associated with LTC wellness programs and potential claim cost reductions resulting from the programs may be incorporated into reserve adequacy testing, including Actuarial Guideline 51 stand-alone long-term care analysis, per actuarial standards of practice.
      ii. Rates: As data emerges, future cash flows associated with LTC wellness programs and potential claim cost reductions resulting from the programs may be incorporated into lifetime loss ratio projections associated with rate-increase filings, per actuarial standards of practice.
      iii. The NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation and NAIC Health Actuarial Task Force-adopted Consolidated, Most Commonly Asked Questions - States' LTC Rate Increase Reviews document suggest that consistency between rate increase assumptions and reserve adequacy assumptions (noting reserve adequacy assumptions may include a margin to account for moderately adverse conditions) may be expected by some regulators.
      iv. Reasonable value: The Long-term Care (EX) Task Force has tentatively established guidance that reduced benefit options in lieu of rate increases should provide reasonable value in comparison to the economic value of maintaining benefits and paying the increased premium. To the extent that LTC wellness benefits are tied into reduced benefit options, the holistic concept of reasonable value will likely be a consideration.
   d. Next steps
      i. Determine the NAIC venue to work through LTC wellness actuarial issues.

8. Data privacy
   a. Issue: utilization of consumers’ data for wellness initiatives can be used to develop the marketing strategy and a specific wellness initiative, as well as to analyze the impact or effects of a wellness initiative. The use of Big Data or artificial intelligence to develop the target demographic for new sales, the selection of the existing consumers for wellness initiatives, or to determine the results of the initiative, could result in an insurer or third-party data vendor using the data in a way that could be unethical, discriminatory, confusing, or otherwise problematic.
      i. With many of the tech advancements, data on the policyholder would be accessed to, e.g., help identify warning signs of risks such as falls and early-stage dementia.
   b. Current observations
i. The standards applied by insurance companies and tech firm vendors to ensure certain levels of privacy are generally unknown.

ii. There are lessons from other types of insurance on the types of privacy-related issues that may develop.

iii. There are cases, and perhaps a trend, of programs/interventions being implemented without utilizing significant amounts of policyholder personally identifiable information.

iv. States’ continuous adoption of data and privacy regulations will need to be available for insurers to assess the compliance of their wellness initiatives.

c. Addressing of issues

   i. Data Use to Identify Wellness Initiatives:
      1. Policyholders’ considerations:
         a. Confusion about why they are being solicited for the initiative.
         b. Suspicion about the motivation of the insurer.
         c. General lack of awareness that data is being collected, and what data is being collected.
         d. General lack the awareness or understanding on how data is collected and used.
         e. Will they know if their data was used to determine a specific wellness initiative for them versus being selected as part of a class of policyholders?
         f. Will the policyholder know what data is going to be used prior to participation?
         g. Should the policyholder have the option to “opt in/out” of their data being used internally for other initiatives or for external sale or use?
         h. Should policyholders have the ability to have appropriate control over their information, including the ability to access and correct inaccuracies, consistent with legitimate business purposes and/or legal requirements to retain such information?
      2. Insurer considerations:
         a. Should insurer communications include why a wellness initiative is being offered; including what data is being used?
         b. How should insurers use clear and concise notice about the collection, use, and disclosure of personal information?
         c. Should insurers purchase data regarding their policyholders (e.g. data that shows specific policyholders may have a near term claim - purchasing canes, grab bars, electronic fall detectors, etc.)?
         d. How should wellness initiatives be marketed to a policyholder? Insurers may need to limit what is advertised on the envelope, postcard, etc. due to HIPAA concerns.
         e. Should insurers partner with vendors or service providers to supply specific policyholder data to the wellness company? What data should be sent? How will the data be transferred?
f. Should insurers focus their data on policyholder specific needs and only offer services relevant to the ongoing needs?

g. How are opt in/out options, disclosures, etc. being shared with the consumer? Email, letter, text, etc. Is it appropriate to the policyholder’s needs or preferences?

h. When using third party data providers, what screening or data protection programs are in place?

ii. **Data Use During Wellness Initiative Development:**

   1. Should insurers purchase policyholder specific information from third party data sources?
      a. Data collected during purchases, search history, television programming, etc.
      b. Should it always be headless, anonymized, or deidentified?
   2. When considering big data, are there unacceptable “correlations”? How will insurers recognize relevant correlations vs irrelevant statistically significant correlations?
   3. Are there data use standards, controls, definitions of personal data, or a data privacy review body in place to ensure the data is used, stored, or shared ethically?
   4. When evaluating the data for wellness initiatives, will it focus on policyholder specific information – for example, will the policyholder’s claims detail or demographic factors determine the type of wellness initiative offered to that policyholder?
   5. Will the risk of a data breach be assessed and protected against by the insurer as well as all vendors or third-party data suppliers?
   6. Does the insurer have procedures in place to notify the policyholders of a potential breach?

iii. **Wellness Results Data Use:**

   1. Should the results be sold? Aggregate vs specific demographic information?
   2. Should insurers use the results internally for cross marketing other wellness initiatives?
   3. Should the policyholder be notified and have the option to “opt in/out” of letting the insurer use the data?
   4. Should the results be shared with the policyholder, POA, third party notifier? What guardrails should be in place relative to that sharing?
   5. How should the data be shared, if at all, with other vendors or service providers?
   6. How long will the data be retained? Will the data be destroyed or disposed?

d. **Dependencies**

   i. Unfair Discrimination

   ii. States’ adoption of wellness initiatives could make it difficult to implement a program uniformly.

e. **Next steps:**
i. Reach out to experts in the health insurance and Medicare Advantage, Medicare Supplement, or Medicaid / PACE areas to learn from their experiences.
ii. Identify applicable state privacy laws and HIPAA anti-marketing restrictions.
iii. Require insurance companies to provide information on privacy protection matters when claims management processes are established.
iv. Determine if policyholder approval of use of expanded data can be established at certain points in time:
   1. At times of options in lieu of rate increases, can insurance companies get agreement to attain more policyholder data?
v. Can new contracts be written with evergreen access to some private data?

9. Other considerations
   a. Issue: other legal or market and administrative issues may come into play as LTC wellness programs are established.
   b. Current observations
      i. There are dozens or hundreds of cutting-edge technological advancements being developed to help with aspects of LTC claims management.
         1. It is difficult for insurance companies and regulators to determine which tech advancements are most promising in terms of likelihood of success and degree of impact on consumer health and reducing claims cost.
      ii. TPAs or reinsurers used by direct-writing insurance companies may be resistant to administering these additional activities or may be concerned about potential legal ramifications that could impact their firms.
      iii. Insurers could potentially be subject to requirements if a policyholder, e.g., is identified as having cognitive impairment and therefore be a risk related to driving or finances.
   c. Next steps
      i. Determine if there is objection to an insurance company offering an extra-contractual wellness benefit that is not tied to loss ratio / benefits / contracted obligations, i.e., out of expenses?
      ii. Determine if benefits offered outside the contract could be considered in a similar category as because a reduced benefit option in lieu of a rate increase, which is essentially a mutually-agreed-to restructuring of the insurance contract.
      iii. Either identify or ensure industry members are identifying requirements related to disclosing, e.g., when a policyholder has cognitive impairment and may be a high-risk driver.
      iv. Regulatory guidance may help innovators engage in this space.

10. Miscellaneous topics
    a. How will insurers report on issues and learnings?
    b. This document will likely need to be updated with new learnings or issues.
c. Continuous collaboration with insurers regarding issues or new initiatives will likely be needed.

d. Note that there are hybrid products that contain wellness benefits. However, the scope of this document is wellness associated with stand-alone LTC insurance policies, which tend to have more volatile financial profiles than hybrid products.
Checklist for Premium Increase Communications

Adopted by the Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup 11/19/21

AUTHORITY

The Long-Term Care Insurance Reduced Benefit Options (RBO) (EX) Subgroup is composed of regulators from 17 state insurance departments. It has been tasked with assisting the Long-Term Care Insurance (EX) Task Force in completing the following charge:

*Identify options to provide consumers with choices regarding modifications to long-term care insurance (LTCl) contract benefits where policies are no longer affordable due to rate increases.*

The Long-Term Care Insurance (EX) Task Force (Task Force) adopted the Long-Term Care Insurance RBO Communication Principles. The Long-Term Care Insurance RBO EX Subgroup has been charged with developing a complementary checklist that can be leveraged by state regulators and Long-Term Care Insurance insurers.

INTRODUCTION

This checklist is intended to establish a consistent approach to drafting and reviewing Long-Term Care Insurance RBO policyholder communications. The checklist can be used as guidance and does not carry the weight of law or impose any legal liability.

State regulators who consider the checklist excessive, deficient, or not focused on issues specific to consumer experiences in their state are encouraged to modify the checklist to suit the needs of the Department.

Leveraging the checklist could enable insurers and state regulators to mitigate consumer confusion and complaints, improve the quality of consumer communications, and ensure that consumer communications:

- Read in a clear, logical, not overly complex manner.
- Present options fairly and without subtle coercion.
- Include appropriate referrals to external resources, definitions, disclosures, and visualization tools.
The Task Force RECOMMENDS that state regulators adapt the checklist to reflect their state regulations, laws, or statutes and use the checklist when reviewing filed Long-Term Care Insurance RBO Communications.

CALLS ON all insurance companies to consider the checklist when developing reduced benefit option policyholder communications in the event of a rate increase.

### Checklist for Premium Increase Communications

| Insurer name: |  |
| Date of filing: |  |
| Product form: |  |
| Tracking number(s) SERFF rate filing: |  |
| Tracking number(s) SERFF form filing: |  |

<table>
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<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th><strong>SERFF FILING</strong></th>
<th>Page Reference and Filing Notes</th>
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<tr>
<td>☐</td>
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<td>1. Does the filing contain all required materials including: policyholder communication, supplemental FAQ, graphs, illustrations, website screenshots (expected if communication refers policyholder to website for more information)?</td>
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<td>2. Has actuarial review of the rate increase been completed?</td>
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<td>3. Will notice of the rate action be mailed at least 45 days prior to the policyholder anniversary date (or billing date if state law allows)?</td>
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<td>4. Have all new innovative RBO options presented in the communication been clearly explained in the filing? Have they been vetted by policy and actuarial staff?</td>
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</table>
5. Do reviewers understand any variable information that appears in the communication?

6. Were state-specific or contract-specific pre-rate increase filing notification procedures followed? For example: VT has insurers notify consumers of rate increases when filed in addition to notification Y before effective date. PA posts filed rate increase details on their website.

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<th>Yes</th>
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7. Is the communication easy to follow? Does it flow logically? Does it display the essential information and/or the primary action first (followed by the nonessential information)? Is the primary message of the communication presented first and clearly worded?

8. Are all technical insurance terms clearly explained in the communication?

9. Are all technical terms used consistently throughout the communication?

10. Is the communication in an easily readable font? For example: Is the type at least 11-point type?

11. Does the communication use headings to help the reader find information easily?

12. Is white space (margins, lines spacing, and spacing between paragraphs) sufficient and consistent?

13. Are tables, charts, and other graphics, easy to read and understand? (See question 18 for reference).
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<th>Question</th>
<th>Score</th>
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<tr>
<td>14. Are the grade level and reading ease scores appropriate according to state readability standards?</td>
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<td>15. Are reduced benefit options clear and not misleading? For example: Are there side-by-side illustrations of options compared with current benefits?</td>
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<tr>
<td>16. Does the communication include diminished contrast features that may make it harder to read? Examples include: Use of Italics, Narrow margins (top and bottom less than 1.5 inches), All caps (all bold is acceptable), Difficult to read text (fonts other than Sans Serif or Courier), Different colors throughout, Small font</td>
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<tr>
<td>Reviewers should aim to review these communications in the size and contrast in which a consumer would see them; a print test may be beneficial.</td>
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<td>17. If FAQs are included, are they succinct and easy to understand?</td>
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<td>18. Does the communication include notice that policyholders with disabilities and policyholders for whom English is not a first language can request ongoing accommodations that will enable them to read online and written materials and notices? For example, accessibility of its online and written material to all interested parties, including those with disabilities such as blindness or macular degeneration deafness and hearing loss, learning disabilities,</td>
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cognitive limitations, limited movement, speech disabilities, photosensitivity, and combinations of these.

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<th>Yes</th>
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<th>IDENTIFICATION</th>
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<td>Page Reference and Filing Notes</td>
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19. Does the communication answer what is happening? 

20. Does the communication answer why the consumer is receiving a rate increase? 

21. Does the communication reflect negatively on the Department of Insurance? 

22. Does the communication indicate when the rate increase will be effective? 

23. Does the communication clearly indicate the policyholder has options? 

24. Does the communication clearly indicate how the consumer may elect an option? Does the election documentation allow the consumer to clearly indicate his or her choice? Does the election form description of options match the description of options found earlier in the communication, such that consumers will not be confused looking at the election form? 

25. Does the communication clearly explain that the consumer is not being singled out for the increase? 

<p>| Yes | No | N/A | COMMUNICATION TOUCH AND TONE |
|-----|----|-----|Page Reference and Filing Notes |</p>
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<tr>
<th>Question</th>
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<td>26. Does the communication remind consumers to reflect on the original</td>
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<td>reason they bought the policy?</td>
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<td>27. Does the communication express an understanding of the difficulty of</td>
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<td>evaluating choices?</td>
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<td>28. Is there a statement telling consumers how to contact the insurer for</td>
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<td>more information or help understanding their options?</td>
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<td>29. Are the options represented fairly? If one option is emphasized,</td>
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<td>mentioned multiple times or bolded when the other options are not.</td>
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<td>30. Are words used that could influence a policyholder’s decision, such</td>
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<td>as must or avoid? For instance, consider demonstrating immediacy by</td>
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<td>using the word “now” and avoiding words like “must.” Consider “manage</td>
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<td>an increase” instead of “avoid an increase.”</td>
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<td>31. Is the insurer’s consumer service number easy to find? Is it clear</td>
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<td>what hours and days consumer service is open? Regulators may consider</td>
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<td>testing the phone number to ensure it connects easily to live company</td>
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<td>representatives without long wait times.</td>
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<td>32. Are website links accurate and functional?</td>
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<td>33. Does the insurer encourage consumers to consult with multiple sources</td>
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<td>to include any of the following: Financial advisor, producer, state</td>
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<td>SHIP program (where applicable) with the state-specific name of the</td>
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<td>program or trusted family member?</td>
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<td>Yes/No/N/A</td>
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<td>34. Does the Insurer encourage consumers to consult the Department of Insurance?</td>
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<td>35. Does the communication encourage consumers to consult with a tax advisor if the reduction options include a cash buy out or could cause loss of Partnership status?</td>
<td>Yes/No/N/A</td>
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<tr>
<td><strong>UNDERSTANDING OPTIONS - PRESENTATION</strong></td>
<td>Page Reference and Filing Notes</td>
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<td>36. Does the communication have a clearly worded, descriptive title or subject line? For example: Your Long-Term Care Premiums Are Increasing.</td>
<td>Yes/No/N/A</td>
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<td>37. Are the options included with the rate increase notification communication? Is it clear that the policyholder can ask for additional options?</td>
<td>Yes/No/N/A</td>
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<td>38. Are the number of options presented reasonable? If there are more than 5, engage with insurer to understand what is being presented</td>
<td>Yes/No/N/A</td>
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<td>39. Is the right to reduce coverage at any time of a policyholder's choosing clear? Are the instructions about how to do that clear?</td>
<td>Yes/No/N/A</td>
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<td>40. Is there enough information to make a decision? If other sources are referenced like videos, websites, etc. are they supplemental education materials or are they required sources to choose an option?</td>
<td>Yes/No/N/A</td>
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<td><strong>UNDERSTANDING OPTIONS – PAST RATE ACTIONS</strong></td>
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<td>41. Does the communication include a statement that premiums may increase in the future? Is it clear that any future increase will include RBOs? Is the plan for filing future rate increases disclosed and clear?</td>
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<td>42. Does the communication include a 10-year nationwide rate increase history for this and similar forms?</td>
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<td>43. Does the communication disclose the policy is guaranteed renewable and clearly explain guaranteed renewable?</td>
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<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td><strong>UNDERSTANDING OPTIONS – WINDOW OF TIME TO ACT</strong></td>
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<td>44. Does the communication indicate what the reader must do to elect an option and provide a deadline to do it?</td>
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<td>45. If options are only available during the decision window, is that limitation clear to consumers?</td>
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<td>46. Does the communication indicate what happens if the policyholder does not send payment? For example, if the policy lapses within 120 days, does it advise Contingent Benefit Upon Lapse will apply, if applicable?</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td><strong>UNDERSTANDING OPTIONS – CURRENT BENEFITS</strong></td>
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<td>47. Does the communication include all the following applicable information? Current policy benefits (daily benefit, elimination period, current lifetime maximum benefit in dollars, inflation option, partnership status)?</td>
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<td>48. If current benefits have an inflation option, does the communication clearly explain the impact that changes to this inflation option may have on benefits now and in the future?</td>
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<td>Yes No N/A UNDERSTANDING OPTIONS – PERSONAL DECISION</td>
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<td>49. Can the insurer confirm policyholders will see only those options that are available to them (and not be shown options that are not available to them)?</td>
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<td>Yes No N/A UNDERSTANDING OPTIONS – VALUE OF OPTIONS</td>
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<td>50. Does the communication prompt the policyholder to consider their personal situation, such as: current age, health conditions, financial position, availability of caregivers, spouse or partner impacts, and potential need for and cost of care?</td>
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<td>Yes No N/A UNDERSTANDING OPTIONS – IMPACT OF DECISION</td>
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<td>51. Is the narrative describing the Contingent Nonforfeiture (CNF) and other limited benefit options clear that there is a reduction in the current policy’s LTC benefits? The narrative does not have to include the dollar value for CNF.</td>
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<td>Yes No N/A UNDERSTANDING OPTIONS – IMPACT OF DECISION</td>
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<td>52. Is there a prominent statement telling policyholders they can maintain their current benefits by paying the increased premium?</td>
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<td>53. Do the options reflect the impact of removing or reducing the inflation option on the growth or reduction of future benefits?</td>
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<td>54. If dropping inflation protection results in the loss of accumulated benefit amount, is that clearly explained?</td>
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<td>55. For phased-in increases: Is there a table with all phase-in dates and premium amounts if no RBO is selected? Does the communication clearly state if RBO(s) are limited to only the first rate increase or will be available during each phase of the rate increase?</td>
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<td>56. For phased-in increases, are there communications sent at least 45 days before each phase of the increase?</td>
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<td>57. Does the communication disclose that all reduction options require careful consideration and may not be equal in value?</td>
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The Special (EX) Committee on Race and Insurance met in San Diego, CA, Dec. 14, 2021. The following Special Committee members participated: David Altmaier, Co-Chair (FL); Dean L. Cameron, Co-Chair (ID); Raymond G. Farmer, Chair Emeritus (SC); Andrew N. Mais, Co-Vice Chair (CT); Chlora Lindley-Myers, Co-Vice Chair (MO); Lori K. Wing-Heier (AK); Jim L. Ridling (AL); Alan McClain (AR); Peni Itula Sapini Teo represented by Elizabeth Perri (AS); Ricardo Lara (CA); Michael Conway (CO); Karima M. Woods (DC); Trinidad Navarro (DE); Colin M. Hayashida (HI); Doug Ommen (IA); Dana Popish Severyninghaus (IL); Amy L. Beard (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); James J. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Eric A. Cioppa (ME); Anita G. Fox (MI); Grace Arnold (MN); Edward M. Deleon Guerrero (MP); Mike Chaney (MS); Mike Causey represented by Michelle Osborne (NC); Jon Godfread (ND); Eric Dunning (NE); Marlene Caride (NJ); Russell Toal (NM); Barbara D. Richardson (NV); Adrienne A. Harris represented by My Chi To (NY); Judith L. French represented by Tynesia Dorsey (OK); James J. Donelon (LA); Gary D. Anderson (MA); Kathleen A. Birrane (MD); Eric A. Cioppa (ME); Anita G. Fox (MI); Grace Arnold (MN); Edward M. Deleon Guerrero (MP); Mike Chaney (MS); Mike Causey represented by Michelle Osborne (NC); Jon Godfread (ND); Eric Dunning (NE); Marlene Caride (NJ); Russell Toal (NM); Barbara D. Richardson (NV); Adrienne A. Harris represented by My Chi To (NY); Judith L. French represented by Tynesia Dorsey (OK); Andrew R. Stolfi (OR); Jessica K. Altman (PA); Elizabeth Kelleher Dwyer (RI); Larry D. Deiter (SD); Carter Lawrence (TN); Cassie Brown (TX); Jonathan T. Pike (UT); Scott A. White represented by Rebecca Nichols (VA); Tregenza A. Roach (VI); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler (WA); Mark Afable (WI); Allan L. McVey (WV); and Jeff Rude (WY).

1. **Adopted its Summer National Meeting Minutes**

Director Lindley-Myers made a motion, seconded by Ms. Osborne, to adopt the Special Committee’s Aug. 15 minutes (see *NAIC Proceedings – Summer 2021, Special (EX) Committee on Race and Insurance*). The motion passed unanimously.

2. **Received a Status Report on Workstream One**

Superintendent Cioppa reported that Workstream One is charged with continuing research and analysis to identify issues and develop specific recommendations on action steps state insurance regulators and companies can take to improve the level of diversity and inclusion in the industry, including: 1) seeking additional engagement from stakeholders to understand the efficacy of diversity-related programs, how companies measure their progress, and what state insurance regulators can do to support these efforts; and 2) collecting input on any existing gaps in available industry diversity-related data.

Since the adoption of its 2021/2022 charges, the Workstream met in regulator-only session three times and held one open call with stakeholders. The Workstream initially met in September to regroup and discuss its updated charges and next steps.

In October, the Workstream heard a presentation from California and New York regarding their respective diversity, equity, and inclusion (DE&I) efforts and the diversity-related industry data that these states are collecting.

In November, the Workstream held a public call with stakeholders to better understand industry diversity-related programs, how companies are measuring progress, and what state insurance regulators can do to support these efforts. Representatives from several companies and trades spoke, including: the American Property Casualty Insurance Association (APCIA); Blue Cross and Blue Shield of Illinois (BCBSIL); Cambia; CUNA Mutual Group; the Greater New York Mutual Insurance Company; the National Association of Mutual Insurance Companies (NAMIC); Shelter Insurance; and Zurich North America (Zurich). Their testimonies were encouraging, and state insurance regulators are pleased by the industry’s willingness to step up and take action. The Special Committee asked three of the presenters—APCIA, Dr. Leroy David Nunery (Plūs Ultré LLC), BCBSIL, and Zurich to provide an update to the Special Committee, as it believes their testimony will benefit the full Special Committee.

The Workstream is now discussing next steps. State insurance regulators want to support the insurance industry in increasing diversity and inclusion at all levels of their organizations and be of assistance in bringing more and diverse talent into the applicant pool. The Workstream looks forward to continuing this important work.

3. **Received a Status Report on Workstream Two**

Commissioner Stolfi reported that Workstream Two continues gathering responses to the survey intended to examine, at the zone level, best practices and initiatives state insurance departments may consider when promoting DE&I in their departments.
The Workstream will meet to discuss a method and forum to share diversity and inclusion best practices among state insurance regulators. So far, 26 responses have been received. The Special Committee sent a reminder email earlier this week with a link to the survey, and it encourages every state to respond as soon as possible.

The NAIC continues with its work implementing diversity initiatives. Previously, the Special Committee asked members to share their diversity contacts with Evelyn Boswell, NAIC Director of Diversity, Equity, and Inclusion.

Ms. Boswell convened the first State Diversity Leader’s Forum held on Oct. 18. This Forum provides a space for diversity leaders in each state to come together and discuss best practices in promoting diversity in their respective insurance departments. Ms. Boswell also convened the DE&I table talk during this meeting. If anyone would like to be included in these efforts, they should please send diversity contact information to Ms. Boswell.

4. Received a Status Report on Workstream Three

Commissioner Schmidt reported that Workstream Three met Dec. 1 and heard from interested parties about its Charge F to: 1) continue research and analysis of insurance, legal, and regulatory approaches to address unfair discrimination, disparate treatment, proxy discrimination, and disparate impact; and 2) make recommendations for statutory and regulatory changes and additional steps, including developing analytical and regulatory tools to assist state insurance regulators in defining, identifying, and addressing unfair discrimination.

The Workstream believes an important first step to address this charge is to consider the drafting of a white paper to define some of these terms, as well as to set forth next steps for the Workstream.

During its Dec. 1 conference call, the Casualty Actuarial Society (CAS) previewed several papers it will be releasing in early 2022 that will: 1) define discrimination in insurance; 2) understand potential influences of racial bias on property/casualty (P/C) insurance; 3) provide approaches to address racial bias in financial services, including lessons learned for the insurance industry; and 4) assess methods for quantifying discriminatory effects on protected classes in insurance. The CAS provided the Workstream with an overview of those papers, and the Workstream believes the papers will be useful in drafting the white paper.

The Workstream also heard from several other consumer and industry groups about how to define these terms, as well as how to audit algorithms to ensure there is no disparate impact. The presentation slides and audio are posted on the NAIC website. The Workstream will continue these discussions with a goal of drafting a white paper outline and taking comments on that outline.

5. Received a Status Report on Workstream Four

Commissioner Afable reported that Workstream Four held a regulator-only session in October to discuss how best to develop a work plan related to its charges. After reviewing its charges, the Workstream members concluded that there is a need for data to drive discussion and advance the understanding of these issues and next steps. The Workstream, in conjunction with the other workstreams, needs to explore how best to move forward with identifying data that may already exist, in addition to collecting data going forward.

The Workstream will meet in open session in January to review how it fits into the larger work of the Special Committee and the other workstreams as it moves forward to address the issues identified in its charges.

6. Received a Status Report on Workstream Five

Commissioner Altman reported that since Workstream Five’s last update to the Special Committee at the Summer National Meeting, the Workstream met Dec. 3, Nov. 18, Oct. 14, Sept. 9, and Aug. 26. Most of these meetings have focused on the Workstream’s draft “Principles for Data Collection” document.

As currently drafted, the “Principles for Data Collection” document provides high-level guiding principles for the collection and treatment of data on race, ethnicity, and other demographic characteristics in the health insurance business. The document reflects the Workstream’s discussions and recommendations from various stakeholders provided during several of the Workstream’s meetings. Commissioner Altman said one consistent theme expressed by stakeholders is that robust data collection is a key to both quantifying existing disparities and evaluating the effectiveness of initiatives to address those disparities.
In developing the document, the Workstream worked to include high-level principles to guide in the collection, maintenance, protection, and reporting of enrollee demographic data, while acknowledging the regulatory barriers to such collection and the sensitive nature of collecting and using such data from enrollees.

Commissioner Altman noted that the Workstream received robust feedback, much of which has been accepted and thoroughly discussed. She thanked the stakeholders from industry, the consumer representatives, the state insurance regulators, and all for the level of discussion the Workstream has been able to have so far.

During its Dec. 3 meeting, Commissioner Altman said the Workstream almost completed its discussions on the draft document, including potential revisions based on the comments received. The Workstream plans to hold one last meeting to finalize the document before the end of the year or early next year. After the data collection document is finalized, the Workstream will forward it to the Special Committee for consideration.

Commissioner Lara reported that in addition to discussions on the data collection document, the Workstream’s Sept. 9 meeting focused on other issues identified in the Workstream’s report to the Special Committee as areas it wanted to obtain more information around maternal health disparities and coverage losses among children. The Workstream heard a presentation on maternal health disparities and how state insurance regulators can improve maternal health disparities, such as more enhanced data collection and ensuring network adequacy standards provide access to quality providers and culturally competent care.

The presentation on coverage losses among children highlighted the benefits to children of being insured and pointed out the adverse effects to maternal and infant outcomes for uninsured mothers. The presenters also highlighted the increase in the rate of uninsured children in recent years, particularly for Latinx children. To address these issues, the presenters had several recommendations, including enhancing outreach to community-based organizations.

The Workstream also moved forward with another area it identified in its report to the Special Committee as being extremely important—provider networks, provider directories, and cultural competency. During the Workstream’s Oct. 14 meeting, it reviewed a draft Provider Network white paper outline. The outline reflects the Workstream discussions during its July 8 meeting. The Workstream exposed the outline for a public comment period ending Nov. 8. As part of that exposure, the Workstream asked for volunteers based on the outline to draft sections of the white paper. In looking ahead, the Workstream plans to finalize the Provider Network white paper outline early next year and assign volunteers to draft sections.

Birny Birnbaum (Center for Economic Justice—CEJ) thanked the members of the Special Committee for its work on race and insurance. He noted that with the DE&I framework, it is important to measure in order to track progress, just as important as identifying the right things to measure is critically important. The CEJ suggests that it is not sufficient to simply measure activities. Outcomes should also be measured so it can be determined if progress is being made (e.g., whether NAIC events feature speakers and participants from communities of color and whether the NAIC and state insurance departments increase the number of people of color in senior management).

Mr. Birnbaum said while the NAIC DE&I framework and report highlights the NAIC’s activities, no metrics were seen for measuring success. He noted that in some areas, progress has been slow. For example, today's Center for Insurance Policy and Research (CIPR) event on lessons learned from the pandemic includes no consumer stakeholders or stakeholders from communities of color.

Mr. Birnbaum said he mentions this to raise awareness, not to criticize, and to make the point that to know progress is being made on DE&I, measurables should be identified to measure outcomes. He said his final point is that DE&I is obviously critical to offer opportunities to members of communities of color, but DE&I alone cannot address structural racism. He said it does not matter how many people of color you have in senior management if you are not taking the steps to address the structural forces that disproportionately affect communities of color. He urged NAIC members to put some metrics in place for DE&I and set up other work to make progress in the Special Committee’s efforts.

7. **Heard an Update on CO SB 21-169 – Restrict Insurers’ Use of External Consumer Data**

Commissioner Conway provided an update on Colorado Senate Bill 21-169. He said the core goal of the legislation is to protect Colorado consumers from insurance practices that result in unfair discrimination based on race, color, national or ethnic origin, religion, sex, sexual orientation, disability, gender identity, or gender expression. He said the law is focused on ensuring external consumer data is not used in a way that unfairly discriminates against consumers. He said the core idea came from recognizing that the insurance department would not have the resources or expertise to compete with insurance companies and state insurance regulators and the industry need to find a way to ensure the industry is using big data components responsibly.
He said the intention is to find ways for the industry to stress test their own systems, identify issues that may be occurring with big data systems and algorithms, and take corrective action to address consumer harms identified. To address questions about there being a potential problem requiring legislation, he shared a few examples of different studies that have been performed over the year. He noted that this has been a well-documented issue where there are potential issues with big data and artificial intelligence (AI) not only within the insurance industry but outside the insurance industry. The auto insurance study cited is a ProPublica study. The life insurance study was done by Haven Life. The homeowners insurance study was done by St. John’s University. The studies will be posted on the Colorado Division’s website.

Commissioner Conway said at its core, the law says a simple correlation to risk will not be sufficient if the underlying insurance practice also correlates to a protected class and negatively affects that class. He said it will be a balancing test that the law requires to be defined through a stakeholder process. He said the law is primarily focused on personal lines of insurance, life, health, property, and casualty. He said the insurance practices subject to the law are marketing, underwriting, pricing, utilization management, reimbursement methodologies, and claims management. He said the risk management framework required by the law includes providing information on the external consumer data and information source used, explaining how it is used, establishing and maintaining a risk management framework, attesting to its implementation, and providing an assessment of the results of the framework or a similar process. He said the plan is to begin stakeholder meetings in mid-January 2022, and the rules will be effective, at the earliest, Jan. 1, 2023. He encouraged all stakeholders to engage with him in the process and check the Division’s website regularly for updates.

Commissioner Altman asked if Commissioner Conway plans to share aggregate information, broad outcomes, or lessons learned from the process, either publicly or with fellow state insurance regulators. Commissioner Conway said at a bare minimum, the information will be shared on an aggregated level.

8. Heard Comments from Interested Parties

a. APCIA/Plus Ultré LLC

Jessica Hanson Hanna (APCIA) provided an introduction on the APCIA’s industry initiatives to promote and advance a more diverse and inclusive industry. She said the APCIA cofounded the insurance careers movement, a global grassroots initiative that brings together more than 1,000 insurance companies, agents and brokers, trade associations, and other industry partners to inspire more people to choose insurance as a career and remain working in the insurance industry. Other initiatives she listed include the APCIA Board of Directors’ DE&I strategic priority, the APCIA’s Emerging Leaders program, and a board level APCIA working group on social equity and inclusion established in 2020 to oversee the APCIA’s initiatives and long-term planning. Finally, the APCIA created its DE&I catalog created in partnership with Dr. Nunery to catalog its members’ diversity and inclusion programs at the workforce level, the board level, and the supply chain level on an anonymized basis. The APCIA’s four key goals are to: 1) establish DE&I investment and commitment among its membership; 2) understand the depth of DE&I practices among its member companies; 3) be able to provide guidance and insights to members as a trusted industry repository of information; and 4) inform the PC industry on advocacy and reputational positioning on DE&I issues at the local, regional, and national levels.

Dr. Nunery noted that the DE&I catalog assessed and captured aggregated P/C insurance DE&I practices on a voluntarily basis from 52 different organizations and a number of small, medium, and large companies based on direct premiums written. The catalog captured information on diversity, market served, employee bases, geography, size, and infrastructure. Dr. Nunery reviewed slides showing how the participating companies have adopted and implemented DE&I practices.

Dr. Nunery noted that DE&I is an emerging discipline; just a few years ago no one was really talking about it as a professional practice or approach, and these practices vary depending on the company’s clients, the board makeup, who the employees are, and the adoption rate. In essence, there is a mixture of results, and the larger companies, those with 1 billion or more direct premiums written, tend to have a deeper embedding likely because they have the infrastructure to do so. Dr. Nunery said if DE&I is embedded as either a core value or strategic element, it should go to a depth that includes personal accountability. Regarding DE&I alignment to objectives and compensation, he said 73% of companies did not have DE&I metrics included as part of organizational key performance indicators, and 85% have not done that in terms of compensation. He said the more executives and managers that are measured on DE&I practices, the more progress will be made.

Dr. Nunery went on to cover conducting and responding to employee surveys, recruiting challenges in hiring practices, and having a chief diversity office on staff with the authority to ensure that implementation moves forward and DE&I is embedded. Dr. Nunery talked in more detail about recruitment, retention policies and practices, and the importance of sharing information and practices. He said the challenge is putting diversity into practice and measuring outcomes. Regarding diverse recruiting
strategies, he said a big challenge is making insurance a destination students and career changers should be aware of. It is important to quantify recruiting practices and efforts by doing things such as asking interviewed candidates and hiring managers for feedback. Dr. Nunery concluded with the impact and engagement of DE&I on governance and boards of directors by sharing the importance of bringing board members, managers, executives, and commissioners into the conversation so there is a sense of what can be accomplished beyond hiring diverse employees and engaging every community so they feel a part of what is being done.

b. BCBSIL

Harmony Harrington (BCBSIL) said the Health Care Service Corporation (HCSC), which includes BCBSIL, supports an environment where all 24,000 employees and nearly 17 million members and community members should feel valued, empowered, and recognized for their unique talents, perspectives, and differences. DE&I really permeates all areas of the company and is part of the fabric of how the company has been built.

Ms. Harrington went on to share more about HCSC’s DE&I efforts. She said all HCSC employees complete an annual DE&I education course designed to meet employees where they are in their journey and build each year. The HCSC also offers a monthly speaker series with topics that include how to be an inclusive ally, what the difference is between equity and equality and why it matters, and even generational diversity at work. Ms. Harrington said BCBSIL continues to advance its ability to collect data internally and create diverse pipelines through annual talent reviews and succession planning efforts. She shared metrics of the diverse workforce. She shared more about employee-initiated business resource groups where employees participate in mentoring, develop professionally, educate the company on culture, and get involved in the community. She talked about BCBSIL efforts in Chicago opening two multipurpose community centers in partnership with local nonprofit organizations offering employee workspace and a community health and wellness hub, as well as launching a high school student development program with local nonprofits providing mentorship and job shadowing designed to address social determinants of health, including education, access, and equity economic stability and emotional and social support.

Ms. Harrington went on to talk about BCBSIL efforts addressing health equity, cultural competency, and implicit bias in health care. BCBSIL created the Institute for Physician Diversity (IPD) to strategically partner the payer with academic medical schools, teaching hospitals, and nonprofit associations to contribute to the systematic increase in the number of underrepresented minority physicians through innovative alliances and collective accountability with medical schools, graduate medical education programs, and other medical education stakeholders. Ms. Harrington said BCBSIL also developed the Health Equity Hospital Quality Incentive Pilot Program with the goal to improve care and quality by reducing racial and ethnic health disparities for members who get care at participating health systems that demonstrate a commitment to pursuing health equity and reducing health disparities for members served at the hospital. She said other BCBSIL health equity work with providers includes grants awarded to organizations to support health care organizations and hospitals in eliminating an identified health care disparity in their local community, as well as BCBSIL-funded cultural competency and implicit bias education, including incentives for value-based care arrangements to complete the trainings.

Ms. Harrington said BCBSIL is focused on and committed to not only the physical health improvement of communities, but also the economic health improvement; understanding an individual's geography can also determine their best health. She provided examples of community engagement like health education and outreach teams, employee engagement through volunteerism, the neighborhood community centers, and community grants and sponsorship supporting frontline community organization that support access to care, shelters, behavioral health care, maternal health supports, and COVID-19 health education and access.

Commissioner Lara noted the Special Committee has seen a language barrier in terms of access to health care, especially for immigrant communities that do not feel comfortable speaking in English or have the translation. He asked what strategies BCBSIL is implementing to be able to eliminate that language barrier.

Ms. Harrington noted that from a BCBSIL perspective, it has member facing customer advocates who speak or help translate in a variety of languages to best serve diverse members. From a community perspective, BCBSIL partners with nonprofit local organizations on the ground that can help educate and support community members on their health journey. For the community centers, BCBSIL hired from the community, with employees who speak Spanish and can work with Spanish speaking community members.
c. **Zurich**

Jose Ramos (Zurich) noted that in conversations about race and insurance, it is important to talk about representation. He said within the actuarial profession there is not a lot of black and Hispanic representation, specifically it is a combined less than 5%, and the representation of people of color in the insurance industry drops off at progressive levels of leadership. He said as he advanced in his career, it was very rare for him to work with colleagues who were black or Hispanic or who had his background or looked like him.

Mr. Ramos went on to talk about Zurich’s diversity and inclusion efforts, which includes an Executive Diversity and Inclusion Council chaired by the chief executive officer (CEO), a DE&I office, nine employee resource groups, and DE&I councils within different business units in the organization. He said Zurich is continuing to make progress on DE&I and is focused on strategically aligning and connecting DE&I efforts across the organization to maximize impact. He said Zurich is looking to embed DE&I throughout the organization. For employees, Zurich has leadership programs with a focus on diverse representation, development programs at mid-career levels, and an apprenticeship program for employees that are starting out their insurance career. Mr. Ramos said to accelerate progress, Zurich is looking to have greater levels of accountability in the business units and leadership across their organization.

Mr. Ramos concluded his remarks talking about representation, transparency, and metrics measuring progress. Regarding transparency, he said Zurich released to employees and externally gender, race, and ethnic representation at different levels of the organization, including senior leadership and management. In terms of analytics metrics insights, he said Zurich is focused on turning data into insights and having an evidence-based approach where it can prove or disprove assumptions based on a combination of quantitative and qualitative evidence allowing the organization to focus on the behaviors that lead to meaningful change. He said Zurich will keep working to understand the trends, patterns, and drivers to better understand the different dimensions of diversity and trends that Zurich is seeing in representation.

Commissioner Altmaier noted that CEJ and NAMIC had submitted additional comments that are available on the website.

Having no further business, the Special (EX) Committee on Race and Insurance adjourned.
The Information Systems (EX1) Task Force met Nov. 18, 2021. The following Task Force members participated: Ricardo Lara, Chair, represented by David Noronha (CA); Kathleen A. Birrane, Vice Chair, represented by Paula Keen (MD); Lori K. Wing-Heier represented by Anna Latham (AK); Alan McClain represented by Letty Hardee (AR); Michael Conway represented by Peg Brown (CO); Trinidad Navarro represented by Tim Li (DE); Colin M. Hayashida (HI); Sharon P. Clark represented by Satish Akula (KY); Chlora Lindley-Myers, Cynthia Amann, and Jo LeDuc (MO); Barbara D. Richardson (NV); Judith L. French represented by Tynesia Dorsey (OH); Cassie Brown represented by Luke Bellsnyder (TX); and Scott A. White represented by Vicki Ayers and Trish Todd (VA). Also participating were: Bud Leiner (AZ); Rebecca Smid (FL); Tate Flott, Brenda Johnson, and Linda Scott (KS); Bruce Matlock (LA); Laurie Scully (ND); Rachel Chester (RI); Joseph Javier (SC); and Chad Thompson (UT).

1. **Adopted its Summer National Meeting Minutes**


2. **Received an IT Operational Summary Report**

Scott Morris (NAIC) highlighted several sections included in the Information Technology (IT) Operational Report received by the Task Force members. The report provides updates on technology initiatives at the NAIC, upcoming improvements, impacts to state technology, new offerings from the NAIC, and general updates on the activities of the NAIC technology team.

   a. **Product Highlights**

The State Based Systems (SBS) team is focusing on new state implementations. Two states went live successfully: 1) Vermont on Aug. 17 (warranty period has completed); and 2) Connecticut on Nov. 8. Work is underway to implement Kansas in January 2022, Massachusetts in February 2022, and Hawaii in the third quarter of 2022. Additionally, a high probability state is in contract negotiations for June 2022.

Other key product highlights include:

- The first phase of the System for Electronic Rates & Forms Filing (SERFF) Modernization project is complete. Key outputs included a future state architectural diagram with the proposed set of tools and a seven-stage implementation plan. Next steps with the Oversight Group are to: 1) demonstrate the sampling of features developed during the project; 2) share the timeline, costs, and tooling; and 3) discuss options for moving forward.
- The Structured Securities (STS) platform in the Automated Valuation Service Plus (AVS+) was updated to enable 12,745 residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS) to receive an NAIC designation instead of price breakpoints to determine the designation. This new information will be available in the year-end 2021 file.
- Four of the five cloud environments have been migrated to Amazon Web Services (AWS) from the NAIC data center. The fifth environment (Production) is planned for migration on Dec. 4.

   b. **Innovation and Technology**

The Regulatory Data Collection (RDC) system continues to evolve to meet the ever-increasing data collection needs of state insurance regulators.

- In September, RDC collected data for the 2018 and 2019 principle-based reserving (PBR) data submissions due on Sept. 30. Nearly 213 million records were processed for these two large submissions, most of which were submitted on the last two days of the month. One of the larger files, with more than 7 million records, was processed in approximately 15 minutes. Recent system performance enhancements and the ability to instantly scale up computing resources in the cloud positioned RDC well to meet this record demand with relative ease.
• Other recent enhancements have drastically decreased the time needed to set up a new data call while reducing the reliance on Information Technology Group (ITG) technical staff.

The Center for Insurance Policy and Research (CIPR) team joined with the NAIC’s Legal Division to build a Tableau dashboard tool to visualize and compare the NAIC’s Insurance Data Security Model Law (#668) with the laws as adopted by each state. There are about 190 NAIC model laws and many versions adopted by state legislatures with varying degrees of differences to the original model. The tool allows state insurance regulators to see similarities and deviations from the model language and view a side-by-side comparison of sections of the model. The team has plans to build out additional dashboards for other NAIC models.

On Sept. 1, ITG hosted the annual 2021 NAIC Demo Day event. Demo Day is as an opportunity to spread awareness of new technology uses at the NAIC and provide a forum for staff to present their exciting new work to leadership and peers. This two-and-a-half-hour virtual event was attended by staff across the organization and consisted of nine presentations, each approximately 15 minutes in length.

3. Received a Portfolio Update and Project Status Reports

Sherry Stevens (NAIC) reported on the project portfolio. As of November, the NAIC’s technical project portfolio includes 21 active technical projects. Two projects completed since the last report.

Having no further business, the Information Systems (EX1) Task Force adjourned.
LIFE INSURANCE AND ANNUITIES (A) COMMITTEE

Life Insurance and Annuities (A) Committee Dec. 15, 2021, Minutes................................................................. 6-2
Accelerated Underwriting (A) Working Group Dec. 6, 2021, Minutes (Attachment One)........................................ 6-5
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Date: 12/20/21

Life Insurance and Annuities (A) Committee
San Diego, California
December 15, 2021

The Life Insurance and Annuities (A) Committee met in San Diego, CA, Dec. 15, 2021. The following Committee members participated: Glen Mulready, Vice Chair (OK); Jim L. Ridling (AL); Karima M. Woods represented by Philip Barlow (DC); Doug Ommen represented by Kim Cross (IA); Dean L. Cameron represented by Randy Pipal (ID); Vicki Schmidt (KS); James J. Donelon represented by Tom Travis (LA); Barbara D. Richardson (NV); Adrienne A. Harris represented by My Chi To (NY); Judith L. French represented by Jana Jarret (OH); Elizabeth Kelleher Dwyer (RI); Carter Lawrence represented by Brian Hoffmeister (TN); and Mark Afable represented by Nathan Houdek and Richard Wicks (WI). Also participating was: Mike Boerner (TX).

1. **Adopted its Summer National Meeting Minutes**

   Director French made a motion, seconded by Mr. Travis, to adopt the Committee’s Aug. 16 minutes (see NAIC Proceedings – Summer 2021, Life Insurance and Annuities (A) Committee). The motion passed unanimously.

2. **Adopted the Reports of its Working Group and Task Force**

   Director French made a motion, seconded by Mr. Travis, to adopt the following reports: the Accelerated Underwriting (A) Working Group, including its Dec. 6 minutes (Attachment One); and the Life Actuarial (A) Task Force. The motion passed unanimously.

3. **Received a Memorandum from the Life Actuarial (A) Task Force and the Valuation Analysis (E) Working Group on the FSAP Recommendation.**

   Commissioner Mulready explained that Mr. Boerner authored a memorandum as chair of the Life Actuarial (A) Task Force and the Valuation Analysis (E) Working Group to the Life Insurance and Annuities (A) Committee following up on a recommendation in the 2020 Financial Sector Assessment Program (FSAP) report regarding actuarial resources. The memorandum explains that having the necessary actuarial support for principle-based reserving (PBR) is important, and to that end the NAIC has added seven actuaries to its staff to help with PBR, mostly just to help PBR work as it was designed. Commissioner Mulready said the memorandum from Mr. Boerner indicates appreciation for the resources provided and states that if more resources are needed, NAIC leadership will be notified. Commissioner Mulready explained that the Committee is receiving this memorandum and is committed to monitoring how things are developing with PBR.

4. **Adopted the Life Actuarial (A) Task Force’s 2022 Proposed Charges**

   Mr. Boerner summarized the Life Actuarial Task Force’s 2022 Proposed charges. He explained that the charges are largely unchanged from 2021 and only make necessary extensions to the time frames for completing the charges.

   Birny Birnbaum (Center for Economic Justice—CEJ) commented that he would like to see actuaries move away from having charges addressing consumer-facing issues, like the Indexed Universal Life (IUL) Illustration (A) Subgroup charge to: Monitor the results and practices of IUL illustrations following implementation of Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold On or After December 14, 2020 (AG 49-A). Provide recommendations for consideration of changes to Life Insurance Illustrations Model Regulation (#582) to the Life Actuarial (A) Task Force, as needed.

   Mr. Birnbaum said he wrote a comment letter suggesting that the Life Insurance and Annuities (A) Committee adopt a new charge to broadly look at issues involving life insurance illustrations.

   Director French made a motion, seconded by Mr. Travis, to adopt the Life Actuarial (A) Task Force’s 2022 proposed charges. (see NAIC Proceedings – Fall 2021, Executive (EX) Committee and Plenary, Attachment Three). The motion passed unanimously.
5. **Adopted Revisions to AG 25**

Mr. Boerner said that revisions to *Actuarial Guideline XXV—Calculation of Minimum Reserves and Minimum Nonforfeiture Values for Policies With Guaranteed Increasing Death Benefits Based on an Index* (AG 25) pertain to very specific types of life insurance products, which include pre-need funeral policies and other small dollar policies with guaranteed increasing death benefits tied to a cost of living index. He said the revisions include the removal of the fixed 4% nonforfeiture interest rate floor to align AG 25 with the *Valuation Manual*.

Director French made a motion, seconded by Commissioner Schmidt, to adopt the revisions to AG 25 *(see NAIC Proceedings – Fall 2021, Executive (EX) Committee and Plenary, Attachment Five)*. The motion passed unanimously.

6. **Adopted the 2022 GRET**

Mr. Boerner explained that the development and adoption of the Generally Recognized Expense Table (GRET) is an annual process to provide expenses that are used by a significant percentage of life insurance companies in their life insurance illustrations pursuant to the *Life Insurance Illustrations Model Regulation* (#582). As in previous years, the Society of Actuaries (SOA) Committee on Life Insurance Company Expenses submitted its GRET analysis to the Life Actuarial (A) Task Force for the upcoming year. The SOA followed the same methodology in developing the 2022 GRET as last year for the 2021 GRET.

Commissioner Schmidt made a motion, seconded by Superintendent Dwyer, to adopt the 2022 GRET *(see NAIC Proceedings – Fall 2021, Executive (EX) Committee and Plenary, Attachment Four)*. The motion passed unanimously.

7. **Adopted its 2022 Proposed Charges**

Commissioner Mulready explained that the 2022 proposed charges of the Life Insurance and Annuities (A) Committee were included in the meeting materials and had been posted on the Committee web page since Nov. 15. He said that the proposed charges are largely unchanged from the 2021 charges and reflect the working groups and their charges that were disbanded during 2021. He said the proposed 2022 charges also include an update to the Annuity Suitability (A) Working Group charge to reflect that the Working Group is continuing its work on a frequently asked questions (FAQ) document.

Commissioner Mulready explained that there were a few issues with the charges for the Committee to discuss. He reminded the Committee that at the Summer National Meeting, it asked Mr. Wicka, chair of the Life Insurance Illustration Issues (A) Working Group, to draft a “chair report” to guide the Committee in discussing the future of the Working Group and its charge. Additionally, Mr. Birnbaum submitted comments on the proposed charges.

Commissioner Mulready said the chair report (Attachment Two) is included in the meeting materials and was posted along with the Committee’s proposed charges on Nov. 15. He explained that the chair report includes an overview of the Life Insurance Illustrations Issues (A) Working Group’s history and progress to date. He said the report also includes the chair’s recommendations that the Committee adopt the “chair report” as the final report of the Working Group and disband the Working Group. The report explains that the chair report will be part of the official record in the *NAIC Proceedings*, making the revisions the Working Group has developed to date available for individual states to consider when exploring the possibility of enacting a summary disclosure requirement.

Commissioner Mulready said that NAIC funded consumer representative Brenda J. Cude (University of Georgia) and Mr. Birnbaum commented on the chair report. Commissioner Mulready explained that Ms. Cude wrote in support of keeping the Working Group and made four points in support of her view: 1) well-crafted disclosures are helpful to consumers, and consumer testing could ensure the policy overview is helpful; 2) states may be laboratories for policy change, but not typically for the development of consumer disclosures like the policy overview; 3) it is not clear that continuing with the Working Group is not supported by a sufficient number of the NAIC members; and 4) the templates are too unfinished to be picked up by the states. There needs to at least be an explanation of the purpose of the templates and drafting notes to indicate where the information should be specific to the policy.

Commissioner Mulready said that Mr. Birnbaum submitted two comment letters—one on the 2022 proposed charges and the other on the chair report. On the 2022 proposed charges, Mr. Birnbaum suggested: 1) creating a new charge to review existing NAIC models that address life insurance illustrations in order to develop consistent content and consumer protection principles throughout; and 2) retaining the substance of the Life Insurance Illustration Issues (A) Working Group, but renaming the group and revising the charge to develop a policy overview document to replace the policy summary in the *Life Insurance Disclosure*
Model Regulation (#580). He explained that Mr. Birnbaum’s second letter was addressing the chair report and urged the Committee to retain the revised charge as outlined in his comment letter on the proposed charges.

Ms. To shared New York’s perspective on the recommendation in the chair report. She said the chair report was thoughtful, detailed, and useful. She said New York appreciates the consideration that led to the recommendation in the report to disband the Working Group and delete its charge, but New York is disappointed that such an important consumer protection issue did not generate the level of support necessary to move forward with the policy overview. She said the chair report highlights that specific issues had been identified with the documents used by insurers that hinder consumer understanding of life insurance products, which are complex. She said the report explained that in recognition of these issues, stakeholders coalesced around the idea of a short consumer-friendly overview that summarizes a policy’s key features, but that the same group of stakeholders could not reach consensus on the form of a summary or when it would be presented to consumers.

Ms. To said that New York does not believe that this is a good outcome for consumers. She said consumers should have clear, concise, accurate, and realistic descriptions and illustrations of the complex products they purchase, which is not a controversial position. She said there are obviously different ways of achieving that goal, but New York thinks that a uniform policy overview would have been an important step in the right direction. She mentioned that the chair report invites states to play their role as the laboratories for policy change and experiment with the disclosures and disclosure model. Ms. To said that New York intends to take up that invitation.

Mr. Birnbaum offered some comments in opposition to disbanding the Working Group and its charge. He said that it is critical to understand that illustrations are not only the primary tool used by producers to sell products, but also they determine the structure and complexity of products. He said this is known based on insurer behavior after Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies With Index-Based Interest to Policies Sold on or After December 14, 2020 (AG 49) was changed and companies changed their products in order to maintain high accumulation values.

Mr. Birnbaum also questioned the assertion in the report that there was a lack of consensus. He said there was little representation on the Working Group in terms of the number of states. He said he cannot understand why there was a lack of consensus on the issue of providing consumers with a buyer’s guide and a better summary overview for shopping prior to purchase. He said the issue that seems to stymie consensus is that consumers should not get information necessary to make a purchase decision prior to the purchase.

He also said the assertion that the states could take the work product developed so far, when it is unadopted and opposed by industry, does not make sense. He said unfinished Working Group products is not a recipe for uniform and consistent high-level consumer protection across the states. He said it is a recipe for disparate treatment across the states. He said that with leadership and support from the Committee, the policy overview could be completed expeditiously.

Commissioner Mulready mentioned that the Life Insurance Online Guide (A) Working Group does not have a chair. He said that if this continues to be a priority for the Committee, there needs to be a chair, or possibly co-chairs, and he asked for volunteers. He suggested perhaps Jennifer Cook (NAIC) could put together some information regarding the Working Group that might be helpful in recruiting a new chair.

Ms. Cross made a motion, seconded by Commissioner Schmidt, to revise the 2022 proposed charges as recommended in the chair report by adopting the chair report as the final work product of the Life Insurance Illustration Issues (A) Working Group and disbanding the Working Group and its charge (see NAIC Proceedings – Fall 2021, Executive (EX) Committee and Plenary, Attachment Three). The motion passed, with Mr. Barlow voting no.

Having no further business, the Life Insurance and Annuities (A) Committee adjourned.
The Accelerated Underwriting (A) Working Group of the Life Insurance and Annuities (A) Committee met Dec. 6, 2021. The following Working Group members participated: Mark Afable, Chair (WI); Grace Arnold, Vice Chair (MN); Jason Lapham (CO); Cynthia Amann (MO); Chris Aufenthie (ND); Lori Barron (OH); Elizabeth Kelleher Dwyer (RI); and Lichiou Lee (WA).

1. Discussed the Latest Draft of the Accelerated Underwriting Educational Report

Commissioner Afable explained that the purpose of the meeting is to discuss the comments received on the latest draft accelerated underwriting educational report dated Nov. 8 (Attachment One-A). He said the Working Group exposed the report on Nov. 8 for a public comment period ending Dec. 3. He added that the report is available on the Working Group’s web page.

Commissioner Arnold explained that this is the first time the entire report has been exposed for comment; although, parts of the report have been released previously and revised based on comments received. She said four comment letters on the Nov. 8 draft report were submitted from Birny Birnbaum (Center for Economic Justice—CEJ); Brendan Bridgeland (Center for Insurance Research—CIR); Sue Bartholf (American Academy of Actuaries—Academy); and David Leifer and Gabrielle Griffith (American Council of Life Insurers—ACLI).

Commissioner Arnold offered each of the commenters the opportunity to summarize their comment letters.

a. Center for Economic Justice

Mr. Birnbaum said his comment letter is lengthy, but he mentioned four specific points he wanted to highlight. First, he said the definition of accelerated underwriting used in the draft report is problematic. He said the report misses the key distinction between traditional underwriting and accelerated underwriting; i.e., the acquisition and use of non-traditional, non-medical data. He said it is not the use of predictive models or machine learning (ML) that distinguishes traditional underwriting from accelerated underwriting. He said the new regulatory oversight steps needed to protect consumers from unfair discrimination and racial bias are obscured by conflating non-traditional and non-medical information with predictive modeling, which has long been used in traditional underwriting.

Second, Mr. Birnbaum said categorizing data into traditional data, non-traditional data, and Fair Credit Reporting Act (FCRA) data is problematic. He said the FCRA protects data that falls in the other two categories and is not an appropriate third category of data. He suggested that the FCRA should be discussed in the context of providing a template for some of the regulatory changes and new consumer protections needed for accelerated underwriting.

Mr. Birnbaum said another shortcoming in the report is that the NAIC’s artificial intelligence (AI) principles are simply repeated, and there is no discussion on how to implement them. He said the purpose of the AI principles was to serve as the foundation for working groups to develop the application-specific regulatory guidance needed to operationalize those principles. He said the paper should make recommendations for specific regulatory actions (e.g., new uses of existing regulatory authorities and tools and new regulatory authorities) needed to ensure that the AI principles are implemented for accelerated underwriting.

Mr. Birnbaum also said he strongly disagrees with the suggestion in the report that market conduct examinations are sufficient to ensure that accelerated underwriting algorithms meet all the stated regulatory goals. He said market conduct examinations are not the appropriate tool to establish the new guidance needed for insurers’ use of big data and AI. He said there are no standards for market conduct examiners, nor are there existing metrics or data sources available to market analysts to trigger the types of concerns raised in the paper regarding racial bias or problems with data or algorithms. He said the recommendations in the paper need to be expanded. He said they are subject to misinterpretation due to their brevity.

Mr. Birnbaum referenced seven specific statutory and regulatory recommendations in his comment letter that he would like the Working Group to consider including in the paper:
1. Require life insurers to routinely file a list of the types, sources, and uses of non-medical data for life insurance marketing, underwriting, claim settlement, and antifraud.

2. Require life insurers to routinely file and state insurance regulators to routinely review algorithms used for marketing, underwriting, claims settlement, and antifraud in the same manner that auto and home insurers are required to file credit-based insurance scoring models.

3. Require that all data sources used by insurers meet the consumer protection requirements of the FCRA, including consent, disclosure, challenge, and correction.

4. Develop specific guidance and requirements for insurer testing of data sources and algorithms for actuarial soundness and protected class bias. (Look to the approach used by the New York Department of Financial Services [NYDFS] in the cited Circular 1.)

5. Recommend the development of guidance for life insurer collection and treatment of applicant data on race, ethnicity, and other demographic characteristics to assist insurers and state insurance regulators in assessing proxy discrimination and disparate impact based on protected class characteristics.

6. Develop and update guidance for third parties providing pricing algorithms to insurers. Absent oversight of vendors providing these collective-pricing or collective-claims settlement algorithms, the third-party algorithm provider may be engaging in prohibited antitrust and anti-competitive activities.

7. Request that the Market Regulation and Consumer Affairs (D) Committee direct the Market Conduct Annual Statement Blanks (D) Working Group to complete its work on the accelerated underwriting revisions to the Life Insurance Market Conduct Annual Statement (MCAS) line independently of the work of the Accelerated Underwriting (A) Working Group.

Mr. Aufenthie asked Mr. Birnbaum to explain his understanding of the difference between non-medical data and non-traditional data. Mr. Birnbaum explained that non-medical data, like credit information, is used in traditional underwriting; but this same data, or variations of this data is broken down in a much more granular level to become non-traditional data. Another example is biometric screening at one end and facial recognition. Mr. Aufenthie asked Mr. Birnbaum whether he agrees with the statement that process is just as important as the data. Mr. Birnbaum replied that he mostly agrees with the statement. He said the use of new data sources necessarily requires the use of predictive models and AI. He said the new data is not used to predict mortality, like traditional data, but to achieve the same outcomes as traditional underwriting. He said this is why focusing on predictive modeling misses the sources and uses of new types of data. However, he said focusing on the sources and types of new data will necessarily lead to looking at the predictive models and ways companies are using this data.

b. Center for Insurance Research

Mr. Bridgeland said he supports Mr. Birnbaum’s comment letter and the detailed analysis he provided regarding the numerous consumer issues arising from the use of accelerated underwriting programs. Mr. Bridgeland explained that his comments focus on making editorial and language suggestions designed to provide a more balanced tone and support the purpose of the paper as an “educational report” rather than an “advocacy piece.” He said analysis of the benefits of accelerated underwriting to consumers is ongoing and some of his suggested revisions are intended to support this reality. Some of his other suggested revisions clarify that not all jurisdictions allow the use of behavioral data or credit scores, and other comments question the meaning of terms used like assessor data or voter information. Mr. Bridgeland also questioned the inclusion of possible data sources, like voice recognition to determine smoker status, as being untested scientifically, and the facial recognition, given the evidence of racial bias in its use that has come to light. Karl Ricanek (Lapetus Solutions Inc.) explained that facial recognition is the technology that was at issue in the film “Coded Bias,” but there is also facial analytics, which is different, and perhaps the report should make the distinction.

c. American Academy of Actuaries

Ms. Bartholf summarized the Academy’s comment letter. She said the Academy supports the general direction of the draft report, but it is concerned that some of the recommendations may be challenging to implement from a practical standpoint, and others may require more detail in order to ensure that they support the Working Group’s charge.
Ms. Bartholf also said the Academy observed that many of the presentations provided to the Working Group included consumer benefits of accelerated underwriting, but the paper tends to focus on the potential issues. She said the Academy believes the paper might be more balanced if it included more discussion of the favorable impacts to the consumer.

Ms. Bartholf also said the Working Group heard from a variety of stakeholders regarding different practices and with different perspectives, but not all of the information provided should be generalized across the life insurance industry. She said the Academy comment letter includes some specific suggested revisions throughout the paper to avoid overgeneralizations.

Ms. Bartholf said the Academy is concerned with the definition in the report. She said the definition conflates the general concept of accelerated underwriting and the use of data and predictive models in underwriting. She said data and predictive models are used in all forms of underwriting. She said the Academy recommends revisiting this definition and the use of these terms in the report.

Ms. Bartholf said the Academy questions the footnote reference to Actuarial Standard of Practice (ASOP) No. 12—Risk Classification (for All Practice Areas) in the bullet point “FCRA data may be used to predict mortality, but there may not be a reasonable explanation for that correlation.” She said the Academy does not see a relationship to ASOP No. 12, and it suggests quoting the applicable language or removing the reference.

d. American Council of Life Insurers

Mr. Leifer summarized the ACLI comment letter. He said the ACLI likes how the paper is developing and believes there is useful information contained in the current draft that should be helpful to state insurance regulators and stakeholders as accelerated underwriting evolves. He said the ACLI comment letter includes a few language tweaks that are self-explanatory. He said from a big picture perspective, the ACLI is concerned that there are some negative inferences about accelerated underwriting that have not happened. He said accelerated underwriting is an evolving area, but the report should be careful not to overgeneralize.

Mr. Leifer said the ACLI is concerned that in places throughout the paper, the types of data used in traditional underwriting versus accelerated underwriting are mischaracterized, as well as the types of data sources, combining those that are more typically or traditionally used with more novel ones that are not used with prevalence (if at all) by the life industry. He said the ACLI recommends emphasizing in the paper that while the technology is new, its risk for unfair discrimination should not be viewed differently than traditional underwriting. Peter Kochenburger (University of Connecticut School of Law) said it is essential to examine racial bias beyond traditional underwriting.

2. Discussed Next Steps

Commissioner Arnold explained that the ad hoc drafting group planned to meet and discuss the comments provided in detail. She said the plan is to revise the report and expose it for another public comment period prior to the 2022 Spring National Meeting.

Having no further business, the Accelerated Underwriting (A) Working Group adjourned.
DRAFT 11-8-21

Comments should be sent to jcook@naic.org by close of business Dec. 3, 2021

Accelerated Underwriting (A) Working Group
Ad Hoc Drafting Subgroup

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Introduction

In 2019, the National Association of Insurance Commissioners (NAIC) established the Accelerated Underwriting (A) Working Group to consider the use of external data and data analytics in accelerated life insurance underwriting, including consideration of the ongoing work of the Life Actuarial (A) Task Force on the issue and, if appropriate, draft guidance for the states. In addition, the 2021 charges of the Special Committee on Race and Insurance direct the working group to include an assessment of and recommendations, as necessary, regarding the impact of accelerated underwriting on minority populations. A more detailed procedural background can be found in the appendix. This paper is the output of over a year's work by regulators to understand the current state of the industry and its use of accelerated underwriting. It summarizes what the Working Group has learned over the past year, contextualizes that learning and the topic of accelerated underwriting within other NAIC work and standard regulatory product evaluation processes, and makes recommendations for regulators and insurers when evaluating accelerated underwriting.

Accelerated underwriting in life insurance may provide potential benefits to both consumers and insurers, if applied in a fair and non-discriminatory manner. In order to fairly deliver the benefits of more convenient and cost-effective processes, regulators and insurers should be guided by current law related to fair trade practices and unfair discrimination. Much of the discussion in this paper is framed in these general terms. The Working Group believes the charge to specifically address the impact on minority populations is included in these terms, and we have provided examples to illustrate the impact on minority populations. Future work products of the Working Group may address the charge from the Special Committee on Race and Insurance in more detail.

What is Accelerated Underwriting?

Throughout this paper, we use the term accelerated underwriting in life insurance. We propose the following as a definition:

Accelerated underwriting in life insurance is a process to replace traditional underwriting and allow some applications to have certain medical requirements, e.g., paramedical exams and fluid collection, waived. The process generally uses predictive models or machine learning algorithms to analyze data pertaining to the applicant, which includes both traditional and non-traditional underwriting data provided by the applicant directly, as well as data obtained through external sources.

Predictive models examine data sets for patterns to predict and assign the risk category, e.g., a model developer enters data points (potentially hundreds of thousands), and the model finds patterns and identifies future predictions of risk and assigns an insured to a risk category.¹ Machine learning algorithms are a process or set of

¹ For a more detailed discussion of predictive models in property and casualty insurance, see the Casualty Actuarial and Statistical (C) Task Force Regulatory Review of Predictive Models White Paper, Adopted by the Property and Casualty Insurance (C) Committee on Dec. 8, 2020.
rules executed to solve an equation\(^2\), e.g., a life insurance underwriter uses a set of rules to place an individual insured in a particular risk category. The ‘learning’ part of machine learning means that those programs change how they process data over time, much as humans change how they process data by learning. Machine learning often falls into two groups: supervised or unsupervised. The difference between the two is whether the program is directed to analyze patterns or is self-automated.

Predictive models or machine learning trains a system to make judgments when exposed to data that is unfamiliar to serve as a substitute for human-centric decision making. These are both subcategories of artificial intelligence, which should not be confused with a static rule-based algorithm.

Life insurance underwriting is the process of determining eligibility and classifying applicants into risk categories to determine the appropriate rate to charge for transferring the financial risk associated with insuring the applicant. Traditional life insurance underwriting involves assessing the applicant’s physical health, then determining whether an applicant is eligible for coverage and the risk class to which that individual belongs. Accelerated underwriting relies on predictive models or machine learning algorithms to perform some of the tasks of an underwriter. The exact parameters of the application of accelerated underwriting vary by insurer.

Presentations made to the Working Group indicated that life insurers use accelerated underwriting in primarily two ways: 1) Accelerated underwriting is used to triage applicants, where unsuccessful applicants are re-routed to traditional underwriting, and successful ones continue through the accelerated underwriting process; or 2) Accelerated underwriting is used to rate applicants based on risk categories.

Most predictive or machine learning algorithms used in life insurance underwriting are in their second or third generation. The COVID-19 pandemic sped up the adoption of accelerated underwriting in the industry as both consumers and insurers looked for options to purchase and write policies that relied more on technology and involved less in-person contact. This has highlighted the need for ongoing monitoring of the machine learning algorithms—both their development and their uses in the marketplace.

Presentations made to the Working Group indicated that adverse underwriting decisions are sometimes reviewed by human underwriters. Companies presenting to the Working Group stated that the accelerated underwriting process is less cumbersome, costs less than traditional underwriting, improves the underwriting experience for consumers, shortens issue times, and increases policy acceptance rates.\(^3\)

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**General Discussion of Issues and Recommendations**

Increasing automation of life insurance underwriting presents new regulatory challenges. Regulators must ensure that the process is **fair, transparent, and secure**. With regard to accelerated underwriting in life insurance:

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\(^2\) The Big Data and Artificial Intelligence (EX) Working Group developed a survey to conduct analysis on private passenger automobile (PPA) insurers’ use and governance of big data, as used in an artificial intelligence (AI) and machine learning (ML) system. The survey is being conducted under the examination authority of Connecticut, Illinois, Iowa, Louisiana, Nevada, North Dakota, Pennsylvania, Rhode Island, and Wisconsin. This analysis will help inform the Working Group in completing its long-term goals of developing guidance and recommendations to update the existing regulatory framework for the use of big data and AI, including how to monitor and oversee the industry’s compliance with the NAIC’s AI principles. The survey work may be expanded to other lines of insurance as needed, such as life insurance and homeowners insurance. For the purposes of the survey only, AI/ML is defined as, “an automated process in which a system begins recognizing patterns without being specifically programmed to achieve a pre-determined result.” This is different from a standard algorithm that consists of a process or set of rules executed to solve an equation or problem in a pre-determined fashion, and evolving algorithms are considered a subset of AI/ML.


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insurance, this concern pertains to input data, the predictive model or machine learning algorithm, and the results of the process. One particular challenge is the potential for unfair discrimination. Due to the fact that accelerated underwriting relies on predictive models or machine learning algorithms, it may lead to unexpected or unfairly discriminatory outcomes even though the input data may not be overtly discriminatory. It is critical to test the conclusions up front, on the back end, as well as, randomly, to ensure the machine learning algorithm does not produce unfairly discriminatory ratings. Testing can also be important in determining if a machine learning algorithm is accurate across demographic categories.

Such scrutiny is especially important when behavioral data is utilized. Behavioral data may include gym membership, one’s profession, marital status, family size, grocery shopping habits, wearable technology, and credit attributes. Although medical data has a scientific linkage with mortality, behavioral data may lead to questionable conclusions as correlation may be confused with causation.

**Recommendations**

Consistent with the artificial intelligence principles approved by the NAIC in 2020⁴, the use of accelerated underwriting in life insurance should be fair and transparent. Companies should be accountable for operating in compliance with applicable laws, and the process and data used needs to be secure. To accomplish these objectives, regulators should dialogue with life insurers and third-party vendors to determine if consumer data is being used in problematic or unfair ways or generating unfair outcomes.

Insurers and other parties involved in accelerated underwriting in life insurance should:

- Take steps to ensure data inputs are transparent, accurate, reliable, and the data itself does not have any unfair bias.
- Ensure that the external data sources, algorithms or predictive models are based on sound actuarial principles with a valid explanation or rationale for any claimed correlation or causal connection.
- Ensure that the predictive models or machine learning algorithm within accelerated underwriting has an intended outcome and that outcome is being achieved.
- Ensure that the predictive models or machine learning algorithm achieve an outcome that is not unfairly discriminatory.
- Be able to provide the reason(s) for an adverse underwriting decision to the consumer and all information upon which the insurer based its adverse underwriting decision.
- Take steps to protect consumer privacy and ensure consumer data is secure.
- Have a mechanism in place to correct mistakes if found.
- Produce information upon request as part of regular rate and policy reviews or market conduct examinations.

**Input data**

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⁴ See National Association of Insurance Commissioners (NAIC) Principles on Artificial Intelligence (AI) – Fair and Ethical a. AI actors should respect the rule of law throughout the AI life cycle. This includes, but is not limited to, insurance laws and regulations, such as those relating to trade practices, unfair discrimination, access to insurance, underwriting, privacy, consumer protection and eligibility practices, rate making standards, advertising decisions, claims practices, and solvency. b. Consistent with the risk-based foundation of insurance, AI actors should proactively engage in responsible stewardship of trustworthy AI in pursuit of beneficial outcomes for consumers and to avoid proxy discrimination against protected classes. AI systems should not be designed to harm or deceive people and should be implemented in a manner that avoids harmful or unintended consequences and corrects and remediates for such consequences when they occur.
Predictive models or machine learning algorithms within the accelerated underwriting process rely heavily on data and multiple variables. Examples of the variables used by some accelerated underwriting models include customer disclosures, prescription history, digital health records, credit attributes, medical information bureau data, public records, motor vehicle reports, smartphone apps, consumer activity wearables, claim acceleration tools, individual consumer risk development systems, purchasing history, behavior learned through cell phone usage, and social media because accelerated underwriting relies on predictive models or machine learning algorithms, it may lead to unexpected or unfairly discriminatory outcomes, even though the input data may be facially neutral.

### Traditional Data

Traditional data used in life insurance underwriting includes data collected through a traditional underwriting process. This data may include the following:

- Application data, e.g., medical records, prescription questions, vocation questions, financial profile
- Tele-interview
- Medical records
- Data from the Medical Information Bureau (MIB) \(^5\)
- Data from Motor Vehicle Records
- Prescription drug history
- Public records, e.g., criminal records, bankruptcy records, civil litigation, etc.
- Paramedical or medical exam, including EKG’s in some instances
- Fluids, e.g., blood, urine, swab/saliva test to determine tobacco usage
- Financial and tax information

Considerations for use of Traditional Data

- Traditional data has a long and established history in the life insurance industry. Carriers, producers, and consumers are generally familiar with the process.
- Traditional data has a history of usage by insurance carriers. Trained underwriters and producers have years of experience and often understand the process well.
- The relationship of the traditional data elements to the risk is well established and consumers understand how the elements impact their risk classification or premium charged.
- State statutes and case laws were developed based on the use of traditional data containing consumer protections created under the assumption that this was the type of data collected or reviewed during an underwriting process.
- Presentations made to the Working Group represented that time and costs associated with obtaining and reviewing traditional data are significant.

### FCRA Data

Data is subject to the federal Fair Credit Reporting Act (FCRA), which means applicants:

1. Should have a right to be told if this information is used to deny insurance, and
2. Have the ability to request the data a consumer reporting agency is providing to an insurer.

Considerations for use of FCRA Data

- FCRA data is readily available.
- FCRA data is updated regularly.

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\(^5\) This data is subject to the Fair Credit Reporting Act (FCRA).
• FCRA data is already used in property/casualty lines of business.
• There is existing regulation and oversight by the Federal Trade Commission (FTC) and Consumer Financial Protection Bureau (CFPB).
• Not all FCRA data is useful/relevant to life insurance underwriting.
• If there is a dispute about findings, a consumer will have to obtain additional information and formally dispute these findings.
• FCRA data is extensive and accessing such data may result in access to non-usable credit attributes. In other words, significantly more data may be collected than is needed to determine risk.
• As additional rating factors are introduced via insurance scores or with specific data elements, unfair discrimination, including disparate impact, may be introduced or amplified.
• FCRA data may be used to predict mortality, but there may not be a reasonable explanation for that correlation.6

Nontraditional Data

Nontraditional data used in life insurance underwriting may include the following:
• Public records, e.g., assessor data, genealogy records, criminal records, court filings, voter information
• Property/casualty data from adjacent carrier(s)
• Marketing and social data, e.g., shopping habits, mortgage amount/lender, occupation and education, and social media, etc.
• Professional licenses
• Voice recognition used to determine smoking status
• Facial recognition
• Wearable devices

Considerations for use of Nontraditional Data

- Nontraditional data may be used to predict mortality, but there may not be a reasonable explanation for that correlation.
- As additional rating factors are introduced via insurance scores or with specific data elements, disparate impact across and between demographic groups may be introduced or amplified.
- Nontraditional data does not have the same consumer protections as FCRA and traditional data. For example:
  - There may not be a clear path for consumers to know how data affected their application and how inaccurate data may be corrected.
  - The type and purpose of data accessed are not required to be disclosed to the consumer.
  - There may be privacy concerns about the extent of the use of nontraditional data.

Recommendations

Existing regulations apply to accelerated underwriting programs in the same way as traditional underwriting programs. State Departments of Insurance (DOIs) have broad regulatory authority to make inquiries into the processes and procedures of life insurers in order to investigate potential unfair trade practices. Complaints about underwriting practices are opportunities for DOIs to review a life insurer’s use of accelerated underwriting and data collection methods. Additional DOI actions may include market conduct and on-site examinations as appropriate under existing authority.

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6 See Actuarial Standards of Practice (ASOP) No. 12
Specifically, examiners may:
- Review the life insurer’s underwriting practices and underwriting guidelines during an examination or upon initial submission of the policy rates and forms and confirm the proper use of the data elements.
- Request that explanation provided to the consumer for any negative action taken by the life insurer adequately informs the consumer as to why a particular action was taken without the consumer having to make additional inquiries.
- Request information about source data regardless of whether the data or score is provided by a third party.

Form and rate reviewers may:
- Request that the life insurer provides information about how a predictive model or machine learning algorithm will be used.
- Consider requiring the filing of models used to analyze data.
- Consider questioning the extent to which data elements correlate to applicant risk.
- Request information about source data regardless of whether the data or score is provided by a third party.

Life insurers have a responsibility to understand the data they are using. To accomplish this, life insurers should conduct post-issue audits and data analysis. For example, analyses such as evaluating claims and lapse rates may be helpful. Life insurers and third-party vendors should ensure data inputs are accurate and reliable.

Life insurers and third-party vendors should ensure that the external data sources, algorithms, or predictive models are developed with sufficient internal controls and oversight and based on sound actuarial principles with a valid explanation or rationale for any claimed correlation and causal connection.

Data Privacy

Data privacy—a consumer’s ability to retain control over what data can be shared about them and with whom—is not a concern unique to accelerated underwriting in life insurance. Protecting consumer privacy is an issue across all lines of insurance and is the subject of the NAIC Privacy Protections (D) Working Group, formed in 2019 under the parent committee of Market Regulation and Consumer Affairs (D) Committee.

The Working Group’s charge is to review the state insurance privacy protections regarding the collection, use, and disclosure of information gathered in connection with insurance transactions, and make recommended changes, as needed, to certain NAIC models and other existing federal or state statutes. 7

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7 The Working Group has focused its reviews on the Insurance Information and Privacy Protection Model Act #670, and the Privacy of Consumer Financial and Health Information Regulation Model Act #672 – both drafted in response to the enactment of GLBA, and #668 – the Insurance Data Security Model Act, enacted in 2019/20. With a great deal of research assistance from NAIC Legal Staff, the Working Group prepared a gap analysis – upon which it continues to work. The Working Group is also reviewing the consumer data privacy protections other than those already in these models, such as the numerous provisions contained in federal acts such as the Fair Credit Reporting Act (FCRA), the Gramm-Leach Bliley Act (GLBA), the Health Insurance Portability and Affordability Act (HIPAA), Electronic Health Records (EHR), etc. The Working Group is also analyzing the various provisions of recently enacted legislation, such as California’s Consumer Privacy Act (CCPA) and its Consumer Data Privacy Regulation (CCPR), Virginia’s and Colorado’s recently enacted Consumer Privacy Protection laws, certain provisions of the European General Data Protection Regulation (GDPR), the NAIC’s Record Retention Model Regulation and the NAIC’s Unfair Claims Practice Model Act (UCPA). There are a lot of jurisdictional issues that remain to be sorted through.
The primary focus of the Working Group is on the six consumer data privacy rights or types of consumer data privacy protections identified in the NAIC’s Member adopted *Strategy for Consumer Data Privacy Protections* policy statement. The secondary focus is on issues such as notice requirements and standards, disclosure of information collected, disclosure of shared information, requirements to disclose sources of information, requirements to disclose business purposes, and a requirement to disclose third party involvement. The current assignments for the Working Group are intended to create a framework for the policy statement: defining the parameters of these consumer rights by offering suggested definitions, examples of consumer risks, and what may not be protected in federal laws or not covered under NAIC Model laws.

The Privacy Protections Working Group’s policy statement will address the following consumer privacy rights:

1) Right to opt-out of data sharing
2) Right to opt-in of data sharing
3) Right to correct information
4) Right to delete information
5) Right to data portability
6) Right to restrict the use of data

The Accelerated Underwriting (A) Working Group will continue to watch the work of this group. If at any point issues unique to accelerated underwriting arise, we will endeavor to address them in a future work product.

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8 For purposes of the Working Group’s paper, the use of the term “right” should be read as a basic protection, or, denoting access to making a request and not as a guarantee of having the requested right acted upon in the manner as the consumer requests.

9 For purposes of the Working Group’s paper there is a distinction between an individual’s data and information that results from the use of this data, e.g., the insurance score that results from the use of an algorithm.
Appendix A: Additional Procedural Background
At the 2019 NAIC Summer National Meeting, the Life Insurance and Annuities (A) Committee discussed a referral it had received from the Big Data (EX) Working Group. The Big Data Working Group had discussed the use of predictive models in accelerated underwriting in life insurance, instead of medical examinations and the collection of fluids. The Big Data Working Group agreed that the issue would be most appropriately addressed by the life insurance subject matter experts and voted to refer the issue of the use of external data and data analytics in accelerated underwriting in life insurance to the Life Insurance and Annuities (A) Committee (Committee).10

The Committee discussed the referral and acknowledged that there are a multitude of issues surrounding insurers’ use of data models and data analytics; issues that extend into many areas of insurance and overlap with the work of several groups at the NAIC. In addition to the Big Data (EX) Working Group, there is the Innovation and Technology (EX) Task Force, the Artificial Intelligence (EX) Working Group, the Casualty Actuarial and Statistical (C) Task Force, and the Privacy Protections (D) Working Group. The Life Actuarial Task Force was also looking at the use of accelerated underwriting in life insurance from an actuarial perspective, including looking at any potential impact on insurer solvency.

The Committee agreed that an effort to delve into accelerated underwriting in life insurance would need to be narrowly focused while taking into account the work of these other NAIC groups touching on the same topic.

Robert Muriel (IL) chaired the Working Group and Grace Arnold (MN) was the vice-chair. The following were Working Group members: Jason Lapham (CO); Russ Gibson (IA); Rich Piazza (LA); Cynthia Amann (MO); Rhonda Ahrens and Laura Arp (NE); Ross Hartley and Chris Aufenthie (ND); Lori Barron (OH); Elizabeth Kelleher Dwyer (RI); Lichiou Lee (WA); Mark Afable (WI). In January 2021, Commissioner Afable became chair of the Working Group and the rest of the membership remained the same.

The Working Group met for the first time on Oct 2, 2019, and developed a work plan to accomplish its charge. The work plan contemplated the Accelerated Underwriting (A) Working Group progressing through three phases with the goal of completing its charge by the 2020 Fall National Meeting. The first phase was focused on information-gathering. The second phase focused on identifying the issues and deciding on a work product, with the final phase devoted to drafting.

During the information gathering phase, the Working Group heard 15 presentations from varying stakeholders, including an academic (Professor Patrick Brockett11), insurance companies, consulting firms (Deloitte and Milliman), a consumer advocate (Birny Birnbaum—CEJ), the American Academy of Actuaries, lawyers from 2 Illinois law firms (Foley & Lardner and Edelson), a machine learning assurance company (Monitaur), and a data analytics company (Verisk). Several of the presentations were held in regulator-only meetings when requested by presenters in order to share proprietary and confidential company-specific information.

Regulators from the Working Group volunteered to participate in two ad hoc groups to tackle the second and third phases of its work plan: There was an ad hoc NAIC liaison group to ensure awareness of and coordination with any work, including guidelines or protocols, developed by other NAIC groups, past and present, that related to the Working Group. There was also an ad hoc drafting group that agreed to take the information gathered, identify issues, recommend and draft a work product for review and approval by the Working Group.

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11 Gus Wortham Chair in Risk Management and Insurance at the University of Texas at Austin and Editor, North American Actuarial Journal.
In November 2020, the ad hoc drafting group shared with the Accelerated Underwriting (A) Working Group a proposed draft outline for an educational report exploring accelerated underwriting in life insurance to provide guidance to regulators, industry, and consumer advocates, and other stakeholders. In February 2021, the ad hoc groups merged.


Artificial Intelligence/Machine Learning (AI/ML)

AI/ML describes an automated process in which a system begins recognizing patterns without being specifically programmed to achieve a pre-determined result. This is different from a standard algorithm in that an algorithm is a process or set of rules executed to solve an equation or problem in a pre-determined fashion. Evolving algorithms are considered a subset of AI/ML.

Artificial Intelligence / Machine Learning Systems include:

- Systems that adapt and adjust to new data and experience without manual human intervention.
- Systems that arrive at results for which the outcomes and the stepwise approach toward the outcomes were not configured in advance by a human programmer.
- Systems that dynamically respond to conditions in the external environment without the specific nature of such responses being known in advance to the designers of the systems.
- Systems that utilize neural networks and/or deep-learning algorithms, such as supervised, semi-supervised, and unsupervised learning algorithms.
- Systems that engage in automatic speech recognition, facial recognition, image recognition, text recognition, natural language processing, generation of customer-specific recommendations, automated customer communications (e.g., chatbots with non-preprogrammed prompts), autonomous or semi-autonomous vehicle operation or data gathering, or any other approach that does not require either preprogramming or a manual human intervention in every instance of an action or decision.
- Systems that automatically generate adaptive responses based on interactions with a consumer or third party.
- Systems that determine which data elements to rely upon, in a non-preprogrammed fashion, among a variety of possible alternatives.

Artificial Intelligence / Machine Learning Systems are not:

- Static “scorecards” that deterministically map consumer or other risk characteristics to treatments or decisions. (However, an AI/ML system may use the output of such static “scorecards” as input data for the AI/ML system to consider.)
- Systems with solely preprogrammed decision rules (e.g., “If A, then B” applied invariably in all situations).
- Tables of point or factor assignments in rating plans.
- Static rate making and/or predictive modeling methodologies, including linear regression, generalized linear modeling (GLM), or generalized additive modeling (GAM). Purely informational static databases, such as databases used to obtain reference amounts for claim settlements, or static databases pertaining to consumer characteristics or experience, regardless of the amount of information in the database. However, if AI/ML is used to create a static predictive model, that AI/ML system is considered within the scope of this survey.
- Deterministic “phone trees” that navigate consumers through pre-recorded voice prompts.
• Any approach that an insurer could have realistically utilized in the year 2000 or prior.

**AI/ML Use Descriptions and/or Explanations**

**Underwriting: AI/ML Uses**

- **Automated Approval**: Approving an application without human intervention on that particular application.
- **Automated Denial**: Denying an application without human intervention on that particular application.
- **Underwriting Tier Determination**: Decisions regarding the criteria to use to establish specific named or numbered categories (called tiers) which utilize combinations of attributes that affect an insurer’s underwriting decision.
- **Company Placement**: Decisions regarding which of several affiliated companies within an insurance group will accept an individual risk.
- **Input into Non-Automated Approval Decision**: Providing data, analysis, or recommendations regarding a decision to approve an application in a situation where a human decision-maker still has the ability and responsibility to affirmatively consider this information and make a decision independently of the AI/ML system. In this situation, the AI/ML system cannot automatically approve the application, and protocols exist that ensure that each recommendation from the AI/ML system is actively reviewed and not adopted by default.
- **Input into Non-Automated Denial Decision**: Providing data, analysis, or recommendations regarding a decision to deny an application in a situation where a human decision-maker still has the ability and responsibility to affirmatively consider this information and make a decision independently of the AI/ML system. In this situation, the AI/ML system cannot automatically deny the application, and protocols exist that ensure that each recommendation from the AI/ML system is actively reviewed and not adopted by default.
- **Automate Processing Thru the Agency Channel**: Enabling agencies to receive certain information about applicants automatically without specifically requesting that information and/or to provide quotes to the applicants and/or recommend a decision regarding the application to the agent without being based on preprogrammed decision rules.
CHAIR REPORT
LIFE INSURANCE ILLUSTRATION ISSUES (A) WORKING GROUP

Per the request of the Life Insurance and Annuities (A) Committee, this report provides an overview of the Life Insurance Illustrations (A) Working Group’s (LIIWG) history and progress to date. The report also includes the Chair’s recommendations regarding the future direction of the Working Group.

In 2016, concerns were raised at the NAIC regarding consumer understanding of complex life insurance products such as indexed universal life products. The A Committee decided to address these concerns by forming a Working Group to explore how consumer understanding for all life insurance products could be improved. The Working Group was given a broad charge over all life products and the charge was not limited to indexed universal life products.

The LIIWG is charged to:

- Explore how the narrative summary required by Section 7B of the Life Insurance Illustrations Model Regulation (#582) and the policy summary required by Section 5A(2) of the Life Insurance Disclosure Model Regulation (#580) can be enhanced to promote consumer readability and understandability of these life insurance policy summaries, including how they are designed, formatted and accessed by consumers.

Current Summary Disclosure Requirements in NAIC Model Regulations

Before discussing the working group, I believe it is helpful to understand the current requirements in the NAIC model regulations that are part of the working group’s charge. The model regulations take a two-track approach to consumer disclosure requirements. Policies are divided into those identified to be marketed with an illustration and those identified to be marketed without an illustration.

No policy is required to be illustrated, however, those policies that are illustrated must follow the requirements of the Life Insurance Illustrations Model Regulation (#582) (Illustrations Model). Specifically relevant to the working group’s charge, illustrations must contain a “narrative summary” that is a “brief description of the policy being illustrated.” This description must include things such as the premium outlay, a description of any policy features shown in the illustration, and definitions of key terms used in the illustration.

For policies that are not illustrated, the Life Insurance Disclosure Model Regulation (#580) (Disclosure Model) requires that the policyholder be provided with a “policy summary” which is defined “as a written statement describing the elements of the policy.” The information that must be provided in a policy summary includes the annual premium for the basic policy and each optional rider, the amount payable upon death, the total guaranteed cash surrender value and information regarding policy loan interest rates.

Under the two model regulations, a policyholder will always receive some form of summary disclosure, either in the form of the narrative summary accompanying an illustration or a policy summary for the unillustrated products. However, while there is some overlap, the information required for each summary is not exactly the same.

History of Working Group Activity

To complete its charge, the Working Group first decided that it needed to review current narrative summaries and policy summaries to identify any issues that could be addressed to improve consumer understanding. The Working Group requested, and the American Council of Life Insurers (ACLI) compiled, sample narrative summaries and policy summaries for the three main types of life insurance products: term, whole and universal life. The Working Group established an ad hoc subgroup consisting of regulators, life insurers and consumer representatives to review these summaries to identify areas that could be improved.

During this review, several issues were identified as hampering the usefulness of narrative and policy summaries in promoting consumer understanding of life products. (See, for example, NAIC Proceedings – Summer 2016, Life Insurance and Annuities (A) Committee, Attachment Five and NAIC Proceedings – Spring 2017, Life Insurance and Annuities (A) Committee,
Attachment Nine-A). One overarching issue identified was that the narrative and policy summaries were often not designed as direct consumer disclosures. They were designed to be explained to the consumer by a financial professional and serve as a tool for the key features of the policy to be identified by a financial professional. To make these documents more consumer friendly would, to a certain extent, require a change in the audience they were written for.

The group also identified three specific issues with the summaries themselves. First, it was determined that current summary disclosures were quite lengthy which impeded consumer understanding. For example, summary disclosures for even simple term policies often ran to ten or more pages. Given the length of these summaries, it could be difficult for a consumer to locate key features of the policy.

Second, the summaries showed variations in layout and the accessibility of the language used. As can be expected, the samples varied in quality between different insurers and some samples were more consumer-friendly then others. Some summaries also contained puffery or marketing language that were not necessarily directly related to the purpose of the disclosure.

Third, the structure of the model regulations drove some of the issues with the summary’s length and made them less consumer friendly. For example, the narrative summary requires that key terms in the illustration be described and defined. These definitions would often run several pages. While these definitions are important to understanding the illustration, they run counter to the narrative summaries purpose to provide a “brief” description of the policy. Similarly, the policy summary requires a five-year illustration of the policy’s premium and benefit patterns that serves as a kind of “mini-illustration.” Thus, both the narrative summary and policy summary work to cross purposes to some degree as they are required to be both brief summaries of the policy and to provide comprehensive information.

While the ad hoc group was reviewing the sample documents, a consensus emerged between the life insurers, regulators and consumer representatives as to how the Working Group could meet its charge. There was agreement that a one or two-page summary disclosure or “Policy Overview” should be created that only listed a policy’s key features. This document would be created specifically for consumers while leaving the current structure of the narrative and policy summaries in place. The consensus was that current summaries served important purposes such as defining key terms and providing the “mini-illustration,” but that the key features of the policy should be listed in a more accessible way.

This context is important to address one of the comments made by the ACLI. Specifically, that the Working Group did not identify any specific issues or problems with current summaries. As stated, the ad hoc group did in fact identify specific issues that hindered consumer understanding of life insurance products. More importantly, a consensus developed that a Policy Overview document would be helpful to consumers and meet the working group’s charges. With agreement from all interested parties, including the life insurer representatives, on exploring a possible solution, there was little value in spending a great deal of time indexing issues beyond those already noted in the meeting minutes.

Development of a Policy Overview Document

To develop the Policy Overview, the Working Group started by identifying the key elements that consumers should be aware of in purchasing a life insurance policy. To complete this task, the Working Group started with simple term products before identifying key features in whole and universal life products. The key elements identified by the Working Group include basic features of the policy such as the premium, benefit amount, loan and investment features, riders and other benefits. It also included elements that would be unique to each type of life product such as the term of the policy or a description of the cost of insurance charges for universal products.

After identifying the key elements, the Working Group began developing revisions to the Disclosure Model to create the legal structure for the adoption of the Policy Overview. Changes were made to the Disclosure Model to require a short, consumer-friendly disclosure containing the required key elements that would be provided in the same form for illustrated and non-illustrated products. While there was general agreement on the key elements to be included in the Policy Overview, there were a couple of issues where there was not consensus that I will highlight.

The first area of disagreement was whether the Policy Overview should have a required format or whether insurers should be given latitude as to how they developed the Policy Overview. Consumer representatives argued that the Policy Overview should

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1 The working group considered adopting this policy overview as a cover page to the narrative summary of an illustration or to the policy summary for the non-illustrated products. As discussions progressed a consensus emerged that the policy overview should be a separate document that was provided to the consumer in the same form for illustrated and non-illustrated products.
be delivered on a required template so that consumers could compare products from different insurers. The life insurance industry supported more flexibility arguing that life insurers needed to have the ability to customize the Policy Overview to their specific products. The Working Group determined that a template would not be required but that the Working Group would develop sample Policy Overviews that insurers could use as an example in creating the Policy Overview.

The second issue of disagreement involved the delivery requirement for the Policy Overview. The current delivery requirement in the Disclosure Model requires that the buyer’s guide and policy summary be delivered “prior to accepting the applicant’s initial premium” or if the “policy for which application is made contains an unconditional refund provision” delivery may be made with the policy. Some regulators and the life insurance industry supported keeping the current delivery requirement. However, other regulators and consumer representatives argued that the Policy Overview should be required to be delivered at the time of application. They argued that the Policy Overview would be of most use to consumers prior to purchase and that the delivery of the Policy Overview at application would not be burdensome due to changes in technology that made delivery easier.

Because there was no consensus from the Working Group on the delivery requirement, the Working Group requested that the Life Insurance and Annuities (A) Committee provide direction on what the delivery requirement should be. The Chair of the Committee at the time instructed the Working Group to draft the model law changes in the alternative so that the Committee could decide the issue of timing of delivery.

Attached to this report are two version of the amendments to the Disclosure Model. Attachment A contains the amendments to the model law to adopt a Policy Overview without changing the delivery requirement, i.e., delivery at the time of policy delivery if there is a free look period. Attachment B contains the amendments to the model law to adopt the Policy Overview with language that requires that the Policy Overview be delivered at application. The delivery language included was modified from the Annuity Disclosure Model Law (#245). That language reads:

Where the application for a life insurance policy is taken at a face-to-face meeting, the applicant at or before the time of application shall be given the Policy Overview. Where the application for a life insurance policy is taken by means other than in a face-to-face meeting, the applicant shall be sent the Policy Overview not later than five business days after the receipt of the application.

After completing work on the revisions to the Model Regulation, the Working Group turned to developing the sample Policy Overview. The Working Group looked for existing disclosure documents that might serve as a starting point for the development of the Policy Overview. It was noted that in 2007 the ACLI developed a drafting guide and focus-group tested templates for insurers to develop annuity disclosures “in a truly consumer-friendly manner.” The Working Group asked the ACLI and its members if they would be willing to develop similar templates for the proposed Policy Overview. The ACLI declined the working group’s invitation to do so. Nevertheless, the Working Group used these annuity disclosure templates as the base to build the Policy Overview samples.

In early 2021, the Working Group completed its development of sample Policy Overviews for term products after incorporating comments from the life insurance industry, consumer representatives, and regulators. Attachment C to this report is the sample Policy Overview with the current delivery requirements. Attachment D contains the sample Policy Overview for a delivery requirement at application. The Working Group decided to present the attached draft model law revisions and sample Policy Overviews to the Life Insurance and Annuities (A) Committee for consideration and for further guidance. The Committee issued a request for comment on these drafts from interested parties on August 11, 2021.

**Chair’s Recommendations**

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2 It should also be noted that there are some minor differences in the key data elements for the alternative revisions to account for the different delivery requirements. For example, the revisions for delivery at application require an estimated premium versus the actual premium since the actual premium would not be known prior to underwriting.

3 While work on the sample templates was ongoing, in 2020 ACLI informed the A committee that it opposed the enactment of a policy overview document arguing that it would not enhance consumer understanding of life insurance products. ACLI also declined to provide comments on the sample policy overviews to be delivered at application because of their opposition to changing the delivery requirement.
After review of the comments received from interested parties and discussions with members of the Committee, the following are my recommendations as Chair for the future of the Working Group. These recommendations are based solely on my opinion and have not been adopted by the Working Group.

The comments received by the Life Insurance and Annuities (A) Committee show that there is not a consensus regarding whether the proposed Policy Overview will aid consumers in understanding life products. ACLI, Finseca, the National Association of Insurance and Financial Advisors (NAIFA), the National Alliance of Life Companies (NALC) and the states of Ohio and Utah all expressed opposition to the adoption of a Policy Overview requirement. While the comments differed to various degrees, they all expressed concern that an additional consumer disclosure will only serve to further confuse consumers or provide little additional value.

Consumer Representatives Brenda Cude and Birny Birnbaum as well as the state of New York expressed support for the development of the Policy Overview. They argue that the Policy Overview would be helpful to consumers and serve to increase consumer understanding of life products.

Both sides of the issue make valid points regarding the proposed Policy Overview and it is not possible to determine whether the Policy Overview will aid consumers without it being used in the marketplace. This new disclosure may aid consumers by providing a simple way to access key information or it may create confusion or simply be redundant. At this point, it is simply a matter of opinion whether or not this document would improve consumer understanding. This uncertainty, in my opinion, argues against the adoption of NAIC model law revisions to require a Policy Overview.

First, one of the NAIC’s criteria for adoption of a model law is that the issue calls for a minimum national standard. There is currently a minimum national standard for consumer disclosures in the Illustrations and Disclosure models. To adopt significant changes to this national standard and encourage states to adopt them, there should be relative certainty and agreement that the revisions will have the desired effect. As noted, it is untested and a matter of disagreement whether or not the Policy Overview will aid consumers.

In many instances, NAIC model laws are based on regulations or laws that have been enacted by some states or other regulators. To my knowledge, no state has adopted a summary disclosure requirement such as the one that is being contemplated by the working group. This is an area where the state’s strengths as laboratories for policy change should be utilized and where a top-down approach seems inappropriate. To be clear, the Policy Overview that was developed may be an effective way to aid consumer understanding of life products but until this idea is tried by some states it is not clear this should be adopted as a best practice and national standard by the NAIC.

Second, based on the comment letters and my discussions with commissioners, I question whether the proposed model meets the NAIC’s requirement for the approval of a model law. Adoption of a model law requires approval by two-thirds of the NAIC members. Voting to approve indicates that the member will support adoption of the model in their state as a priority. Three states submitted comments on the adoption of a Policy Overview, two opposed the changes and one state supported it. Among the states that have not commented, I have not received an indication that the adoption of a summary disclosure for life insurance is currently a top priority of their state.

For these reasons, it is my recommendation that the Life Insurance and Annuities (A) Committee not adopt the Policy Overview revisions as a model law change. For states that are interested in pursuing regulation in this area, the revisions that were developed by the Working Group are attached to this report and can be used as a starting point for individual states that wish to enact a Policy Overview or similar summary disclosure requirement. If summary disclosures of life insurance products prove effective in educating consumers, the NAIC can always revisit whether such requirements should be adopted as a national standard with the benefit of the experience of those states.

In summary, I recommend that the Committee consider adopting this report as the final report of the Working Group and the Working Group be disbanded. By adopting this report, the revisions the Working Group has developed will be available for individual states to consider when exploring the possibility of enacting a summary disclosure requirement.

Finally, I would like to thank all the members of the Working Group for their time and commitment and their insightful comments on how we could improve consumer understanding of life insurance products. It is my hope that the life insurance industry can use some of these insights in drafting more consumer-friendly disclosures.
LIFE INSURANCE DISCLOSURE MODEL REGULATION

Section 1. Authority

This rule is adopted and promulgated by the commissioner of insurance pursuant to [insert state equivalent to Section 4A(1) of the Unfair Trade Practices Act] of the Insurance Code.

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

Section 2. Purpose

A. The purpose of this regulation is to require insurers to deliver to purchasers of life insurance information that will improve the buyer’s ability to select the most appropriate plan of life insurance for the buyer’s needs and improve the buyer’s understanding of the basic features of the policy that has been purchased or is under consideration.

B. This regulation does not prohibit the use of additional material that is not a violation of this regulation or any other [state] statute or regulation.

Section 3. Scope

A. Except for the exemptions specified in Section 3B, this regulation shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. Section 5B shall apply only to an existing nonexempt policy held by a policyowner residing in this state. This regulation shall apply to any issuer of life insurance contracts including fraternal benefit societies.

B. This regulation shall not apply to:

(1) Individual and group annuity contracts;

(2) Credit life insurance;

(3) Group life insurance (except for disclosures relating to preneed funeral contracts or prearrangements; these disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy);
(4) Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. Section 1001 et seq. as amended; or

(5) Variable life insurance under which the amount or duration of the life insurance varies according to the investment experience of a separate account.

Section 4. Definitions

For the purposes of this regulation, the following definitions shall apply:

A. “Buyer’s Guide” means the current Life Insurance Buyer’s Guide adopted by the National Association of Insurance Commissioners (NAIC) or language approved by the commissioner.

B. “Current scale of nonguaranteed elements” means a formula or other mechanism that produces values for an illustration as if there is no change in the basis of those values after the time of illustration.

C. “Illustration” means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years that is subject to [insert state equivalent to Life Insurance Illustrations Model Regulation (#582)].

D. “Nonguaranteed elements” means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

E. “Policy data” means a display or schedule of numerical values, both guaranteed and nonguaranteed for each policy year or a series of designated policy years of the following information: illustrated annual, other periodic, and terminal dividends; premiums; death benefits; cash surrender values and endowment benefits.

F. “Policy Overview” means a brief summary of the policy prepared in accordance with this regulation and an example may be found in Appendix A.

G. “Guaranteed Premium and Benefit Patterns Summary” is a separate document that accompanies the Policy Overview where the insurer has identified the policy as one that will not be marketed with an illustration.

H. “Preneed funeral contract or prearrangement” means an agreement by or for an individual before that individual’s death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

Section 5. Duties of Insurers

A. Requirements Applicable Generally

(1) The insurer shall provide a Buyer’s Guide to all prospective purchasers, prior to accepting the applicant’s initial premium or premium deposit. However, if the policy for which application is made contains an unconditional refund provision of at least ten (10) days, the Buyer’s Guide may be delivered with the policy or prior to delivery of the policy.

(2) The insurer shall provide a Policy Overview to all prospective purchasers. Delivery of the Policy Overview shall be consistent with the time for delivery of the Buyer’s Guide as specified in Paragraph (1). Insurers should endeavor to limit the length of the Policy Overview to the minimum length necessary to reasonably inform consumers of the information required to be included in the Policy Overview. The Policy Overview is not required to be in a specific format beyond the requirements of this Section. The Policy Overview must be prepared in language and in a format that would be understood by a typical person within the segment of the public to which the policy
is directed. A sample Policy Overview that meets the requirements of this Section is provided in Appendix A. A Policy Overview shall include the following topics with appropriate headings:

(a) An introductory section containing the following language: “This document lists this insurance policy’s key features and benefits. You can get a similar summary of key policy features from other insurance companies to help you compare similar policies. If you have questions about life insurance generally or other types of policies, the National Association of Insurance Commissioners has useful information at https://content.naic.org/consumer/life-insurance.htm/. If you have questions about this particular life insurance policy, ask the agent, broker, advisor, or a company representative. If you have questions about company or agent licensing, contact [insert reference to state department of insurance].”

(b) “Company [and Agent Information]” which shall contain the name, address, email address and phone contact information of the insurance company and insurance agent, if an agent is involved.

(c) “Information We Use to Determine Your Premium” which shall include the following information about the policy owner and insured, as applicable:

(i) A brief description of the data elements that the insurer collects from the applicant and other sources that are used to determine an applicant’s premium;

(ii) A brief description of the policy features that will affect the amount of premium such as the amount of the death benefit and optional riders;

(iii) How risk class is assessed to generate the quote.

(d) “Cost Information” which shall include the following information, as applicable:

(i) An explanation of how much the life insurance policy costs or is estimated to cost at the time of application, including initial premium or the estimated premium quoted at the time of application and an explanation of differences in costs based on premium mode selected;

(ii) A summary of the available options for funding the policy and the minimum funding needed to maintain the policy in force;

(iii) An explanation of whether the premium can vary and, if so, how the premium will be determined;

(iv) An explanation of any costs associated with cancelling the policy (i.e. surrender charges) and, if yes, the period of time the charges apply or, if no, whether any money is eligible to be returned;

(v) If applicable, a narrative description of fees other than premium;

(vi) If applicable, a narrative explanation of the cost of insurance fee, how the cost of insurance fee changes with age, a narrative explanation of the net amount of risk to which the fee will apply, and the maximum allowable cost of insurance fee allowed under the policy.

(e) “Policy Information” which shall include the following information, as applicable:

(i) Policy type (Including single or joint policy);

(ii) Policy name;
(iii) State of issue;  
(iv) An indication of whether the policy is term or permanent life insurance, and if it is term insurance, the length of the initial term, including whether and how the term may be extended;  
(v) If the Policy Overview is provided prior to underwriting, a general description of what the policyholder needs to do to obtain the policy;  
(vi) If the Policy Overview is provided prior to underwriting, the following statement: “In the course of considering an insured’s application, an insurer may request or collect health information about the insured in variety of ways.” The statement shall indicate whether a physical examination or questionnaire will be required;  
(vii) Death benefit or the death benefit as applied for;  
(viii) A yes or no indication of whether the death benefit can change, and if yes, a summary of the reasons and timing for a change in the death benefit;  
(ix) Policy loan options and applicable charges.  

(f) “Additional Policy Benefits” which shall include the following information, as applicable:  
(i) A yes or no indication of whether a waiver of premium or deductions option is available, and if yes, a summary of the options available;  
(ii) A yes or no indication of whether policy conversion options exist and, if yes, a brief summary of conversion options available;  
(iii) If the policy has a term, a yes or no indication of whether there are o  
(iv) A yes or no indication of the availability of optional riders and, if yes, a summary of how the insured may obtain additional information regarding the availability and costs of optional riders;  
(vi) A yes or no indication of any living benefit option(s), and if yes, a summary of the option(s);  
(vii) A yes or no indication of whether the policy can accumulate cash value, and if yes, a summary of the benefit;  
(viii) A yes or no indication of whether there are guaranteed interest rates on fixed accounts and, if yes, the amount of the guaranteed interest rate;  
(ix) A yes or no indication of whether there are indexed account options and if yes, a summary of how the insured may obtain additional information regarding indexed account options.  

(3) The insurer shall provide a Guaranteed Premium and Benefits Patterns Summary to prospective purchasers where the insurer identified the policy form as one that will not be marketed with an illustration. Delivery of the Guaranteed Premium and Benefits Patterns Summary shall be consistent with the time for delivery of the Buyer’s Guide as specified in Paragraph (1). The Guaranteed Premium and Benefits Pattern Summary shall show guarantees only and include all required information set out in a manner that does not minimize or render any portion of the summary.
obscure. Any amounts that remain level for two (2) or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts shall be listed in total, not on a per thousand or per unit basis. If more than one insured is covered under one policy or rider, death benefits shall be displayed separately for each insured or for each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as a blank space. The following amounts, where applicable, for the first five (5) policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns; including at least one age from sixty (60) through sixty-five (65) and policy maturity:

(a) The annual premium for the basic policy;
(b) The annual premium for each optional rider;
(c) The amount payable upon death at the beginning of the policy year regardless of the cause of death, other than suicide or other specifically enumerated exclusions, that is provided by the basic policy and each optional rider; with benefits provided under the basic policy and each rider shown separately;
(d) The total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider;
(e) Any endowment amounts payable under the policy that are not included under cash surrender values above;
(f) The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is adjustable, the Guaranteed Premium and Benefits Patterns Summary shall also indicate that the annual percentage rate will be determined by the company in accordance with the provisions of the policy and the applicable law.

B. Requirements Applicable to Existing Policies.

(1) Upon request by the policyowner, the insurer shall furnish either policy data or an in force illustration as follows:

(a) For policies issued prior to the effective date of [insert state equivalent to Life Insurance Illustrations Model Regulation], the insurer shall furnish policy data, or, at its option, an in force illustration meeting the requirements of [insert state equivalent to Life Insurance Illustrations Model Regulation].

(b) For policies issued after the effective date of the illustration regulation that were declared not to be used with an illustration, the insurer shall furnish policy data, limited to guaranteed values, if it has chosen not to furnish an in force illustration meeting the requirements of the regulation.

(c) If the policy was issued after the effective date of the illustration regulation and declared to be used with an illustration, an in force illustration shall be provided.

(d) Unless otherwise requested, the policy data shall be provided for twenty (20) consecutive years beginning with the previous policy anniversary. The statement of policy data shall include nonguaranteed elements according to the current scale, the amount of outstanding policy loans, and the current policy loan interest rate. Policy values shown shall be based on the current application of nonguaranteed elements in effect at the time of the request. The insurer may charge a reasonable fee, not to exceed $[insert amount], for the preparation of the statement.
(2) If a life insurance company changes its method of determining scales of nonguaranteed elements on existing policies; it shall, no later than when the first payment is made on the new basis, advise each affected policy owner residing in this state of this change and of its implication on affected policies. This requirement shall not apply to policies for which the amount payable upon death under the basic policy as of the date when advice would otherwise be required does not exceed $5,000.

(3) If the insurer makes a material revision in the terms and conditions under which it will limit its right to change any nonguaranteed factor; it shall, no later than the first policy anniversary following the revision, advise each affected policy owner residing in this state.

Section 6. Preneed Funeral Contracts or Prearrangements

The following information shall be adequately disclosed at the time an application is made, prior to accepting the applicant’s initial premium or deposit; for a preneed funeral contract or prearrangement that is funded or to be funded by a life insurance policy:

A. The fact that a life insurance policy is involved or being used to fund a prearrangement;
B. The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person;
C. The relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;
D. The impact on the prearrangement:
   (1) Of any changes in the life insurance policy including but not limited to, changes in the assignment, beneficiary designation or use of the proceeds;
   (2) Of any penalties to be incurred by the policyholder as a result of failure to make premium payments;
   (3) Of any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy;
E. A list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;
F. All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement;
G. Any penalties or restrictions, including but not limited to geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and

Drafting Note: States should consider whether the insurance regulator has the authority to enforce the provisions of Subsections E, F and G.

H. If so, the fact that a sales commission or other form of compensation is being paid and the identity of the individuals or entities to whom it is paid.

Section 7. General Rules

A. Each insurer shall maintain, at its home office or principal office, a complete file containing one copy of each document authorized and used by the insurer pursuant to this regulation. The file shall contain one copy of
each authorized form for a period of three (3) years following the date of its last authorized use unless otherwise provided by this regulation.

B. An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he or she is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which the agent is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.

C. An insurance producer shall not use terms such as “financial planner,” “investment advisor,” “financial consultant,” or “financial counseling” in such a way as to imply that he or she is primarily engaged in an advisory business in which compensation is unrelated to sales unless that is actually the case. This provision is not intended to preclude persons who hold some form of formal recognized financial planning or consultant designation from using this designation even when they are only selling insurance. This provision also is not intended to preclude persons who are members of a recognized trade or professional association having such terms as part of its name from citing membership, providing that a person citing membership, if authorized only to sell insurance products, shall disclose that fact. This provision does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

D. Any reference to nonguaranteed elements shall include a statement that the item is not guaranteed and is based on the company’s current scale of nonguaranteed elements (use appropriate special term such as “current dividend” or “current rate” scale.) If a nonguaranteed element would be reduced by the existence of a policy loan, a statement to that effect shall be included in any reference to nonguaranteed elements. A presentation or depiction of a policy issued after the effective date of the [insert citation to state equivalent to Life Insurance Illustrations Model Regulation] that includes nonguaranteed elements over a period of years shall be governed by that regulation.

Section 8. Failure to Comply

Failure of an insurer to provide or deliver a Buyer’s Guide, an in force illustration, a policy summary or policy data as provided in Section 5 shall constitute an omission that misrepresents the benefits, advantages, conditions or terms of an insurance policy.

Section 9. Separability

If any provisions of this rule be held invalid, the remainder shall not be affected.

Section 10. Effective Date

This rule shall become effective [insert a date at least 6 months following adoption by the regulatory authority].
LIFE INSURANCE DISCLOSURE MODEL REGULATION

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Section 10. Effective Date

Section 1. Authority

This rule is adopted and promulgated by the commissioner of insurance pursuant to [insert state equivalent to Section 4A(1) of the Unfair Trade Practices Act] of the Insurance Code.

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

Section 2. Purpose

A. The purpose of this regulation is to require insurers to deliver to purchasers of life insurance information that will improve the buyer’s ability to select the most appropriate plan of life insurance for the buyer’s needs and improve the buyer’s understanding of the basic features of the policy that has been purchased or is under consideration.

B. This regulation does not prohibit the use of additional material that is not a violation of this regulation or any other [state] statute or regulation.

Section 3. Scope

A. Except for the exemptions specified in Section 3B, this regulation shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. Section 3B shall apply only to an existing nonexempt policy held by a policyowner residing in this state. This regulation shall apply to any issuer of life insurance contracts including fraternal benefit societies.

B. This regulation shall not apply to:

(1) Individual and group annuity contracts;
(2) Credit life insurance;
(3) Group life insurance (except for disclosures relating to preneed funeral contracts or prearrangements; these disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy);
Life Insurance and Annuities (A) Committee
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(4) Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. Section 1001 et seq. as amended; or

(5) Variable life insurance under which the amount or duration of the life insurance varies according to the investment experience of a separate account.

Section 4. Definitions

For the purposes of this regulation, the following definitions shall apply:

A. “Buyer’s Guide” means the current Life Insurance Buyer’s Guide adopted by the National Association of Insurance Commissioners (NAIC) or language approved by the commissioner.

B. “Current scale of nonguaranteed elements” means a formula or other mechanism that produces values for an illustration as if there is no change in the basis of those values after the time of illustration.

C. “Illustration” means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years that is subject to Life Insurance Illustrations Model Regulation (#582).

D. “Nonguaranteed elements” means the premiums, credited interest rates (including any bonus), benefits, values, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

E. “Policy data” means a display or schedule of numerical values, both guaranteed and nonguaranteed for each policy year or a series of designated policy years of the following information: illustrated annual, other periodic, and terminal dividends; premiums; death benefits; cash surrender values and endowment benefits.

F. “Policy Overview” means a brief summary of the policy prepared in accordance with this regulation and an example may be found in Appendix A.

G. “Guaranteed Premium and Benefit Patterns Summary” is a separate document that accompanies the Policy Overview where the insurer has identified the policy as one that will not be marketed with an illustration.

H. “Preneed funeral contract or prearrangement” means an agreement by or for an individual before that individual’s death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

Section 5. Duties of Insurers

A. Requirements Applicable Generally

(1) The insurer shall provide a Buyer’s Guide to all prospective purchasers, prior to accepting the applicant’s initial premium or premium deposit. However, if the policy for which application is made contains an unconditional refund provision of at least ten (10) days, the Buyer’s Guide may be delivered with the policy or prior to delivery of the policy.

(2) The insurer shall provide a Policy Overview to all prospective purchasers. Where the application for a life insurance policy is taken at a face-to-face meeting, the applicant at or before the time of application shall be given the Policy Overview. Where the application for a life insurance policy is taken by means other than in a face-to-face meeting, the applicant shall be sent the Policy Overview not later than five business days after the receipt of the application. The Policy Overview is a summary of the high level features and terms of the policy. Insurers should endeavor to limit the length of the Policy Overview to the minimum length necessary to reasonably inform consumers of
the information required to be included in the Policy Overview. The Policy Overview is not required to be in a specific format beyond the requirements of this Section. The Policy Overview must be prepared in language and in a format that would be understood by a typical person within the segment of the public to which the policy is directed. A sample Policy Overview that meets the requirements of this Section is provided in Appendix A. A Policy Overview shall include the following topics with appropriate headings:

(b) An introductory section containing the following language: “This document lists this insurance policy’s key features and benefits. You can get a similar summary of key policy features from other insurance companies to help you compare similar policies. If you have questions about life insurance generally or other types of policies, the National Association of Insurance Commissioners has useful information at https://content.naic.org/consumer/life-insurance.htm/. If you have questions about this particular life insurance policy, ask the agent, broker, advisor, or a company representative. If you have questions about company or agent licensing, contact [insert reference to state department of insurance].”

(c) “Company [and Agent] Information” which shall contain the name, address, email address and phone contact information of the insurance company and insurance agent, if an agent is involved.

c) “Information We Use to Determine Your Premium” which shall include the following information about the policy owner and insured, as applicable:

(i.) A brief description of the data elements that the insurer collects from the applicant and other sources that are used to determine an applicant’s premium;

(ii.) A brief description of the policy features that will affect the amount of premium such as the amount of the death benefit and optional riders;

(iii) How risk class is assessed to generate the quote;

d) “Cost Information” which shall include the following information, as applicable:

(i) An explanation of how much the life insurance policy is estimated to cost at the time of application, including the estimated premium and an explanation of the differences in cost based on premium mode selected;

(ii) A summary of the available options for funding the policy and the minimum funding needed to maintain the policy in force;

(iii) An of whether the premium can vary and, if so, how the premium will be determined;

(iv) An explanation of any costs associated with cancelling the policy (i.e. surrender charges) and, if yes, the period of time the charges apply or, if no, whether any money is eligible to be returned;

(iv) A yes or no indication of whether there is an option to lower benefits to reduce premium;

(v) If applicable, a narrative description of fees other than premium;

(vi) If applicable, a narrative explanation of the cost of insurance fee, how the cost of insurance fee changes with age, a narrative explanation of the net amount of risk
“Policy Information” which shall include the following information, as applicable:

(i) Policy type (including single or joint policy);

(ii) Policy name;

(iii) State of issue;

(iv) An indication of whether the policy is term or permanent life insurance, and if it is term insurance, the length of the initial term, including whether and how the term may be extended;

(v) A general description of what the policyholder needs to do to obtain the policy;

(vi) The following statement: “In the course of considering an insured’s application, an insurer may request or collect health information about the insured in variety of ways.” The statement shall indicate whether a physical examination or questionnaire will be required;

(vii) Death benefit that is available or the death benefit as applied for;

(viii) A yes or no indication of whether the death benefit can change, and if yes, a summary of the reasons and timing for a change in the death benefit;

(f) “Additional Policy Benefits” which shall include the following information, as applicable:

(ii) A yes or no indication of whether a waiver of premium or deductions option is available, and if yes, a summary of the options available;

(ii) A yes or no indication of whether policy conversion options exist and, if yes, a summary of conversion options available;

(iii) A yes or no indication of the availability of optional riders and, if yes, a summary of how the insured may obtain additional information regarding the availability and costs of optional riders;

(iv) A yes or no indication of any living benefit option(s), and if yes, a summary of the option(s);

(v) A yes or no indication of whether the policy can accumulate cash value, and if yes, a summary of the benefit;

(vi) A yes or no indication of whether there are guaranteed interest rates on fixed accounts and, if yes, the amount of the guaranteed interest rate;

(vii) A yes or no indication of whether there are indexed account options and if yes, a summary of how the insured may obtain additional information regarding indexed account options.
(3) The insurer shall provide a Guaranteed Premium and Benefits Patterns Summary to prospective purchasers where the insurer identified the policy form as one that will not be marketed with an illustration. Delivery of the Guaranteed Premium and Benefits Patterns Summary shall be consistent with the time for delivery of the Buyer’s Guide as specified in Paragraph (1). The Guaranteed Premium and Benefits Pattern Summary shall show guarantees only and include all required information set out in a manner that does not minimize or render any portion of the summary obscure. Any amounts that remain level for two (2) or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts shall be listed in total, not on a per thousand or per unit basis. If more than one insured is covered under one policy or rider, death benefits shall be displayed separately for each insured or for each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as a blank space. The following amounts, where applicable, for the first five (5) policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns; including at least one age from sixty (60) through sixty-five (65) and policy maturity:

(a) The annual premium for the basic policy;
(b) The annual premium for each optional rider;
(c) The amount payable upon death at the beginning of the policy year regardless of the cause of death, other than suicide or other specifically enumerated exclusions, that is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately;
(d) The total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider;
(e) Any endowment amounts payable under the policy that are not included under cash surrender values above;
(f) The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is adjustable, the Guaranteed Premium and Benefits Patterns Summary shall also indicate that the annual percentage rate will be determined by the company in accordance with the provisions of the policy and the applicable law.

B. Requirements Applicable to Existing Policies.

(1) Upon request by the policyowner, the insurer shall furnish either policy data or an in force illustration as follows:

(a) For policies issued prior to the effective date of [insert state equivalent to Life Insurance Illustrations Model Regulation], the insurer shall furnish policy data, or, at its option, an in force illustration meeting the requirements of [insert state equivalent to Life Insurance Illustrations Model Regulation].

(b) For policies issued after the effective date of the illustration regulation that were declared not to be used with an illustration, the insurer shall furnish policy data, limited to guaranteed values, if it has chosen not to furnish an in force illustration meeting the requirements of the regulation.

(c) If the policy was issued after the effective date of the illustration regulation and declared to be used with an illustration, an in force illustration shall be provided.
(d) Unless otherwise requested, the policy data shall be provided for twenty (20) consecutive years beginning with the previous policy anniversary. The statement of policy data shall include nonguaranteed elements according to the current scale, the amount of outstanding policy loans, and the current policy loan interest rate. Policy values shown shall be based on the current application of nonguaranteed elements in effect at the time of the request. The insurer may charge a reasonable fee, not to exceed $[insert amount], for the preparation of the statement.

(2) If a life insurance company changes its method of determining scales of nonguaranteed elements on existing policies; it shall, no later than when the first payment is made on the new basis, advise each affected policy owner residing in this state of this change and of its implication on affected policies. This requirement shall not apply to policies for which the amount payable upon death under the basic policy as of the date when advice would otherwise be required does not exceed $5,000.

(3) If the insurer makes a material revision in the terms and conditions under which it will limit its right to change any nonguaranteed factor; it shall, no later than the first policy anniversary following the revision, advise each affected policy owner residing in this state.

Section 6. Preneed Funeral Contracts or Prearrangements

The following information shall be adequately disclosed at the time an application is made, prior to accepting the applicant’s initial premium or deposit; for a preneed funeral contract or prearrangement that is funded or to be funded by a life insurance policy:

A. The fact that a life insurance policy is involved or being used to fund a prearrangement;

B. The nature of the relationship among the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person;

C. The relationship of the life insurance policy to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

D. The impact on the prearrangement:

   (1) Of any changes in the life insurance policy including but not limited to, changes in the assignment, beneficiary designation or use of the proceeds;

   (2) Of any penalties to be incurred by the policyholder as a result of failure to make premium payments;

   (3) Of any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy;

E. A list of the merchandise and services which are applied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;

F. All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy and the amount actually needed to fund the prearrangement;

G. Any penalties or restrictions, including but not limited to geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and

Drafting Note: States should consider whether the insurance regulator has the authority to enforce the provisions of Subsections E, F and G.
H. If so, the fact that a sales commission or other form of compensation is being paid and the identity of the individuals or entities to whom it is paid.

Section 7. General Rules

A. Each insurer shall maintain, at its home office or principal office, a complete file containing one copy of each document authorized and used by the insurer pursuant to this regulation. The file shall contain one copy of each authorized form for a period of three (3) years following the date of its last authorized use unless otherwise provided by this regulation.

B. An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he or she is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which the agent is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.

C. An insurance producer shall not use terms such as “financial planner,” “investment advisor,” “financial consultant,” or “financial counseling” in such a way as to imply that he or she is primarily engaged in an advisory business in which compensation is unrelated to sales unless that is actually the case. This provision is not intended to preclude persons who hold some form of formal recognized financial planning or consultant designation from using this designation even when they are only selling insurance. This provision also is not intended to preclude persons who are members of a recognized trade or professional association having such terms as part of its name from citing membership, providing that a person citing membership, if authorized only to sell insurance products, shall disclose that fact. This provision does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies.

D. Any reference to nonguaranteed elements shall include a statement that the item is not guaranteed and is based on the company’s current scale of nonguaranteed elements (use appropriate special term such as “current dividend” or “current rate” scale.) If a nonguaranteed element would be reduced by the existence of a policy loan, a statement to that effect shall be included in any reference to nonguaranteed elements. A presentation or depiction of a policy issued after the effective date of the [insert citation to state equivalent to Life Insurance Illustrations Model Regulation] that includes nonguaranteed elements over a period of years shall be governed by that regulation.

Section 8. Failure to Comply

Failure of an insurer to provide or deliver a Buyer’s Guide, an in force illustration, a policy summary or policy data as provided in Section 5 shall constitute an omission that misrepresents the benefits, advantages, conditions or terms of an insurance policy.

Section 9. Separability

If any provisions of this rule be held invalid, the remainder shall not be affected.

Section 10. Effective Date

This rule shall become effective [insert a date at least 6 months following adoption by the regulatory authority].
Attachment C

Term Life Sample (post UW)

ABC Insurance Co. Guaranteed Level Term

This document lists this insurance policy’s key features and benefits. You can get a similar summary of key policy features from other insurance companies to help you compare similar policies. If you have questions about life insurance generally or other types of policies, the National Association of Insurance Commissioners has useful information at https://content.naic.org/consumer/life-insurance.htm/. If you have questions about this particular life insurance policy, ask the agent, broker, advisor, or a company representative. If you have questions about company or agent licensing, contact [insert reference to state department of insurance].

Company and Agent Information

ABC Insurance Company, 111 Half Street, Washington, DC
email@email.com
202-111-222

Prepared by Agent Joe Smith, 111 Main St., Kansas City, MO
email@email.com
816-111-222

Information We Use to Determine Your Premium

Policy Owner and Insured
This overview is prepared for John Smith for insurance on the life of John Smith.

Information We Obtain From You

Age
Sex
Family History
Tobacco Use
Occupation
Hobbies

Information We Obtain From Other Sources

Credit Reports
Motor Vehicle Registration
Auto, Home and other Insurance Claims
Driving Records
Medical Prescriptions
Criminal History

Policy Features that will Affect the Premium

Amount of the Death Benefit
Optional Riders

How We Assess Your Risk
We have X rate levels for (smokers/non smokers). John Smith’s premium will be based on the Y best of the X levels.
Cost Information

What Does this Life Insurance Policy Cost?

The premium is $AAA annually or $BBB quarterly or $CCC monthly. You may pay the premium monthly, quarterly or semi-annually or annually. If you pay premiums monthly, quarterly or semi-annually the total premium you pay will be more than if you pay annually.

Will my premium ever change?

The premium will stay the same for the initial term of the policy. After that term ends, the premium will increase each year if you chose to renew the policy.

Are there any costs if I decide to cancel the policy? Do I get any money back if I cancel the policy?

No, there are no costs to cancel this policy. However, if you do cancel this policy, you won’t get any money back.

Policy Information

What is the name of this policy?

This is a policy to be issued in Wisconsin called Guaranteed Level Term.

Does the policy ever end? If so, what is the term of the policy

Yes. The policy ends when the term you choose (20 years) ends but you can choose to renew this policy each year until you are age 95. The premium will increase each year you renew the policy.

What is the death benefit?

The death benefit is $500,000.

Can the death benefit change?

No, the death benefit will stay the same unless you ask, and the company agrees to increase it.

Can I take a loan from my policy?

No. You can’t borrow money from this policy.

Additional Policy Benefits

Does the policy have a waiver of premium option?

Yes, you can buy a waiver of premium rider for an extra cost. A waiver of premium rider for this policy means you won’t have to pay premiums after you’ve been totally disabled for at least 4 months.

Can I convert this policy to another type of life insurance?

Yes, you can convert this policy to a whole life insurance policy before the policy term ends, as long as you’re younger than age 70.

Are there other policy enhancements or optional riders available for this policy?

Yes, there are other policy enhancements – know as riders. Ask the agent, broker, advisor, or a company representative offering this product about them.
Is there a policy option that allows me to access my death benefit while I’m alive?

Yes, for additional premium, you can get part of your death benefit before you die if you are terminally ill.

Does this policy accumulate cash value?

No. This policy provides no cash benefits other than the death benefit.
Attachment D

Term Life Sample (at application)

**ABC Insurance Co. Guaranteed Level Term**

This document lists this insurance policy’s key features and benefits. You can get a similar summary of key policy features from other insurance companies to help you compare similar policies. If you have questions about life insurance generally or other types of policies, the National Association of Insurance Commissioners has useful information at https://content.naic.org/consumer/life-insurance.htm/. If you have questions about this particular life insurance policy, ask the agent, broker, advisor, or a company representative. If you have questions about company or agent licensing, contact [insert reference to state department of insurance].

**Company and Agent Information**

ABC Insurance Company, 111 Half Street, Washington, DC
e-mail@email.com
202-111-222

Prepared by Agent Joe Smith, 111 Main St., Kansas City, MO
e-mail@email.com
816-111-222

**Information We Use to Determine Your Premium**

**Policy Owner and Insured**

This overview is prepared for John Smith for insurance on the life of John Smith.

**Information We Obtain From You**

Age
Sex
Family History
Tobacco Use
Occupation
Hobbies

**Information We Obtain From Other Sources**

Credit Reports
Motor Vehicle Registration
Auto, Home and other Insurance Claims
Driving Records
Medical Prescriptions
Criminal History

**Policy Features that will Affect the Premium**

Amount of the Death Benefit
Optional Riders

**How We Assess Your Risk**

We have X rate levels for (smokers/non smokers). John Smith’s premium will be based on the Y best of the X levels.
Cost Information

What Does this Life Insurance Policy Cost?

The premium is $AAA annually or $BBB quarterly or $CCC monthly. You may pay the premium monthly, quarterly or semi-annually or annually. If you pay premiums monthly, quarterly or semi-annually the total premium you pay will be more than if you pay annually.

Will my premium ever change?

The premium will stay the same for the initial term of the policy. After that term ends, the premium will increase each year if you chose to renew the policy.

Are there any costs if I decide to cancel the policy? Do I get any money back if I cancel the policy?

No, there are no costs to cancel this policy. However, if you do cancel this policy, you won’t get any money back.

Policy Information

What is the name of this policy?

This is a policy to be issued in Wisconsin called Guaranteed Level Term.

Does the policy ever end? If so, what is the term of the policy?

Yes. The policy ends when the term you choose (20 years) ends, but you can choose to renew this policy each year until you are age 95.

Can I extend the term of coverage?

Yes. After the initial term ends, you can renew this policy until you are age 95. The premium will increase each year you renew the policy.

What is the death benefit?

You have selected a death benefit of $500,000 to generate this quote. You may select a death benefit between $250,000 and $2 million subject to underwriting approval.

Can I take a loan from my policy?

No. You can’t borrow money from this policy.

What do I need to do to buy this policy?

You’ll need to fill out an application. You also must go through an underwriting process. Underwriters review your application and decide if you’re eligible to buy this policy, and, if you are, what your premium would be and how much coverage you could buy.

In the course of considering your application, an insurer may request or collect health information about you in a variety of ways. You might be approved to buy a policy without any information about your health. If you aren’t, you may still be eligible for this policy, but you’ll be required to fill out a health questionnaire and undergo a physical examination.
Additional Policy Benefits

**Does the policy have a waiver of premium option?**

Yes, you can buy a waiver of premium rider for an extra cost. A waiver of premium rider for this policy means that you won’t have to pay premiums after you’ve been totally disabled for at least 4 months.

**Can I convert this policy to another type of life insurance?**

Yes, you can convert this policy to a whole life insurance policy before the policy term ends, as long as you’re younger than age 70.

**Are there other policy enhancements or optional riders available for this policy?**

Yes, there are other policy enhancements – known as riders. agent, broker, advisor or a company representative offering this product about them.

**Is there a policy option that allows me to access my death benefit while I’m alive?**

Yes, for additional premium, you can get part of your death benefit before you die if you are terminally ill.

**Does this policy accumulate cash value?**

No. This policy provides no cash benefits other than the death benefit.
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The Life Actuarial (A) Task Force met Dec. 8, 2021. The following Task Force members participated: Cassie Brown, Chair, represented by Mike Boerner, Rachel Hemphill, and Karen Jiang (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Charles Hale (AL); Ricardo Lara represented by Thomas Reedy (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Derek Wallman (NE); Marlene Caride represented by Kevin Clarkson (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Adopted its Dec. 1, Nov. 18, Nov. 4, Oct. 21, Sept. 30, and Sept. 16 Minutes**

The Task Force met Dec. 1, Nov. 18, Nov. 4, Oct. 21, Sept. 30, and Sept. 16. During these meetings, the Task Force took the following action: 1) adopted its Summer National Meeting minutes; 2) adopted its 2022 proposed charges; 3) adopted the Society of Actuaries’ (SOA’s) 2022 Generally Recognized Expense Table (GRET); 4) adopted the SOA historical mortality improvement (HMI) recommendation and the HMI scale factors; 5) adopted amendment proposal 2021-13, which corrects language that allows the addition of prescribed mortality margins for some Life/Long-Term Care (LTC) combination products to decrease, rather than increase, modeled reserves; 6) adopted amendment proposal 2021-12, which corrects a reference error in VM-21, Requirements for Principle-Based Reserves for Variable Annuities, and clarifies the requirements for variable annuity contracts with no minimum guaranteed benefits under three prescribed assumptions in VM-21 Section 6C; 7) exposed amendment proposal 2021-11, which addresses items related to VM-21 information necessary for regulatory review that companies did not include in their VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation, reports; and 8) adopted revisions to *Actuarial Guideline XXV—Calculation of Minimum Reserves and Minimum Nonforfeiture Values for Policies with Guaranteed Increasing Death Benefits Based on an Index* (AG 25), which remove the fixed 4% nonforfeiture rate floor to align AG 25 with the VM-02, Minimum Nonforfeiture Mortality and Interest, changes implemented for the 2021 Valuation Manual.

Mr. Leung made a motion, seconded by Mr. Yanacheak, to adopt the Task Force’s Dec. 1 (Attachment One), Nov. 18 (Attachment Two), Nov. 4 (Attachment Three), Oct. 21 (Attachment Four), Sept. 30 (Attachment Five), and Sept. 16 (Attachment Six) minutes; The motion passed unanimously.

2. **Adopted the Report of the Longevity Risk (E/A) Subgroup**

Mr. Leung made a motion, seconded by Mr. Yanacheak, to adopt the report of the Longevity Risk (E/A) Subgroup (Attachment Seven). The motion passed unanimously.

3. **Adopted the Report of the GI Life Valuation (A) Subgroup**

Mr. Leung made a motion, seconded by Mr. Yanacheak, to adopt the report of the Guaranteed Issue (GI) Life Valuation (A) Subgroup (Attachment Eight). The motion passed unanimously.

4. **Adopted the Report of the Experience Reporting (A) Subgroup**

Mr. Leung made a motion, seconded by Mr. Yanacheak, to adopt the report of the Experience Reporting (A) Subgroup (Attachment Nine). The motion passed unanimously.

5. **Adopted the Report of the VM-22 (A) Subgroup**

Mr. Sartain said the comment letters on the VM-22, Statutory Maximum Valuation Interest Rates for Income Annuities, Framework exposure are posted on the Valuation Manual (VM)-22 (A) Subgroup web page. He said the Subgroup will work.
on consolidating the comments in preparation for a discussion on Subgroup calls that will begin in January, with a goal of having a second exposure next summer.

Mr. Sartain said the Subgroup created a drafting group to develop prescribed assumptions for a standard projection amount (SPA). He said it has not been decided whether the SPA will be used as a floor or a disclosure item. He said the varying nature of fixed annuities makes developing an SPA for VM-22 more challenging than the VM-21 SPA development efforts. He noted that the drafting group has been subdivided into two groups. The first group focuses on mortality, and the second group focuses on contract holder behavior. Mr. Sartain said the mortality group decided to use four product categories: structured settlements, other individual payout annuities, deferred annuities, and group annuities and pension risk transfer business. He said the short-term plan is to develop product assumptions for use in a VM-22 field test and a process for determining the appropriate assumptions for the future. He said factors generated from recent studies may be applied to existing basic mortality tables in the short-term approach. He indicated that the long-term approach for group annuities may be to collect company mortality data by adding to the VM-51, Experience Reporting Formats, data call.

Mr. Sartain said the Subgroup sent a letter to the American Academy of Actuaries (Academy) and the SOA requesting the development of mortality assumptions appropriate for use as prescribed assumptions for an SPA for structured settlements. He said similar requests for mortality assumptions have been drafted for other individual payout annuities and deferred annuities.

Mr. Leung made a motion, seconded by Mr. Chou, to adopt the report of the VM-22 (A) Subgroup. The motion passed unanimously.

6. Adopted the Report of the Index-Linked Variable Annuity (A) Subgroup

Mr. Weber said the Subgroup is charged with recommending changes to nonforfeiture or interim values to help address non-uniform state insurance department review and approval of index-linked variable annuities (ILVAs), also known as registered index-linked annuities (RILAs). He said the products are filed as variable annuity contracts and as such are exempted from the requirements of the Standard Nonforfeiture Law for Individual Deferred Annuities (#805). He said the Subgroup is considering what requirements are necessary for a product to be deemed a variable contract. He said the Variable Annuity Model Regulation (#250) defines a variable annuity as a product that provides for annuity benefits that vary according to the investment experience of a separate account or accounts. He said with respect to interim values, the ILVA should be consistent with this definition of variable products. He said state insurance regulators want to avoid the situation where the contract holder experiences losses if the separate account value drops, without experiencing commensurate reward when the separate account value increases. He said the Subgroup has developed an actuarial guideline to provide guidance on how ILVAs can be shown to have benefits consistent with the supporting assets. He said the proposed guideline is currently exposed for a public comment period ending Jan. 27, 2022.

Mr. Weber made a motion, seconded by Mr. Clarkson, to adopt the report of the Index-Linked Variable Annuity (A) Subgroup, including its Nov. 23 (Attachment Ten) and Sept. 23 (Attachment Eleven) minutes. The motion passed unanimously.

7. Adopted the Report of the IUL Illustration (A) Subgroup

Mr. Andersen provided background on the indexed universal life (IUL) illustration issues that led to the development of Actuarial Guideline XLIX—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest (AG 49) and Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest Sold On or After December 14, 2020 (AG 49A). He said state insurance regulator reviews have revealed that while illustrated credited rates may have lowered, they have not lowered as much as was contemplated when AG 49-A was adopted. He said a key development that has been identified is the increased use of volatility-controlled funds to rebalance between equities and fixed income assets. He said volatility-controlled funds provide downside protection. He noted that although they may be marketed as uncapped funds, they do not provide an upside that is close to the returns available from uncapped Standard and Poor’s 500 index (S&P 500) funds. He said the main issue that has been identified is companies are increasingly using a portion of the policy hedge budget to provide upside potential to applying a volatility-controlled index, with the remainder funding a fixed bonus for policyholders. He said this reflects some companies’ beliefs that a volatility-controlled fund with a fixed bonus allows illustrations that are more favorable than a traditional capped S&P 500. He said a summary of the issues will be made available to expose for public comment.

Mr. Leung made a motion, seconded by Mr. Yanacheak, to adopt the report of the IUL Illustration (A) Subgroup. The motion passed unanimously.
8. **Re-Exposed Amendment Proposal 2021-11**

Connie Tang (Academy Variable Annuity Reserves and Capital Work Group) said the Academy comment letter (Attachment Twelve) on the exposure of amendment proposal 2021-11 (Attachment Thirteen) suggests quantifying the assumption margins before using a floor and simplifying the assumption margin analysis by focusing on margin analysis for individual risk factors on the 70% conditional tail expectation (CTE 70) instead of CTE 70 and CTE 98. She said an alternative suggestion is to use CTE 70 (adjusted) for the individual margin analysis. Ms. Hemphill said CTE 70 (adjusted) was considered, but the drafters of the amendment proposal chose CTE 70 (best efforts) because it provides a more complete view. She said CTE 98 is needed for the Total Asset Requirement (TAR), so the drafters would not want to remove it. She agreed to consider revising the amendment proposal to incorporate the suggestion of quantifying the margins before applying a floor.

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI comments (Attachment Fourteen) are supportive of adding the guidance in the amendment proposal to VM-21, but it questions the importance of the sensitivity testing requirements and how they can be used to help determine a reasonable margin. He said it is also not clear how the qualified actuary will use the sensitivity testing when setting their margin. He suggested removing that part of the language from the amendment proposal and VM-20, Requirements for Principle-Based Reserves for Life Products. He noted several other suggested edits in the comment letter.

Ms. Hemphill shared an updated draft of the amendment proposal for Task Force consideration. She said most of the ACLI comments were incorporated into the updated draft. The ACLI comments that were not accepted related to sensitivity testing and setting margins for more than one assumption. In response to the Academy comments, Ms. Hemphill proposed adding additional language to paragraphs ii and iii of VM-31 Section 3F(13)d.

Mr. Weber made a motion, seconded by Mr. Yanacheak, to re-expose amendment proposal 2021-11 (Attachment Fifteen), including the edits in response to the accepted ACLI and Academy comments, for a 38-day public comment period ending Jan. 14, 2022. The motion passed unanimously.

9. **Heard an Update on the ESG**

Scott O’Neal (NAIC) presented a slide deck (Attachment Sixteen) on the status of the economic scenario generator (ESG). He said it is unlikely that the ESG will be available for inclusion in the 2023 Valuation Manual. Mr. Boerner said inclusion in the 2023 Valuation Manual would require the Task Force adoption of changes by July 2022. He said given that the field test will not end until summer 2022, there will not be enough time for amendment proposals to be developed and adopted for inclusion in the Valuation Manual.

Mr. O’Neal said Conning has developed a new GEMS Treasury model calibration based on the acceptance criteria defined by the ESG Drafting Group. He said NAIC staff and Conning are analyzing the scenarios based on the new calibration. Those scenarios are expected to be presented to the Drafting Group later in the month. Upon approval of the scenarios by the Drafting Group, the scenarios will be discussed publicly at a joint meeting of the Task Force and the Life Risk-Based Capital (E) Working Group.

Mr. O’Neal discussed the key decisions in the development of the GEMS Equity Model. He said a major consideration is the theoretical and historical relationship between equities and Treasury rates. He said for equity returns and dividends, the GEMS Equity Model is configured with a linkage to Treasury rates. He said there are various ways to link equities and Treasuries, but he noted that it is unknown how much time and effort might be required to alter the existing GEMS equity/treasury linkage if the Drafting Group chooses to modify the GEMS linkage or use a different method. Mr. Bayerle stressed that the equity/treasury linkage is a critical assumption. He said it will be helpful if the Drafting Group provides an estimate of the time to modify the GEMS linkage or change to another method.

Mr. O’Neal said other decisions to be made for the Equity Model include those related to the risk/return relationship between different equity indices and the responsiveness of equity rates to changes in initial market conditions. He said the Drafting Group must also decide whether to use the GEMS Corporate Model in its current form or propose changes to the model. As with the GEMS Equity Model, changes to the GEMS Corporate Model will require development time and effort from Conning.

10. **Discussed Comments on the Proposed AAT Actuarial Guideline Exposure**

Mr. Andersen said the Task Force exposed the concept of an actuarial guideline focusing on the modeling of complex or high yielding assets in asset adequacy testing (AAT) on Sept. 30 for a public comment period ending Dec. 1. His presentation...
Mr. Andersen said after reviewing the information provided by the companies, the concept of an actuarial guideline focusing on the modeling of complex assets was exposed. Commenters were asked to provide feedback on the product scope, the size scope, whether the focus should be on constraints or standards of documentation, and the potential effective date of the guideline. Mr. Andersen discussed a summary of the comments submitted. He said the consensus of the commenters is that the scope should be broadened to include all life insurance company liabilities, especially liabilities related to supporting assets that have significant investment risk. He said there was a consensus that any exemption that is allowed should not be based on the size of the company because even small companies are investing more aggressively but could potentially focus on a ratio of complex, higher-yield assets to overall assets. He said commenters were split on whether to establish constraints or establish documentation requirements. He said there was a consensus to target year-end 2022 as the adoption date for the guideline. He noted that the year-end 2021 activity of appointed actuaries could inform the degree to which the guideline resorts to drastic measures. His final slides listed some potential goals of the AAT guideline.

Mr. Bayerle said while the ACLI comment letter (Attachment Eighteen) supports the regulatory efforts, it has concerns about the need to develop a guideline. He said its preference is to address the issues by enhancing documentation. Edward L. Toy (Risk & Regulatory Consulting LLC—RRC) said the RRC comment letter (Attachment Nineteen) focused on volatility, liquidity, complexity, and credit issues. He offered to assist in the development of a definition of complex assets. Mr. Leung said in addition to his comment letter (Attachment Twenty), he recommends that the Academy practice note on the treatment of spread and default cost assumptions in modeling assets for cashflow testing may be a good source of guidance. Aaron Sarfatti (Equitable) said the Equitable comments (Attachment Twenty-One) express its preference for guardrails, as opposed to constraints. He offered to assist in the development of a definition of complex assets. Mr. Leung noted that the year-end 2021 activity of appointed actuaries could inform the degree to which the guideline resorts to drastic measures. His final slides listed some potential goals of the AAT guideline.

Mr. Andersen said he will provide a revised request for comments focused on the argument of developing constraints versus solely relying on documentation.

11. Heard an Update on the Experience Reporting Data Collection Project

Pat Allison (NAIC) gave a presentation (Attachment Twenty-Six) on the mortality experience data collection project. A total of 110 companies are subject to mortality experience data collection for the 2018 and 2019 observation years, representing 87.5% of industry claims subject to mortality experience data collection. Ms. Allison said companies began submitting data on June 7, with initial submissions due by Sept. 30. She noted that the deadline for companies to correct their submissions is the end of December. She said the schedule calls for the NAIC to submit the aggregate experience data file to the SOA by May 31, 2022. She said to date, 105 companies have submitted data. Four of the remaining five companies have uploaded their data but have yet to submit it. The state insurance regulator for the outstanding company will be contacted by NAIC staff to assist with getting the company to submit its data.

Ms. Allison explained the rules-based data checks, reconciliations, and controls applied to the data upon submission. She said communications are sent to companies whose submissions do not meet the applicable standards. She noted that because of their size and the complexity of their policies, large companies tend to have lower percentages of acceptable data than small companies. She explained that NAIC staff are also reviewing field distributions to check the reasonableness of data. The 150 field distribution charts help identify items such as systematic errors and unusual or unlikely reporting patterns. Ms. Allison noted that there could be very reasonable explanations for the anomalies in the data. She said identification of an anomaly does

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not mean the data is wrong, but it is merely an indication that the company should review the data and provide a valid explanation where possible. She said explanations are tracked to avoid repeating the question next year. She anticipates the process will be easier next year.

Ms. Allison said the NAIC recommends that the Task Force extend the deadline for corrected submissions to March 31, 2022. She said the extension will allow companies more time to correct and resubmit their data. She encouraged companies to not delay submitting their data; they should submit the data as soon as they have addressed the data exceptions and the questions from the data validation and field distribution reviews. She said extending the deadline will not adversely affect the target date for submitting data to the SOA. Mr. Boerner noted that the ability to extend the deadline is provided in the *Valuation Manual*.

The Task Force agreed to extend the deadline to March 31, 2022, without objection.

12. **Heard an Update on FMI**

Marianne Purushotham (Academy Mortality Improvements Life Working Group [MILWG] and SOA Preferred Mortality Project Oversight Group [Joint Committee]) presented an update (Attachment Twenty-Seven) on the methodology for developing future mortality improvement (FMI) rates applicable to the VM-20 reserve valuation. The rates are reviewed annually in a manner similar to the process used for the valuation basic table (VBT) scales. Ms. Purushotham noted that changes to the scale will be subject to a threshold of materiality. A best estimate scale and a loaded scale will be developed. The scales will vary by gender and attained age, and they will be applicable for a 20-year period.

Ms. Purushotham said the Joint Committee will develop a recommendation for reflecting the impact of COVID-19 and determine a method for smoothing FMI rates before presenting the scales to the Task Force for exposure by June 30, 2022. She expects to provide responses to exposure comments and seek Task Force approval of the FMI rates by mid-September 2022. She noted that the appendix to the presentation provides a review of the FMI scale development.

13. **Heard an Update on SOA Research and Education**

Dale Hall (SOA) gave a presentation (Attachment Twenty-Eight) on post-level term lapse and mortality predictive modeling. He said there is sufficient experience to compare graded premium, “jump to annual renewal term” premium experience, and analyze post-level term experience for 15-year level term policies. He said linear regression is used to build a model for shock lapse at the end of the level year period. He encouraged companies to access the model on the SOA website. The presentation also provided SOA analysis of HMI drivers since 1950.

14. **Heard an Update on the Recent Activities of the Academy LPC**

Laura Hanson (Academy Life Practice Council [LPC]) gave a presentation (Attachment Twenty-Nine) on the LPC’s recent activities. She highlighted Academy accomplishments, such as the recent Academy webinars, boot camp, and annual meeting. She mentioned the upcoming Winter 2022 Life Policy Update webinar scheduled for January. She noted Academy efforts to provide policy analysis on the use of annuities in retirement plans, the use of data and algorithms in risk classification and underwriting, and supporting efforts to promote diversity and inclusion within the actuarial profession and in life insurance products.

Having no further business, the Life Actuarial (A) Task Force adjourned.
The Life Actuarial (A) Task Force met Dec. 1, 2021. The following Task Force members participated: Cassie Brown, Chair, represented by Mike Boerner, Rachel Hemphill, and Karen Jiang (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Ben Bock and Thomas Reedy (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Derek Wallman (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Jonathan T. Pike represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Adopted AG 25**

Reggie Mazyck (NAIC) said no comments on *Actuarial Guideline XXV—Calculation of Minimum Reserves and Minimum Nonforfeiture Values for Policies with Guaranteed Increasing Death Benefits Based on an Index* (AG 25) were submitted during the public comment period. Jessica Sever (National Alliance of Life Companies—NALC) expressed NALC’s agreement with the revisions to the guideline. Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI also agrees with the revisions.

Mr. Chou made a motion, seconded by Mr. Weber, to adopt AG 25 (Attachment One-A). The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.

https://naiconline.sharepoint.com/:f:/r/sites/NAICSupportStaffHub/Member_Meetings/Fall_2021/TF/LifeActuarial/LATF Calls/12 01/Dec 1 minutes
Adopted by LATF  
Dec. 1, 2021

ACTUARIAL GUIDELINE XXV

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

A. Valuation - Text

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

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

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

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

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

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

B. Nonforfeiture – Text

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

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

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

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

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

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

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

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

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

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

(a) the nonforfeiture interest rate defined in Section 3 of VM-02, Minimum Nonforfeiture Mortality and Interest, less:
   1. 4.5%–0 bp If the annual increase based on the index is limited to a maximum of 0% through 5.0%.
   2. 4.25%–25 bp If the annual increase based on the index is limited to a maximum of 5.01% through 10.0%.
   3. 4.0%–50 bp For all other plans.

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

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

For purposes of this guideline multiple policies on a single life shall be aggregated and only those policies aggregating not more than $10,000 (or the threshold amount1 after December 31, 2009), shall be considered under B.II.

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

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

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

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

In the case of policies for an initial amount of insurance of $5,000 or less, the IRS rules provide an exception to the prohibition of assuming increasing death benefits. However, since many of the policies for very low amounts of initial face amount of insurance would require relatively high expenses if underwritten, many of the policies are issued with simplified underwriting or on a guaranteed issue basis with lower amounts of death benefits in the early policy years, some of the resulting annual increases are such as would disqualify many of the policies for the exception. Therefore, it is recommended that policies for low amounts of insurance be allowed to qualify under the cash value accumulation test by permitting the nonforfeiture values to be based on a level death benefit and a net assumed nonforfeiture interest rate equal to the maximum nonforfeiture interest rate less an assumed increase based on the index and such factors then adjusted by the projected increases will approximate factors based on assumed increases and the maximum nonforfeiture interest rate. However, the net interest rate is likely to be less than 4%. Thus, the procedure of assuming a level death benefit and a net assumed rate of not less than 4% the VM-02 nonforfeiture interest rate, Applicable Accumulation Test Minimum Rate in the Cash Value Accumulation Test under IRS Section 7702 for policies of low amounts of insurance is apt to produce lower cash values than the procedure for large amounts of insurance. Such lower values can be justified based upon the fact that the highly specialized market is prearranged funeral expenses for very small amounts of insurance per policy.

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

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

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

1 In 2010, the actuarial guideline was modified to substitute a threshold amount for 10,000, such threshold being increased by the change in the CPI-U, the CPI for All Urban Consumers.
The Life Actuarial (A) Task Force and the VM-22 (A) Subgroup of the Life Actuarial (A) Task Force met Nov. 18, 2021. The following Task Force members participated: Cassie Brown, Chair, represented by Mike Boerner, Rachel Hemphill, and Karen Jiang (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Ben Bock and Thomas Reedy (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Amy L. Beard represented by Stephen Chamblee (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Derek Wallman (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Jonathan T. Pike represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

The following Subgroup members participated: Bruce Sartain, Chair, and Vincent Tsang (IL); Elaine Lam and Thomas Reedy (CA); Lei Rao-Knight (CT); Mike Yanacheak (IA); Nicole Boyd (KS); William Leung (MO); Seong-min Eom (NJ); Bill Carmello and Amanda Fenwick (NY); Jonathan T. Pike represented by Tomasz Serbinowski (UT); and Craig Chupp (VA). Also participating was: Ben Slutsker (MN).

1. **Adopted Amendment Proposal 2021-12**

Mr. Chupp proposed an edit to amendment proposal 2021-12 to correct misnumbering.

Mr. Weber made a motion, seconded by Mr. Chou, to adopt amendment proposal 2021-12 (Attachment Two-A), including the editorial change identified by Mr. Chupp. The motion passed unanimously.

2. **Re-Exposed AG 25**

Mr. Chupp said that after discussing his comment letter (Attachment Two-B) with NAIC staff, he agreed to withdraw his first comment. He said that the changes proposed in his second proposal, his fourth comment, and the latter half of his fifth comment were added to *Actuarial Guideline XXV—Calculation of Minimum Reserves and Minimum Nonforfeiture Values for Policies with Guaranteed Increasing Death Benefits Based on an Index (AG 25)* (Attachment Two-C). He said his third comment and the first part of his fifth comment are outside of the scope of the current exposure and will be deferred for a future review of AG 25. Jim Hodges (National Alliance of Life Companies—NALC) said the proposed revisions satisfactorily address the issues the NALC requested the Task Force to consider.

Mr. Chupp made a motion, seconded by Mr. Slutsker, to re-expose AG 25 for a 12-day public comment period ending Nov. 29. The motion passed unanimously.

3. **Agreed to Send a Request for Mortality Rate Development to the SOA and the Academy**

Mr. Sartain said the Standard Projection Amount Drafting Group of the VM-22 (A) Subgroup has drafted a request (Attachment Two-D) for the Society of Actuaries (SOA) and the American Academy of Actuaries (Academy) to develop rates for structured settlement mortality. He asked the Subgroup to approve forwarding the request to the SOA and the Academy. The Subgroup agreed, without objection, to forward the request to the SOA and the Academy.

Having no further business, the Life Actuarial (A) Task Force adjourned.

https://naiconline.sharepoint.com/w:/r/sites/NAICSupportStaffHub/MemberMeetings/Fall 2021/TF/LifeActuarial/LATF Calls/11 18/Nov 18 Minutes

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

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

Identification:
PBR Staff of Texas Department of Insurance

Title of the Issue:

2. Three prescribed assumptions do not have clear requirements for VA contracts with no minimum guaranteed benefits in Additional Standard Projection Amount in VM-21 Section 6.C. These three prescribed assumptions are Partial Withdrawal, Account Value Depletion, and Other Voluntary Contract Termination.

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


January 1, 2022 NAIC Valuation Manual

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

See attached.

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

1. VM-21 requires the CSMP method for Additional Standard Projection Amount be applied to a seriatim in-force to capture the impact of model offices under a few deterministic scenarios. There is an incorrect section reference for the in force method required for the prescribed amounts calculation in the CSMP method. There are also other incorrect section references that need to be corrected.

2. VM-21 does not make clear what requirements should be used for VA contract with no minimum guaranteed benefit for the prescribed assumptions for partial withdrawal, account value depletion and other voluntary contract termination. The requirements for these three prescribed assumptions for VA contracts with no minimum guaranteed benefits should be added to VM-21 Section 6.C.

For Partial Withdrawal assumption, it is reasonable to set the partial withdrawal rate at 3.5% or greater for VA contract with no minimum benefit since the prescribed partial withdrawal rate is 3.5% for GMDB only without guaranteed growth in the benefit basis. For Account Value Depletion assumption, the termination is assumed when the Contract’s account value reaches zero. For Other Voluntary Contract Terminations
assumption, the requirement should be clearly referred to Table 6.3 defined in Full Surrenders of Section 6.C.6.
VM-21 Section 6.B.3

3. Calculation Methodology

   a. CSMP Method:

   i. The company shall apply this method to a seriatim in force.

   ii. Calculate the scenario reserve, as defined in VM-01 and discussed further in Section 4.B, for each of the prescribed market paths outlined in Section 6.B.6 using the same method and assumptions as those that the company uses to calculate scenario reserves for the purposes of determining the CTE70 (adjusted), as outlined in Section 9.C. These scenario reserves shall collectively be referred to as a Company Standard Projection Set.

   iii. Identify the market path from the Company Standard Projection Set such that the scenario reserve is closest to the CTE70 (adjusted), designated as Path A. This scenario reserve shall be referred to as Company Amount A.

   iv. Identify the following four market paths:

      • Two paths with the same starting interest rate as Path A, but equity shocks +/− 5% from that of Path A.

      • Two paths with the same equity fund returns as Path A, but the next higher and next lower interest rate shocks.

   From the four paths, identify Path B whose reserve value is:

      • If Company Amount A is lower than CTE70 (adjusted), the smallest reserve value that is greater than CTE70 (adjusted).

      • If Company Amount A is greater than CTE70 (adjusted), the greatest reserve value that is less than CTE70 (adjusted).

   If none of the four paths satisfy the stated condition, discard the identified Path A, and redo steps (ii i) and (ii iv) using the next closest scenario to CTE70 (adjusted) to be the new Path A in step (iii).

   For the path designated as Path B, the scenario reserve shall be referred to as Company Amount B.

   v. Recalculate the scenario reserves for Path A and Path B using the same method as outlined in step (ii) above, but substitute the assumptions prescribed in Section 6.C and use the modeled in force prescribed by Section 6.B.2a seriatim in force. These scenario reserves shall be referred to as Prescribed Amount A and Prescribed Amount B, respectively.

   vi. Calculate the Prescribed Projections Amount as:
Prescribed Projections Amount

\[ \text{Prescribed Projections Amount} = \text{Prescribed Amount A} + (\text{CTE70 (adjusted)} - \text{Company Amount A}) \times \left( \frac{\text{Prescribed Amount B} - \text{Prescribed Amount A}}{\text{Company Amount B} - \text{Company Amount A}} \right) \]

**VM-21 Section 6.B.6.a**

a. Equity Fund Returns

Eight equity fund return market paths shall be used. These market paths differ only in the prescribed gross return in the first projection year.

The eight prescribed gross returns for equity funds in the first projection year shall be negative 25% to positive 10%, at 5% intervals. These gross returns shall be projected to occur linearly over the full projection year. After the first projection year, all prescribed equity fund return market paths shall assume total gross returns of 3% per annum.

If the eight prescribed equity fund market paths are insufficient for a company to calculate the additional standard projection amount via steps (i) through (vii) outlined in Section 6.B.3.a, then the company shall include additional equity fund market paths that increase or decrease the prescribed gross returns in the first projection year by 5% increments at a time.

**VM-21 Section 6.B.6.b**

If the five prescribed interest rate market paths are insufficient for a company to calculate the Additional Standard Projection Amount via steps (i) through (vii) outlined in Section 6.B.3.a, then the company shall include additional interest rate market paths that increase or decrease the prescribed starting Treasury Department rates at each point on the term structure by increments equal to 25% of the difference between the Treasury Department rate as of the valuation date and 0.01%. The lowest interest rate to be used in this analysis is 0.01%.

**VM-21 Section 6.C.4**

4. Partial Withdrawals

jk. For contracts with no minimum guaranteed benefits, the partial withdrawal amount each year shall equal 3.5% of the Account Value.

jkl. There may be instances where the company has certain data limitations, (e.g., with respect to policies that are not enrolled in an automatic withdrawal program but have exercised a non-excess withdrawal in the contract year immediately preceding the valuation date [Section 6.C.4.g and
Section 6.C.4.i]. The company may employ an appropriate proxy method if it does not result in a material understatement of the reserve.

VM-21 Section 6.C.10
10. Account Value Depletions

The following assumptions shall be used when a contract’s Account Value reaches zero:

a. If the contract has a GMWB, the contract shall take partial withdrawals that are equal in amount each year to the guaranteed maximum annual withdrawal amount.

b. If the contract has a GMIB, the contract shall annuitize immediately. If the GMIB contractually terminates upon account value depletion, such termination provision is assumed to be voided in order to approximate the contract holder’s election to annuitize immediately before the depletion of the account value.

c. If the contract has any other guaranteed benefits, including a GMDB, the contract shall remain in-force. If the guaranteed benefits contractually terminate upon account value depletion, such termination provisions are assumed to be voided in order to approximate the contract holder’s retaining adequate Account Value to maintain the guaranteed benefits in force.

At the option of the company, fees associated with the contract and guaranteed benefits may continue to be charged and modeled as collected even if the account value has reached zero. While the contract must remain in-force, benefit features may still be terminated according to contractual terms other than account value depletion provisions.

d. If the contract has no minimum guaranteed benefits, the contract should be terminated according to contractual terms.

VM-21 Section 6.C.11
11. Other Voluntary Contract Terminations

For contracts that have other elective provisions that allow a contract holder to terminate the contract voluntarily, the termination rate shall be calculated based on the Standard Table for Full Surrenders as detailed above in Table 6.3 with the following adjustments:

a. If the contract holder is not yet eligible to terminate the contract under the elective provisions, the termination rate shall be zero.

b. After the contract holder becomes eligible to terminate the contract under the elective provisions, the termination rate shall be determined using the “Subsequent years” column of Table 6.3.

c. In using Table 6.3, the ITM of a contract’s guaranteed benefit shall be calculated based on the ratio of the guaranteed benefit’s GAPV to the termination value of the contract. The termination value of the contract shall be calculated as the GAPV of the payment stream that the contract holder is entitled to receive upon termination of the contract; if the contract holder has multiple options for the payment stream, the termination value shall be the highest GAPV of these options.
d. For GMWB or hybrid GMIB contracts, for all contract years in which a withdrawal is projected, the termination rate obtained from Table 6.3 shall be additionally multiplied by 60%.

For calculating the ITM of a hybrid GMIB, the guaranteed benefit’s GAPV shall be the larger of the Annuitization GAPV or the Withdrawal GAPV.

e. For contracts with no minimum guaranteed benefits, ITM is 0%; for all contract years in which a withdrawal is projected, the termination rate obtained from Table 6.3 shall be the row in the table for ITM < 50% using the “Subsequent years” column of Table 6.3.
Date: November 4, 2021

Virginia is submitting comments regarding the following exposure:

**AG 25 Revision (Calculation of Minimum Reserves and Minimum Nonforfeiture Values for Policies with Guaranteed Increasing Death Benefits Based on an Index)**

**Comments:**

1. In the first paragraph of B.II, the use of a comma in the title of VM-02 is confusing. Other references to the Valuation Manual in actuarial guidelines do not include the title of the VM section, but just simply use a reference such as VM-21. The reference to VM-02 in the first paragraph under B.II should eliminate the title of VM-02 or use a colon to match exactly the title used in the VM, as such: “VM-02: Minimum Nonforfeiture Mortality and Interest”.

2. The nonforfeiture interest rate used under B.II should not be allowed to be less than the Applicable Accumulation Test Minimum Rate in the CVAT under Section 7702. If the nonforfeiture interest rate under B.II is less than the Section 7702 interest rate, then it seems likely that the policy would not be able to qualify as life insurance under Section 7702. Suggested wording is as follows:

   ... a nonforfeiture interest rate equal to the greater of (a) and (b):

   a. the nonforfeiture interest rate defined in Section 3 of VM-02, less:

      i. 0 bp, if the annual increase based on the index is limited to a maximum of 0% through 5.0%,

      ii. 25 bp, if the annual increase based on the index is limited to a maximum of 5.01% through 10.0%, or

      iii. 50 bp, for all other plans.

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

3. The current wording under B.II of AG 25 regarding the annual adjustment to the present value of future benefits component does not seem to be correct. Since the procedure under B.II is based on a level death benefit, should not the adjustment be the ratio of the current death benefit to the initially projected amount of death benefit?
4. The nonforfeiture interest rate under B.II will always be less than or equal to the VM-02 rate. Therefore, the 3rd sentence of the 4th paragraph under “Background” should read as follows: “Therefore, it is recommended that policies for low amounts of insurance be allowed to qualify under the cash value accumulation test by permitting the nonforfeiture values to be based on a level death benefit and an interest rate no greater than the VM-02 nonforfeiture interest rate and requiring such values to be updated as increases based on the index take place.”

5. I do not fully understand the 5th paragraph under “Background”. The point of this paragraph seems to be to point out that the procedure under B.II is likely to produce lower cash values than the procedure for large amounts of insurance under B.I and that these lower cash values are justified for very small amounts of insurance. I did some sample calculations and it seems that this would still be true with the AG 25 revisions. I also did some sample calculations assuming level premiums and it still seems to hold true. Thus, I am not sure that it is necessary to qualify that this paragraph only applies for single premium policies. Also, the wording in the first sentence is very confusing and does not make sense. It seems to say that the adjusted factors using the B.II procedure will approximate factors based on assumed increases using the B.I procedure. However, I worked through an example with a single premium policy and the cash values adjusted by the ratio of the current death benefit to the initial level death benefit were much lower in the early durations and then grew at a faster rate so that the cash value was equal to the cash value using the B.I procedure at the terminal age. Given this, I recommend that the first sentence be deleted. The 2nd sentence that states that the net assumed rate is not less than the VM-02 nonforfeiture interest rate is incorrect. The 2nd sentence (which would really be the 1st sentence if the existing 1st sentence is deleted) could be re-written as follows: “The procedure of assuming a level death benefit and a net assumed rate that cannot be more than 50 bp lower than the VM-02 nonforfeiture interest rate for policies of low amounts of insurance is apt to produce lower cash values than the procedure for large amounts of insurance.”

Thank you for your consideration of these comments.

Craig Chupp, FSA, MAAA
Life and Health Insurance Actuary
Virginia Bureau of Insurance
craig.chupp@scc.virginia.gov
Phone: (804) 371-9131
ACTUARIAL GUIDELINE XXV

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

A. Valuation - Text

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

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

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

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

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

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

B. Nonforfeiture – Text

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

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

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

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

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

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

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

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

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

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

(a) the nonforfeiture interest rate defined in Section 3 of VM-02, Minimum Nonforfeiture Mortality and Interest, less:
   1. 0 bp If the annual increase based on the index is limited to a maximum of 0% through 5.0%.
   2. 25 bp If the annual increase based on the index is limited to a maximum of 5.01% through 10.0%.
   3. 50 bp For all other plans.

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

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

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

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

BACKGROUND

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

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

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

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

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

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

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

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

\[^1\] In 2010, the actuarial guideline was modified to substitute a threshold amount for 10,000, such threshold being increased by the change in the CPI-U, the CPI for All Urban Consumers.
NAIC Life Actuarial (A) Task Force’s Valuation Manual (VM) - 22 (A) Subgroup requests assistance from the American Academy of Actuaries (the Academy) and the Society of Actuaries (SOA) with respect to the development of appropriate mortality rates to be used as prescribed assumptions within a VM-22 Standard Projection Amount per the Standard Projection Amount Drafting Group’s Statement of Intent. Specifically the VM-22 (A) Subgroup requests the following:

1) In the short term develop best estimate mortality rates for standard Structured Settlement Annuities (SSAs), and if time permits substandard SSAs. We expect the SOA and the Academy to use their professional judgment as to how best to proceed. Our current expectation is that a set of mortality adjustment factors will be applied to the current statutorily prescribed 1983 Individual Annuity Mortality (IAM) Basic Table and the mortality adjustment factors will be developed based on SOA 2005-2017 Structured Settlement Mortality Experience Study. We request the mortality rates be completed in time for the VM-22 Field Study that is currently scheduled to be performed in May 2022.

2) In the longer term develop a new best estimate mortality table for SSAs. We expect the SOA and the Academy to use their professional judgment as to how best to proceed. Our current expectation is for the table to be developed based on the SOA 2005-2017 Structured Settlement Mortality Experience Study.

Thank You,

Bruce Sartain, Chair, NAIC Life Actuarial (A) Task Force VM - 22 (A) Subgroup

* Explore the feasibility of creating a Standard Projection Amount (SPA) using methodology consistent with VM-21. The Drafting Group (DG) will identify the (most) material assumptions by product line, identify appropriate data sources, and determine SPA prescribed assumptions. Those prescribed assumptions will be used to identify company outlier assumptions and substituted for company assumptions in a re-run of the stochastic reserve calculation. The DG is not expected to make a recommendation as to whether the SPA should result in a reserve floor or disclosure item.
The Life Actuarial (A) Task Force met Nov. 4, 2021. The following Task Force members participated: Cassie Brown, Chair, represented by Mike Boerner, Rachel Hemphill, and Karen Jiang (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Ben Bock and Thomas Reedy (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Amy L. Beard represented by Stephen Chamblee (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen (MN); Chloria Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Derek Wallman (NE); Marlene Caride represented by Seong-min Eom (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); Jonathan T. Pike represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. Re-Exposed Amendment Proposal 2021-12

Bill Wilton (Unaffiliated) discussed his comment letter (Attachment Three-A), which recommends that the reference in amendment proposal 2021-12 (Attachment Three-B) to 0% in-the-money (ITM) be changed to 100% ITM. He said the benefit or guarantee is perceived to be ITM when it provides value in excess of the account value. He said when there is no guaranteed benefit, it is considered at-the-money, which implies that the ITM percentage should be 100%. Ms. Jiang disagreed. She said that Section 6 of VM-21, Requirements for Principle-Based Reserves for Variable Annuities, defines ITM as the ratio of the greatest accumulated present value (GAPV) of a guaranteed benefit to the account value (AV). She said that in the case where there is no guaranteed benefit, the GAPV is zero. Therefore, the ratio of GAPV to AV would be zero.

Brian Bayerle (American Council of Life Insurers—ACLI) said the ACLI comment letter (Attachment Three-C) expressed agreement with the changes in the amendment proposal but suggested a few clarifications. He said the requirements of Section 6.B.3.a.i are intended to apply only to Section 6.B.3.a.v and not to Section 6.B.3.a.ii through Section 6.B.3.a.iv. He suggested deleting Section 6.B.3.a.i and revising the wording of what then becomes Section 6.B.3.a.iv by removing the phrase “the modeled in force prescribed by Section 6.B.3.a.i.” Ms. Jiang agreed with the ACLI edits. She provided a version of amendment proposal 2021-12 that includes the changes suggested by the ACLI and other renumbering changes for potential re-exposure.

Mr. Leung made a motion, seconded by Mr. Weber, to re-expose the new version amendment proposal 2021-12 (Attachment Three-D), including the identified edits, for a 12-day public comment period ending Nov. 16. The motion passed unanimously.

2. Adopted Amendment Proposal 2021-13

Mr. Bock made a motion, seconded by Mr. Weber, to adopt amendment proposal 2021-13 (Attachment Three-E), after striking the last sentence in the guidance note. The motion passed unanimously.

3. Received an Update on the ESG

Scott O’Neal (NAIC) provided a presentation (Attachment Three-F) on the status of the economic scenario generator (ESG). He said a large part of the work on the ESG has been the development of acceptance criteria for the treasury model. He noted that the presentation lists the acceptance criteria in priority order. He said Conning Inc. is working on a new Treasury calibration based on the acceptance criteria. He noted that while Conning is working on the Treasury calibration, the ESG drafting group is beginning to work on the equity model. Mr. Carmello voiced concern that the low for long criteria is not conservative enough. He also suggested that the presentation highlight that December 2020 is the reference point for validation of the current acceptance criteria.
4. Received an Update on the Experience Data Collection Project

Pat Allison (NAIC) said the experience data collection project has participation from 110 companies representing 87.5% of industry claims. She said 83 of the participating companies previously participated in either the Kansas or New York data calls. She said 75 full submissions and nine partial submissions have been received. She noted that NAIC staff are currently reviewing submissions and providing validation packages to assist companies in their file cleanup efforts. She said the NAIC staff review also includes analyzing field distributions to screen company data for year-to-year consistency.

5. Discussed Other Matters

Reggie Mazyck (NAIC) said revisions to Actuarial Guideline XXV—Calculation of Minimum Reserves and Minimum Nonforfeiture Values for Policies with Guaranteed Increasing Death Benefits Based on an Index (AG 25) were exposed by the Task Force chair for a public comment period ending Nov. 17. He said the change, which removes the fixed 4% nonforfeiture rate floor, aligns the guideline with the VM-02, Minimum Nonforfeiture Mortality and Interest, changes implemented for the 2021 Valuation Manual. Mr. Mazyck said the Task Force plans to adopt AG 25 prior to the Fall National Meeting. He said the Life Insurance and Annuities (A) Committee and the Executive (EX) Committee and Plenary are expected to consider adoption of AG 25 during the Fall National Meeting.

Having no further business, the Life Actuarial (A) Task Force adjourned.

https://naiconline.sharepoint.com/w:/r/sites/NAICSupportStaffHub/MemberMeetings/Fall 2021/TF/LifeActuarial/LATF Calls/11 04/Nov 4 Minutes
October 19, 2021

Reggie Mazyck
National Association of Insurance Commissioners
1100 Walnut Street – Suite 1500
Kansas City, MO 64106-2197

Re: APF 2021-12

I appreciate the opportunity to provide comments on amendment proposal form 2021-12 proposed by the PBR Staff of Texas Department of Insurance.

I would like clarification on Section 6.C.11. What is the rationale for referencing 0% ITM?

In Section 6.C.3. the following is stated:

The GAPV represents the actuarial present value of the lump sum or income payments associated with a guaranteed benefit. For the purpose of calculating the GAPV, such payments shall include the portion that is paid out of the contract holder’s Account Value.

Since there are no minimum guaranteed benefits and assuming that an account value still exists on the contract, the current requirements of VM-21 would imply a 100% ITM, not 0%.

Should Section 6.C.11 be revised as follows:

e. For contracts with no minimum guaranteed benefits, ITM is 100%; for all contract years in which a withdrawal is projected, the termination rate obtained from Table 6.3 shall be the row in the table for ITM 100-125% < 50% using the “Subsequent years” column of Table 6.3.

Similarly, in Section 6 Full Surrenders, it appears that the current requirements also stated the ITM as 0%. It would seem that ITM should also be 100% in this section. The modification would be:

For contracts with no minimum guaranteed benefits, ITM is 100%; and the row in the table for ITM 100-125% < 50% would apply.

Sincerely,

William H. Wilton, FSA, MAAA
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
PBR Staff of Texas Department of Insurance

Title of the Issue:

2. Three prescribed assumptions do not have clear requirements for VA contracts with no minimum guaranteed benefits in Additional Standard Projection Amount in VM-21 Section 6.C. These three prescribed assumptions are Partial Withdrawal, Account Value Depletion, and Other Voluntary Contract Termination.

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


January 1, 20224 NAIC Valuation Manual

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

See attached.

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

1. VM-21 requires the CSMP method for Additional Standard Projection Amount be applied to a seriatim in-force to capture the impact of model offices under a few deterministic scenarios. There is an incorrect section reference for the in force method required for the prescribed amounts calculation in the CSMP method. There are also other incorrect section references that need to be corrected.

2. VM-21 does not make clear what requirements should be used for VA contract with no minimum guaranteed benefit for the prescribed assumptions for partial withdrawal, account value depletion and other voluntary contract termination. The requirements for these three prescribed assumptions for VA contracts with no minimum guaranteed benefits should be added to VM-21 Section 6.C.

For Partial Withdrawal assumption, it is reasonable to set the partial withdrawal rate at 3.5% or greater for VA contract with no minimum benefit since the prescribed partial withdrawal rate is 3.5% for GMDB only without guaranteed growth in the benefit basis. For Account Value Depletion assumption, the termination is assumed when the Contract’s account value reaches zero. For Other Voluntary Contract Terminations
assumption, the requirement should be clearly referred to Table 6.3 defined in Full Surrenders of Section 6.C.6.
VM-21 Section 6.B.3

3. Calculation Methodology

a. CSMP Method:

i. The company shall apply this method to a seriatim in-force.

ii. Calculate the scenario reserve, as defined in VM-01 and discussed further in Section 4.B, for each of the prescribed market paths outlined in Section 6.B.6 using the same method and assumptions as those that the company uses to calculate scenario reserves for the purposes of determining the CTE70 (adjusted), 2 as outlined in Section 9.C. These scenario reserves shall collectively be referred to as a Company Standard Projection Set.

ii. Identify the market path from the Company Standard Projection Set such that the scenario reserve is closest to the CTE70 (adjusted), designated as Path A. This scenario reserve shall be referred to as Company Amount A.

iii. Identify the following four market paths:

- Two paths with the same starting interest rate as Path A, but equity shocks +/− 5% from that of Path A.

- Two paths with the same equity fund returns as Path A, but the next higher and next lower interest rate shocks.

From the four paths, identify Path B whose reserve value is:

- If Company Amount A is lower than CTE70 (adjusted), the smallest reserve value that is greater than CTE70 (adjusted).

- If Company Amount A is greater than CTE70 (adjusted), the greatest reserve value that is less than CTE70 (adjusted).

If none of the four paths satisfy the stated condition, discard the identified Path A, and redo steps (ii i) and (iiiv ) using the next closest scenario to CTE70 (adjusted) to be the new Path A in step (iii).

For the path designated as Path B, the scenario reserve shall be referred to as Company Amount B.

iv. Recalculate the scenario reserves for Path A and Path B using the same method as outlined in step (ii) above, but substitute the assumptions prescribed in Section 6.C and use the modeled in-force prescribed by Section 6.B.2a seriatim in force. These scenario reserves shall be referred to as Prescribed Amount A and Prescribed Amount B, respectively.

v. Calculate the Prescribed Projections Amount as:
Prescribed Projections Amount

\[ = \text{Prescribed Amount } A + (\text{CTE70 (adjusted)} - \text{Company Amount } A) \]
\[ \times \frac{\text{Prescribed Amount } B - \text{Prescribed Amount } A}{\text{Company Amount } B - \text{Company Amount } A} \]

**VM-21 Section 6.B.6.a**

a. Equity Fund Returns

Eight equity fund return market paths shall be used. These market paths differ only in the prescribed gross return in the first projection year.

The eight prescribed gross returns for equity funds in the first projection year shall be negative 25% to positive 10%, at 5% intervals. These gross returns shall be projected to occur linearly over the full projection year. After the first projection year, all prescribed equity fund return market paths shall assume total gross returns of 3% per annum.

If the eight prescribed equity fund market paths are insufficient for a company to calculate the additional standard projection amount via steps (i) through (vii) outlined in Section 6.B.3.a, then the company shall include additional equity fund market paths that increase or decrease the prescribed gross returns in the first projection year by 5% increments at a time.

**VM-21 Section 6.B.6.b**

If the five prescribed interest rate market paths are insufficient for a company to calculate the Additional Standard Projection Amount via steps (i) through (vii) outlined in Section 6.B.3.a, then the company shall include additional interest rate market paths that increase or decrease the prescribed starting Treasury Department rates at each point on the term structure by increments equal to 25% of the difference between the Treasury Department rate as of the valuation date and 0.01%. The lowest interest rate to be used in this analysis is 0.01%.

**VM-21 Section 6.C.4**

4. Partial Withdrawals

i. For contracts with no minimum guaranteed benefits, the partial withdrawal amount each year shall equal 3.5% of the Account Value.

j. There may be instances where the company has certain data limitations, (e.g., with respect to policies that are not enrolled in an automatic withdrawal program but have exercised a non-excess withdrawal in the contract year immediately preceding the valuation date [Section 6.C.4.g and Section 6.C.4.i]). The company may employ an appropriate proxy method if it does not result in a material understatement of the reserve.
VM-21 Section 6.C.10

10. Account Value Depletions
The following assumptions shall be used when a contract’s Account Value reaches zero:

a. If the contract has a GMWB, the contract shall take partial withdrawals that are equal in amount each year to the guaranteed maximum annual withdrawal amount.

b. If the contract has a GMIB, the contract shall annuitize immediately. If the GMIB contractually terminates upon account value depletion, such termination provision is assumed to be voided in order to approximate the contract holder’s election to annuitize immediately before the depletion of the account value.

c. If the contract has any other guaranteed benefits, including a GMDB, the contract shall remain in-force. If the guaranteed benefits contractually terminate upon account value depletion, such termination provisions are assumed to be voided in order to approximate the contract holder’s retaining adequate Account Value to maintain the guaranteed benefits in force.

At the option of the company, fees associated with the contract and guaranteed benefits may continue to be charged and modeled as collected even if the account value has reached zero. While the contract must remain in-force, benefit features may still be terminated according to contractual terms other than account value depletion provisions.

d. If the contract has no minimum guaranteed benefits, the contract should be terminated according to contractual terms.

VM-21 Section 6.C.11

11. Other Voluntary Contract Terminations
For contracts that have other elective provisions that allow a contract holder to terminate the contract voluntarily, the termination rate shall be calculated based on the Standard Table for Full Surrenders as detailed above in Table 6.3 with the following adjustments:

a. If the contract holder is not yet eligible to terminate the contract under the elective provisions, the termination rate shall be zero.

b. After the contract holder becomes eligible to terminate the contract under the elective provisions, the termination rate shall be determined using the “Subsequent years” column of Table 6.3.

c. In using Table 6.3, the ITM of a contract’s guaranteed benefit shall be calculated based on the ratio of the guaranteed benefit’s GAPV to the termination value of the contract. The termination value of the contract shall be calculated as the GAPV of the payment stream that the contract holder is entitled to receive upon termination of the contract; if the contract holder has multiple options for the payment stream, the termination value shall be the highest GAPV of these options.

d. For GMWB or hybrid GMIB contracts, for all contract years in which a
withdrawal is projected, the termination rate obtained from Table 6.3 shall be additionally multiplied by 60%.

For calculating the ITM of a hybrid GMIB, the guaranteed benefit’s GAPV shall be the larger of the Annuitzation GAPV or the Withdrawal GAPV.

e. For contracts with no minimum guaranteed benefits, ITM is 0%; for all contract years in which a withdrawal is projected, the termination rate obtained from Table 6.3 shall be the row in the table for ITM < 50% using the “Subsequent years” column of Table 6.3.
Mr. Mike Boerner
Chair, NAIC Life Actuarial Task Force (LATF)

Re: APFs 2021-12 and 2021-13

Dear Mr. Boerner:

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit the following comments on APFs 2021-12 and 2021-13.

APF 2021-12
We agree with the proposed changes, but we do have an alternate suggestion for the first proposal that should further enhance the clarity of CSMP implementation for both regulators and companies. It is ACLI’s understanding that the requirements of 6.B.3.a.i intend to apply to 6.B.3.a.v, and not 6.B.3.a.ii through 6.B.3.a.iv. In the current order, this may be a potential source of confusion. We would suggest striking 6.B.3.a.i, relabeling the remaining romanettes and references to them, then revising the text in what will now be 6.B.3.a.iv (as opposed to 6.B.3.a.v) as follows:

iv. Recalculate the scenario reserves for Path A and Path B using the same method as outlined in step (ii) above, but substitute the assumptions prescribed in Section 6.C and use a seriatim inforce the modeled in force prescribed by Section 6.B.3.a.i. These scenario reserves shall be referred to as Prescribed Amount A and Prescribed Amount B, respectively.

APF 2021-13
ACLI believes that a robust principle-based framework should appropriately reflect inherent offsets between risks. However, we do recognize the inherently conservative nature of the statutory reserve framework. We do have concerns regarding the last sentence of the guidance note; given the risks are offsetting, it may not be possible to achieve the level of margin described in this sentence. For this reason, we recommend striking that sentence.

We appreciate the consideration of our comments and look forward to discussing on a future call. Thank you.
Sincerely,

[Signature]

cc: Reggie Mazyck, NAIC
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force  
Amendment Proposal Form*

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

Identification:
PBR Staff of Texas Department of Insurance

Title of the Issue:

2. Three prescribed assumptions do not have clear requirements for VA contracts with no minimum guaranteed benefits in Additional Standard Projection Amount in VM-21 Section 6.C. These three prescribed assumptions are Partial Withdrawal, Account Value Depletion, and Other Voluntary Contract Termination.

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


January 1, 2022 NAIC Valuation Manual

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

See attached.

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

1. VM-21 requires the CSMP method for Additional Standard Projection Amount be applied to a seriatim in-force to capture the impact of model offices under a few deterministic scenarios. There is an incorrect section reference for the in force method required for the prescribed amounts calculation in the CSMP method. There are also other incorrect section references that need to be corrected.

2. VM-21 does not make clear what requirements should be used for VA contract with no minimum guaranteed benefit for the prescribed assumptions for partial withdrawal, account value depletion and other voluntary contract termination. The requirements for these three prescribed assumptions for VA contracts with no minimum guaranteed benefits should be added to VM-21 Section 6.C.

For Partial Withdrawal assumption, it is reasonable to set the partial withdrawal rate at 3.5% or greater for VA contract with no minimum benefit since the prescribed partial withdrawal rate is 3.5% for GMDB only without guaranteed growth in the benefit basis. For Account Value Depletion assumption, the termination is assumed when the Contract’s account value reaches zero. For Other Voluntary Contract Terminations
assumption, the requirement should be clearly referred to Table 6.3 defined in Full Surrenders of Section 6.C.6.
VM-21 Section 6.B.3
3. Calculation Methodology

a. CSMP Method:

   i.ii. Calculate the scenario reserve, as defined in VM-01 and discussed further in Section 4.B, for each of the prescribed market paths outlined in Section 6.B.6 using the same method and assumptions as those that the company uses to calculate scenario reserves for the purposes of determining the CTE70 (adjusted), 2 as outlined in Section 9.C. These scenario reserves shall collectively be referred to as a Company Standard Projection Set.

   iii.ii. Identify the market path from the Company Standard Projection Set such that the scenario reserve is closest to the CTE70 (adjusted), designated as Path A. This scenario reserve shall be referred to as Company Amount A.

   iv.iii. Identify the following four market paths:

      • Two paths with the same starting interest rate as Path A, but equity shocks +/− 5% from that of Path A.

      • Two paths with the same equity fund returns as Path A, but the next higher and next lower interest rate shocks.

         From the four paths, identify Path B whose reserve value is:

         • If Company Amount A is lower than CTE70 (adjusted), the smallest reserve value that is greater than CTE70 (adjusted).

         • If Company Amount A is greater than CTE70 (adjusted), the greatest reserve value that is less than CTE70 (adjusted).

         If none of the four paths satisfy the stated condition, discard the identified Path A, and redo steps (ii) and (iii) using the next closest scenario to CTE70 (adjusted) to be the new Path A in step (iii).

         For the path designated as Path B, the scenario reserve shall be referred to as Company Amount B.

   v.iv. Recalculate the scenario reserves for Path A and Path B using the same method as outlined in step (ii) above, but substitute the assumptions prescribed in Section 6.C and use the modeled in force prescribed by Section 6.B.2a seriatim in force. These scenario reserves shall be referred to as Prescribed Amount A and Prescribed Amount B, respectively.

   v.v. Calculate the Prescribed Projections Amount as:
Prescribed Projections Amount

\[ = \text{Prescribed Amount } A + (\text{CTE70 (adjusted)} - \text{Company Amount } A) \]

\[ \times \left( \frac{\text{Prescribed Amount } B - \text{Prescribed Amount } A}{\text{Company Amount } B - \text{Company Amount } A} \right) \]

**VM-21 Section 6.B.6.a**

**Equity Fund Returns**

Eight equity fund return market paths shall be used. These market paths differ only in the prescribed gross return in the first projection year.

The eight prescribed gross returns for equity funds in the first projection year shall be negative 25% to positive 10%, at 5% intervals. These gross returns shall be projected to occur linearly over the full projection year. After the first projection year, all prescribed equity fund return market paths shall assume total gross returns of 3% per annum.

If the eight prescribed equity fund market paths are insufficient for a company to calculate the additional standard projection amount via steps (i) through (vii) outlined in Section 6.B.3.a, then the company shall include additional equity fund market paths that increase or decrease the prescribed gross returns in the first projection year by 5% increments at a time.

**VM-21 Section 6.B.6.b**

If the five prescribed interest rate market paths are insufficient for a company to calculate the Additional Standard Projection Amount via steps (i) through (vii) outlined in Section 6.B.3.a, then the company shall include additional interest rate market paths that increase or decrease the prescribed starting Treasury Department rates at each point on the term structure by increments equal to 25% of the difference between the Treasury Department rate as of the valuation date and 0.01%. The lowest interest rate to be used in this analysis is 0.01%.

**VM-21 Section 6.C.4**

4. Partial Withdrawals

\[ j. \text{ For contracts with no minimum guaranteed benefits, the partial withdrawal amount each year shall equal 3.5\% of the Account Value.} \]

\[ k. \text{ There may be instances where the company has certain data limitations, (e.g., with respect to policies that are not enrolled in an automatic withdrawal program but have exercised a non-excess withdrawal in the contract year immediately preceding the valuation date [Section 6.C.4.g and} \]
Section 6.C.4). The company may employ an appropriate proxy method if it does not result in a material understatement of the reserve.

**VM-21 Section 6.C.10**

10. Account Value Depletions
The following assumptions shall be used when a contract’s Account Value reaches zero:

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c. If the contract has any other guaranteed benefits, including a GMDB, the contract shall remain in-force. If the guaranteed benefits contractually terminate upon account value depletion, such termination provisions are assumed to be voided in order to approximate the contract holder’s retaining adequate Account Value to maintain the guaranteed benefits in-force. At the option of the company, fees associated with the contract and guaranteed benefits may continue to be charged and modeled as collected even if the account value has reached zero. While the contract must remain in-force, benefit features may still be terminated according to contractual terms other than account value depletion provisions.

d. If the contract has no minimum guaranteed benefits, the contract should be terminated according to contractual terms.

**VM-21 Section 6.C.11**

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For contracts that have other elective provisions that allow a contract holder to terminate the contract voluntarily, the termination rate shall be calculated based on the Standard Table for Full Surrenders as detailed above in Table 6.3 with the following adjustments:

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For calculating the ITM of a hybrid GMIB, the guaranteed benefit’s GAPV shall be the larger of the Annuitzation GAPV or the Withdrawal GAPV.

e. For contracts with no minimum guaranteed benefits, ITM is 0%; for all contract years in which a withdrawal is projected, the termination rate obtained from Table 6.3 shall be the row in the table for ITM < 50% using the “Subsequent years” column of Table 6.3.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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

   Joint submission by:
   -- Staff of Office of Principle-Based Reserving, California Department of Insurance
   -- Texas Department of Insurance

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


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

   See attached Appendix.

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

   See attached Appendix.

NAIC Staff Comments:
Appendix

ISSUE:

It has been observed that adding the prescribed mortality margins for some Life/LTC combination products cause modeled reserves to decrease rather than increase.

SECTION:


REDLINE:

(New) VM-20 Section 9.C.6.e

e. In the event that the prescribed mortality margins set forth above do not produce a reserve increase of adequate magnitude – and in particular when the prescribed margins produce a decrease in the reserve – the company shall derive and use margins that do produce an appropriately conservative result.

Guidance Note: This can occur, for example, when a rider -- such as a long-term care rider -- is being valued together with the base policy, pursuant to Section II, Subsection 6 of the Valuation Manual. Reductions to mortality rates, rather than additions, would potentially be needed in such cases. Such a product/rider combination would likely need to be in its own separate mortality segment. In the case of the product/rider combination, and adequate magnitude for a reserve increase can be thought of in terms of the size of reserve increase that would occur for the product using the tabular prescribed margins if the rider had not been present.

VM-20 Section 9.C.7.a

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

VM-20 Section 9.C.7.b.v

v. For each policy in a given mortality segment, from the start of the projection through policy duration E, the prudent estimate mortality assumptions are the company experience mortality rates (as defined in Section 9.C.2), plus the prescribed margin pursuant to Section 9.C.6.b, and further adjusted by plus any applicable additional margin changes pursuant to Section 9.C.6.d or Section 9.C.6.e.
(New) VM-31 Section 3.D.3.o

  o. Adjustments to Prescribed Margins - Description and rationale for any adjustments made to prescribed mortality margins pursuant to VM-20 Section 9.C.6.d or 9.C.6.e.

**REASONING:**

We want to make sure that mortality margins always increase, rather than decreased, the modeled reserve.
# Treasury Model Acceptance Criteria

<table>
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<th>Item</th>
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<th>Suggested Direction for Next Iteration</th>
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</table>
| **1.** | Low For Long | 10 and 30-year geometric average of 20yr UST below current level  
  a) 10-year threshold: 10%  
  b) 30-year threshold: 5% |
| **2.** | Prevalence of High Rates, Upper Bound on Treasury Rates | a) The scenario set should reasonably reflect history, with some allowance for more extreme high and low interest rate environments  
  b) Upper Bound:  
  i. [20%] is >= [99%]-tile on the 3M yield fan chart, and no more than [5%] of scenarios have 3M yields that go above [20%] in the first 30 years  
  ii. [20%] is >= [99%]-tile on the 10Y yield fan chart, and no more than [5%] of scenarios have 10Y yields that go above [20%] in the first 30 years |
| **3.** | Lower Bound on Negative Interest Rates, Arbitrage Free Considerations | Apply the following guidance for negative rates:  
  a) All maturities could experience negative interest rates  
  b) Interest rates may remain negative for multi-year time periods  
  c) Rates should generally not be lower than -1.5%  
  A floor will likely be employed but the exact form of the floor will be determined later |

---

# Treasury Model Acceptance Criteria

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<th>Category</th>
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</table>
| **4.** | Initial Yield Curve Fit, Yield Curve Shapes in Projection, and Steady State Yield Curve Shape | a) Review initial actual vs. fitted spot curve differences for a sampling of 5 dates representing different shapes and rate levels for the entire curve and review fitted curves qualitatively to confirm they stylistically mimic the different actual yield curve shapes  
  b) The frequency of different yield curve shapes in early durations should be reasonable considering the shape of the starting yield curve (e.g. a flatter yield curve leads to more inversions).  
  c) The steady state curve has normal shape (not inverted for short maturities, longer vs shorter maturities, or between long maturities) |
| **5.** | Realized short and long maturity volatility at different interest rate levels | a) No Criteria for realized short and long maturity volatility at different interest rate levels |
The Life Actuarial (A) Task Force met Oct. 21, 2021. The following Task Force members participated: Cassie Brown, Chair, represented by Mike Boerner; Rachel Hemphill, and Karen Jiang (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Ben Bock and Thomas Reedy (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Amy L. Beard represented by Sharon Comstock (AK); Peter Weber represented by Stephen Chamblee (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Derek Wallman (NE); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Jonathan T. Pike represented by Tomasz Serbinowski (UT); and Scott A. White represented by Craig Chupp (VA).

1. **Adopted the SOA Historical Mortality Improvement Factors**

Marianne Purushotham (Society of Actuaries—SOA) presented the SOA Historical Mortality Improvement (HMI) Recommendation 2021 Scale Update (Attachment Four-A) and the HMI Scale Factors (Attachment Four-B). She said slide 10 of the presentation provides the recommendation for application of the HMI scale for 2021. The SOA recommends: 1) applying the same methodology used in past years; 2) decreasing the HMI scale for males and females; and 3) having individual companies use temporary mortality adjustments to reflect their expectations related to the effects of COVID-19 on short-term mortality levels. She said as more data is amassed, COVID-19 impacts will be reflected in future historical mortality improvement factors. Mr. Chupp expressed concern about the mortality deterioration between ages 25 and 40 that was eliminated by the smoothing technique. Ms. Purushotham said that because the smoothing was applied to all ages, the deterioration in the 25 to 40 age range is spread across all other ages and dampens the mortality improvement in the other age ranges. She said the SOA will consider using a different smoothing technique in the future. Mr. Boerner requested that the HMI Scale Factors and the recommendations on slide 10 for application of the HMI scale be reflected on the SOA website once they are adopted.

Mr. Leung made a motion, seconded by Mr. Unger, to adopt the HMI Factors and the SOA recommendations on slide 10 of the presentation. The motion passed unanimously.

2. **Exposed Amendment Proposal 2021-11**

Ms. Hemphill said amendment proposal 2021-11 seeks to address items related to VM-21, Requirements for Principle-Based Reserves for Variable Annuities, information necessary for review that companies did not include in their VM-31, PBR Actuarial Report Requirements for Business Subject to a Principle-Based Valuation reports. She recommended the changes to VM-21 and referenced the sections of VM-20, Requirements for Principle-Based Reserves for Life Products that the changes are intended to parallel. Mr. Chupp indicated a few reference changes that should be made prior to exposure.

Mr. Weber made a motion, seconded by Mr. Andersen, to expose amendment proposal 2021-11 (Attachment Four-C) for a 40-day public comment period ending Dec. 1, including the edits suggested by Mr. Chupp. The motion passed unanimously.

3. **Discussed Other Matters**

Mr. Mazyck announced that the exposure of the proposed actuarial guideline on asset adequacy testing was extended to Dec. 1.

Having no further business, the Life Actuarial (A) Task Force adjourned.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/Fall 2021/TF/LifeActuarial/LATF Calls/10 21/Oct 21 Minutes.docx
Historical Mortality Improvement Recommendation (VM-20)  
2021 Scale Update

Mortality Improvements Life Work Group (MILWG) of the 
Academy Life Experience Committee and SOA Preferred 
Mortality Project Oversight Group (“Joint Committee”)

Agenda

- Review standard methodology used for 
  Historical Mortality Improvement (HMI) 
  scale development each year
- Review results of application of the 
  methodology for 2021
- Recommendation for HMI scale for use 
  with 2021 valuation under VM20
HMI Standard Methodology

- Most recent HMI data—last 10 years
- Source: Social Security Administration (SSA)
- Historical data only available through the end of the year that is 2 years prior to the current valuation year
- Most recent SSA Alt 2 forecast of future improvements over longer period (20 years)
- Alt 2 = intermediate projection from most recent SSA Trustees Report release
- Average of historical data and forecasted components
- With smoothing process applied

Historical Component:
10-Year Historical Average Annual Improvement

Male 10 Yr Historical Averages - SSA Data

Scale Year / Data Years:
- 2021 / 2009-2019
- 2020 / 2008-2018

Attained Age

2021 Scale Year    2020 Scale Year    2019 Scale Year    2018 Scale Year
Historical Component:
10-Year Historical Average Annual Improvement

Female 10 Yr Historical Averages - SSA Data

Mortality Improvement Rates

Scale Year / Data Years:
2021 / 2009-2019
2020 / 2008-2018
2018 / 2006-2016

Attained Age

2021 Scale Year  2020 Scale Year  2019 Scale Year  2018 Scale Year

Unsmoothed Preliminary—Male
Comparison by Scale Year – 2021 Scale Revised

Males - Compare Unsmoothed Rates

Mortality Improvement Rates

Attained Age

2021 Scale Year  2020 Scale Year  2019 Scale Year  2018 Scale Year
Unsmoothed Preliminary—Female
Comparison by Scale Year - 2021 Scale Revised

Females - Compare Unsmoothed Rates

Smoothed Preliminary—Male
Comparison by Scale Year - 2021 Scale Revised

Males - Compare Smoothed Rates
Smoothed Preliminary—Female
Comparison by Scale Year - 2021 Scale Revised

Recommendation for Application of HMI Scale for 2021 Revised

Recommendation
- Use standard methodology for the published HMI scale for 2021
- Decrease the HMI scale for males and for females for 2021 based on the application of the standard methodology
- Recommend individual companies reflect their expectations around COVID-19 impacts for short-term mortality levels as part of a temporary mortality adjustment

Impact on the 12/31/21 Valuation
- Bring up to valuation date (standard Valuation Basic Table (VBT))
- Note: Companies start with different base mortality levels
  - Possibly higher mortality for the near term to reflect COVID-19
  - HMI scale would not attempt to adjust for COVID-19 as the exposure and the handling of deaths in the underlying company data will vary
Questions?

Contact Information
Marianne Purushotham, FSA, MAAA
Chair, Life MI Subgroup
mpurushotham@limra.com

Khloe Greenwood
Life Policy Analyst
American Academy of Actuaries
greenwood@actuary.org
### Historical Mortality Improvement Rates

To be used for VM20 Products

#### 2021 Recommended Scale

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

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

Identification:
PBR Staff of Texas Department of Insurance

Title of the Issue:
Add a section for other assumptions requirement in VM-21 which covers general guidance and requirements for assumptions, and expense assumptions.

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

VM-21 Section 1.C.2.b, VM-21 Section 12, VM-21 Section 13, VM-21 Section 1.B, VM-21 Section 10.A, VM-31 Section 3.F.3.d, VM-31 Section 3.F.13.d

January 1, 2021 NAIC Valuation Manual

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

See attached.

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

A new section is needed in VM-21 to provide general guidance and requirements for assumptions, similar to VM-20, to address assumption reporting issues identified in VM-21 PBR report reviews, e.g., some companies don’t discuss regular assumption reviews for any necessary updates. In addition, this section provides the specific requirements for assumptions that have not been covered in previous sections of VM-21, i.e., the expense assumptions. VM-21 is not very explicit about expenses (e.g., whether they are fully allocated or include one-time expenses). For VM-20, we have had some material impacts from how companies treat one-time expenses that may be multi-year but temporary. Companies could understatement expenses if there is no adjustment for periodic or other recurrent expenses in expense study years where they do not occur. This APF is to make the VM-21 expense assumption requirement explicit and consistent with what is specified in VM-20 Section 9.E. The new section can also be used to cover any other assumptions requirements that need to be addressed in the future. The reporting requirement of the sensitivity testing and the impact of margin analysis is added to VM-31 to help regulators better understand how companies comply with the newly added assumption guidance and requirements.
VM-21 Section 1.C.2.b

a) Liability risks

i. Reinsurer default, impairment or rating downgrade known to have occurred before or on the valuation date.

ii. Mortality/longevity, persistency/lapse, partial withdrawal and premium payment risks.

iii. Utilization risk associated with guaranteed living benefits.

iv. Anticipated mortality trends based on observed patterns of mortality improvement or deterioration, where permitted.

v. Annuitzation risks.

vi. Additional premium dump-ins (high interest rate guarantees in low interest rate environments).

vii. Applicable expense risks, including fluctuation in maintenance expenses directly attributable to the business, future commission expenses, and expense inflation/growth.

VM-21 Section 12 (new)

Section 12: Other Guidance and Requirements for Assumptions

A. Overview

This section provides guidance and requirements in general for setting prudent estimate assumptions when determining either the stochastic reserve or the reserve for any contracts determined using the Alternative Methodology. It also provides specific guidance and requirements for expense assumptions.

B. General Assumption Requirements

1. The company shall use prudent estimate assumptions for risk factors that are not stochastically modeled by applying margins to the anticipated experience assumptions if such risk factors have been categorized as material risks by following Section 1.B Principle 3 and requirements in Section 12.C.

2. The company shall establish the prudent estimate assumptions for risk factors in compliance with the requirements in Section 12 of Model #820 and must periodically review and update the assumptions as appropriate in accordance with these requirements.

3. The company shall model the following risk factors stochastically unless the company
elects the Alternative Methodology defined in Section 7:

a. Interest rate movements (i.e., Treasury interest rate curves).

b. Equity performance (e.g., Standard & Poor’s 500 index [S&P 500] returns and returns of other equity investments).

4. If the company elects to stochastically model risk factors in addition to the economic scenarios, the requirements in this section for determining prudent estimate assumptions for these risk factors do not apply.

5. The company shall use its own experience, if relevant and credible, to establish an anticipated experience assumption for any risk factor. To the extent that company experience is not available or credible, the company may use industry experience or other data to establish the anticipated experience assumption, making modifications as needed to reflect the circumstances of the company.

a. For risk factors (such as mortality) to which statistical credibility theory may be appropriately applied, the company shall establish anticipated experience assumptions for the risk factor by combining relevant company experience with industry experience data, tables or other applicable data in a manner that is consistent with credibility theory and accepted actuarial practice.

b. For risk factors (such as utilization of guaranteed living benefits) that do not lend themselves to the use of statistical credibility theory, and for risk factors (such as some of the lapse assumptions) to which statistical credibility theory can be appropriately applied but cannot currently be applied due to lack of industry data, the company shall establish anticipated experience assumptions in a manner that is consistent with accepted actuarial practice and that reflects any available relevant company experience, any available relevant industry experience, or any other experience data that are available and relevant. Such techniques include:

i. Adopting standard assumptions published by professional, industry or regulatory organizations to the extent they reflect any available relevant company experience or reasonable expectations.

ii. Applying factors to relevant industry experience tables or other relevant data to reflect any available relevant company experience and differences in expected...
experience from that underlying the base tables or data due to differences between the risk characteristics of the company experience and the risk characteristics of the experience underlying the base tables or data.

iii. Blending any available relevant company experience with any available relevant industry experience and/or other applicable data using weightings established in a manner that is consistent with accepted actuarial practice and that reflects the risk characteristics of the underlying contracts and/or company practices.

c. For risk factors that have limited or no experience or other applicable data to draw upon, the assumptions shall be established using sound actuarial judgment and the most relevant data available, if such data exists.

d. For any assumption that is set in accordance with the requirements of Section 12.B.5.c, the qualified actuary to whom responsibility for this group of contracts is assigned shall use sensitivity testing and disclose the analysis performed to ensure that the assumption is set at the conservative end of the plausible range.

e. The qualified actuary, to whom responsibility for this group of contracts is assigned, shall annually review relevant emerging experience for the purpose of assessing the appropriateness of the anticipated experience assumption. If the results of statistical or other testing indicate that previously anticipated experience for a given factor is inadequate, then the qualified actuary shall set a new, adequate, anticipated experience assumption for the factor.

6. The company shall sensitivity test risk factors that are not stochastically modeled and examine the impact on the stochastic reserve. The company shall update the sensitivity tests periodically as appropriate. The company may update the tests less frequently, but no less than every 3 years, when the tests show less sensitivity of the stochastic reserve to changes in the assumptions being tested or the experience is not changing rapidly. Providing there is no material impact on the results of the sensitivity testing, the company may perform sensitivity testing:

a. Using samples of the contracts in force rather than performing the entire valuation for each alternative assumption set.

b. Using data from prior periods.

Guidance Note: Sensitivity testing every risk factor on an annual basis is not required. For some risk factors, it may be reasonable, in lieu of sensitivity testing, to employ statistical measures for margins, such as adding one or more standard deviations to the anticipated experience assumption.
The company shall vary the prudent estimate assumptions from scenario to scenario within the stochastic reserve calculation in an appropriate manner to reflect the scenario-dependent risks.

C. Assumption Margins

The company shall include margins to provide for adverse deviations and estimation error in the prudent estimate assumption for each risk factor that is not stochastically modeled or prescribed, subject to the following:

1. The level of margin applied to the anticipated experience assumptions may be determined in aggregate or independently as discussed in Section 1.B Principle 3. It is not permissible to set a margin less toward the conservative end of the spectrum to recognize, in whole or in part, implicit or prescribed margins that are present, or are believed to be present, in other risk factors.

Risks that are stochastically modeled (e.g., interest rates, equity returns) or have prescribed margins or guardrails (e.g., assets, revenue sharing) shall be considered material risks. Other risks generally considered to be material include, but are not limited to, mortality, contract holder behavior, maintenance and overhead expenses, inflation and implied volatility. In some cases, the list of material risks may also include acquisition expenses, partial withdrawals, policy loans, annuitizations, account transfers and deposits, and/or option elections that contain an element of anti-selection.

2. The greater the uncertainty in the anticipated experience assumption, the larger the required margin, with the margin added or subtracted as needed to produce a larger modeled TAR than would otherwise result. For example, the company shall use a larger margin when:
   a. The experience data have less relevance or lower credibility.
   b. The experience data are of lower quality, such as incomplete, internally inconsistent or not current.
   c. There is doubt about the reliability of the anticipated experience assumption, such as, but not limited to, recent changes in circumstances or changes in company policies.
   d. There are constraints in the modeling that limit an effective reflection of the risk factor.

3. In complying with the sensitivity testing requirements in Section 12.B.6 above, greater analysis and more detailed justification are needed to determine the level of uncertainty when establishing margins for risk factors that produce greater sensitivity on the stochastic reserve.
4. A margin is permitted but not required for assumptions that do not represent material risks.

5. A margin should reflect the magnitude of fluctuations in historical experience of the company for the risk factor, as appropriate.

6. The company shall apply the method used to determine the margin consistently on each valuation date but is permitted to change the method from the prior year if the rationale for the change and the impact on the stochastic reserve is disclosed.

D. Expense Assumptions

1. General Prudent Estimate Expense Assumption Requirements

In determining prudent estimate expense assumptions, the company:

a. May spread certain information technology development costs and other capital expenditures over a reasonable number of years in accordance with accepted statutory accounting principles as defined in the Statements of Statutory Accounting Principles.

Guidance Note: Care should be taken with regard to the potential interaction with the inflation assumption below.

b. Shall assume that the company is a going concern.

c. Shall choose an appropriate expense basis that properly aligns the actual expense to the assumption. If values are not significant, they may be aggregated into a different base assumption.

Guidance Note: For example, death benefit expenses should be modeled with an expense assumption that is per death incurred.

d. Shall reflect the impact of inflation.

e. Shall not assume future expense improvements.

f. Shall not include assumptions for federal income taxes (and expenses paid to provide fraternal benefits in lieu of federal income taxes) and foreign income taxes.

G. Shall use assumptions that are consistent with other related assumptions.
h. Shall use fully allocated expenses.

**Guidance Note:** Expense assumptions should reflect the direct costs associated with the block of contracts being modeled, as well as indirect costs and overhead costs that have been allocated to the modeled contracts.

i. Shall allocate expenses using an allocation method that is consistent across company lines of business. Such allocation must be determined in a manner that is within the range of actuarial practice and methodology and consistent with applicable ASOPs. Allocations may not be done for the purpose of decreasing the stochastic reserve.

j. Shall reflect expense efficiencies that are derived and realized from the combination of blocks of business due to a business acquisition or merger in the expense assumption only when any future costs associated with achieving the efficiencies are also recognized.

**Guidance Note:** For example, the combining of two similar blocks of business on the same administrative system may yield some expense savings on a per unit basis, but any future cost of the system conversion should also be considered in the final assumption. If all costs for the conversion are in the past, then there would be no future expenses to reflect in the valuation.

k. Shall reflect the direct costs associated with the contracts being modeled, as well as an appropriate portion of indirect costs and overhead (i.e., expense assumptions representing fully allocated expenses should be used), including expenses categorized in the annual statement as “taxes, licenses and fees” (Exhibit 3 of the annual statement) in the expense assumption.

l. Shall include acquisition expenses associated with business in force as of the valuation date and significant non-recurring expenses expected to be incurred after the valuation date in the expense assumption.

m. For contracts sold under a new policy form or due to entry into a new product line, the company shall use expense factors that are consistent with the expense factors used to determine anticipated experience assumptions for contracts from an existing block of mature contracts taking into account:

i. Any differences in the expected long-term expense levels between the block of new contacts and the block of mature contracts.

ii. That all expenses must be fully allocated as required.
under Section 142.DE.1d above.

2. Margins for Prudent Estimate Expense Assumptions

The company shall determine margins for expense assumptions following Section 12.C.

VM-21 Section 13

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

VM-21 Section 1.B

Principle 3: The implementation of a model involves decisions about the experience assumptions and the modeling techniques to be used in measuring the risks to which the company is exposed. Generally, assumptions are to be based on the conservative end of the confidence interval. The choice of a conservative estimate for each assumption may result in a distorted measure of the total risk. Conceptually, the choice of assumptions and the modeling decisions should be made so that the final result approximates what would be obtained for the stochastic reserve at the required CTE level if it were possible to calculate results over the joint distribution of all future outcomes. In applying this concept to the actual calculation of the stochastic reserve, the company should be guided by evolving practice and expanding knowledge base in the measurement and management of risk.

Guidance Note: The intent of Principle 3 is to describe the conceptual framework for setting assumptions. Section 10 provides the requirements and guidance for setting contract holder behavior assumptions and includes alternatives to this framework if the company is unable to fully apply this principle. More guidance and requirements for setting assumptions in general are provided in Section 12.

VM-21 Section 10.A

Section 10: Contract Holder Behavior Assumptions

A. General

Contract holder behavior assumptions encompass actions such as lapses, withdrawals, transfers, recurring deposits, benefit utilization, option election, etc. Contract holder behavior is difficult to predict accurately, and variance in behavior assumptions can significantly affect the results. In the absence of relevant and fully credible empirical data, the company should set behavior assumptions as guided by Principle 3 in Section 1.B and Section 12.

VM-31 Section 3.F.3.d

3. Liability Assumptions and Margins – A listing of the assumptions and margins used in the projections to determine the stochastic reserve, including a discussion of the source(s) and the rationale for each assumption:

a. Premiums and Subsequent Deposits – Description of premiums and subsequent deposits.
b. **Interest Crediting Strategy** – Description of the interest crediting strategy.

c. **Commissions** – Description of commissions, including any commission chargebacks.

d. **Expenses Other than Commissions** – Description and listing of insurance company expenses other than commissions, such as overhead, including:

   i. Method used to allocate expenses to the contracts included in a principle-based valuation under VM-21 and a statement confirming that expenses have been fully allocated in accordance with VM-21 Section 12.D.1.b.

   ii. Method used to apply the allocated expenses to model segments or sub-segments within the cash-flow model.

   iii. Identification of types of costs that were spread, and for how many years, if any cost spreading was done pursuant to VM-21 Section 12.D.1.a.

   iv. Method used to determine margins.

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**VM-31 Section 3.F.13.c (new)**

**c. Sensitivity Tests** – For each distinct product type for which margins were established:

i. List the specific sensitivity tests performed for each risk factor or combination of risk factors, other than those discussed in Section 3.D.3.h.iv and 3.D.3.i.ii.

   

   ii. Indicate whether the reserve was calculated based on the anticipated experience assumptions or prudent estimate assumptions for all other risk factors while performing the tests.

   

   iii. Provide the numerical results of the sensitivity tests for both reserves and capital.

   

   iv. Explain how the results of sensitivity tests were used or considered in developing assumptions.

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**VM-31 Section 3.F.13.d (new)**

**d. Impact of Margin**

i. Company can perform the impact of margin analysis using off-cycle data. The analysis can be done less frequently than annual unless there is change or update in the margins, but not less frequently than every 3 years.
ii. Impact of Margins for Each Risk Factor – The impact of margins on the stochastic reserve for each risk factor, or group of risk factors, that has a material impact on the stochastic reserve, determined by subtracting (i) from (ii), expressed in both dollar amounts and percentages:

(1) The CTE70(best efforts), as outlined in VM-21 Section 9.C, but with the reserve calculated based on the anticipated experience assumption for the risk factor and prudent estimate assumptions for all other risk factors.

(2) The CTE70(best efforts), as outlined in VM-21 Section 9.C, for that group of contracts as reported.

(3) Repeat the impact analysis using the same method on CTE(98) levels.

Guidance Note: Pursuant to VM-21, margins must increase TAR, so the impact of each margin, as calculated above on CTE(98), must be positive.

iii. Aggregate Impact of Margins – the aggregate impact of all margins on the stochastic reserve for that group of contracts determined by subtracting (1) from (2), expressed in both dollar amounts and percentages:

(1) The CTE70(best efforts), as outlined in VM-21 Section 9.C, for that group of contracts, but with the reserve calculated based on anticipated experience assumptions for all risk factors prior to the addition of any margins.

(2) The CTE70(best efforts), as outlined in VM-21 Section 9.C, for that group of contracts as reported.

(3) Repeat the impact analysis using the same method on CTE(98) levels.

iv. Impact of Implicit Margins – For purposes of the disclosures required in 13.d.ii and 13.d.iii above:

(1) If the company believes the method used to determine anticipated experience assumptions includes an implicit margin, the company can adjust the anticipated experience assumptions to remove this implicit margin for this reporting purpose only. If any such adjustment is made, the company shall document the rationale and method used to determine the anticipated experience assumption.

(2) Since the company is not required to determine an anticipated experience assumption or a prudent estimate assumption for risk factors that are prescribed (i.e., interest rates movements, equity performance, default costs and net spreads on reinvestment assets), when determining the impact of margins, the prescribed assumption shall be deemed to be the prudent estimate assumption for the risk factor, and the company can elect to determine an anticipated experience assumption for the risk factor, based on the company's anticipated experience for the risk factor. If this is elected, the company shall document the rationale and method used to determine the anticipated experience assumption.
The Life Actuarial (A) Task Force met Sept. 30, 2021. The following Task Force members participated: Cassie Brown, Chair, represented by Mike Boerner, Rachel Hemphill, and Karen Jiang (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Ben Bock and Thomas Reedy (CA); Michael Conway represented by Eric Unger (CO); Andrew N. Mais represented by Wanchin Chou (CT); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Amy L. Beard represented by Stephen Chamblee (IN); Vicki Schmidt represented by Nicole Boyd (KS); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Derek Wallman (NE); Marlene Caride represented by Kevin Clarkson (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Glen Muley represented by Andrew Schallhorn (OK); and Scott A. White represented by Craig Chupp (VA).

1. Exposed Concepts and Questions Related to a Proposed Actuarial Guideline on AAT

Mr. Andersen said the Valuation Analysis (E) Working Group identified a potential concern about how blocks of legacy deferred annuity products with 3% or higher lifetime credited rate guarantees are being supported in the current low interest rate environment. He noted that transactions related to this business, including acquisitions of companies and reinsurance deals, has resulted in an increased concentration of this risk being held by firms that support the risk with nontraditional assets. He said state insurance regulators should pool their actuarial and capital markets expertise to identify good practices and bad practices. He said state insurance regulators want to avoid the possibility of a company setting up $900 of risky assets in support of a $1,000 liability. The risk of such a scenario occurring increases as the assets held become more complex and are less subject to publicly available valuation. He said the Working Group found that some complex assets have an appropriate risk return profile to support the underlying liability, while others were found to have inflated investment or reinvestment net yield assumptions.

Mr. Andersen said there is a consensus among state insurance regulators discussing this issue that an actuarial guideline should be developed to help ensure reserve adequacy and claims paying ability under moderately adverse conditions, including conditions negatively affecting cash flows from complex assets. He said the guideline should also clarify how margins for uncertainty are established, such that the greater the uncertainty, the larger the required margin and resulting reserve. He said other goals of the guideline will be to recognize that higher asset returns are to some extent associated with higher risk. He said it is possible that sensitivity testing for complex assets supporting certain business, including fixed annuities, may be required. He said the guideline is not contemplated to be a standalone requirement but will provide guidance on modeling and existing asset adequacy requirements. He said the document being considered for exposure represents questions that must be addressed as the guideline is developed. He said there is a possibility that some of the guidance could apply before year-end 2022. Brian Bayerle (American Council of Life Insurers—ACLI) asked how the applicability prior to year-end 2022 would work. Mr. Andersen said it is possible that certain documentation requirements could apply prior to year-end 2022. He asked interested parties to comment on the applicability date.

Mr. Andersen made a motion, seconded by Ms. Eom, to expose the concepts and questions related to a proposed actuarial guideline on AAT (Attachment Five-A) for a 45-day public comment period ending Nov. 15. The motion passed unanimously.

2. Adopted its Summer National Meeting Minutes

Mr. Sartain recommended placing the first sentence of the second paragraph on the report of the VM-22 (A) Subgroup just after the second sentence of the first paragraph and deleting the remainder of the second paragraph.

Mr. Weber made a motion, seconded by Mr. Leung, to adopt the Task Force’s Aug. 12 minutes, including the revision recommended by Mr. Sartain (see NAIC Proceedings – Summer 2021, Life Actuarial (A) Task Force). The motion passed unanimously.
3. **Adopted its 2022 Proposed Charges**

Mr. Boerner questioned whether the target completion dates for the Guaranteed Issue (GI) Life Valuation (A) Subgroup charges and the Longevity Risk (E/A) Subgroup charges should be retained. He pointed out that no other Subgroup charges have target dates. Reggie Mazyck (NAIC) said the target dates were set by the former chair. He suggested removing the target dates to not unfairly saddle the next chair with target dates in which they did not have input.

Mr. Chou made a motion, seconded by Mr. Schallhorn, to adopt the Task Force’s 2022 proposed charges (Attachment Five-B), after removing the target dates. The motion passed unanimously.

4. **Exposed Amendment Proposal 2021-12**

Ms. Hemphill said amendment proposal 2021-12 (Attachment Five-C) corrects a reference error in VM-21, Requirements for Principle-Based Reserves for Variable Annuities, and clarifies the requirements for variable annuity contracts with no minimum guaranteed benefits under three prescribed assumptions in VM-21 Section 6C.

Mr. Weber made a motion, seconded by Mr. Leung, to expose amendment proposal 2021-12 for a 28-day public comment period ending Oct. 27. The motion passed unanimously.

5. **Exposed Amendment Proposal 2021-13**

Mr. Bock said amendment proposal 2021-13 (Attachment Five-D) corrects language that allows the addition of prescribed mortality margins for some Life/Long-Term Care (LTC) combination products to decrease, rather than increase, modeled reserves. Ms. Hemphill suggested changing the word “actuary” in the revision proposed for Section 9C(6)e of VM-20, Requirements for Principle-Based Reserves for Life Products, to “company.”

Mr. Bock made a motion, seconded by Mr. Unger, to expose amendment proposal 2021-13, including the change suggested by Ms. Hemphill, for a 28-day public comment period ending Oct. 27. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.
Consider concept of an actuarial guideline focusing on modeling of complex or high-yielding assets in asset adequacy testing.

Development of an actuarial guideline focusing on modeling of complex or high-yielding assets in asset adequacy testing (AAT), with particular interest in receiving feedback on the following issues:

- **Product scope**: Should the focus be on assets supporting fixed annuities or assets supporting all life insurer liabilities subject to AAT?
- **Size scope**: Should only life insurers or blocks exceeding a certain size threshold be subject to the actuarial guideline?
- **Constraints or documentation**: Should the actuarial guideline focus on establishing constraints related to the modeling of complex or high gross yield assets (impacting AAT results) or providing detailed documentation and sensitivity testing on the modeling of such assets (potentially not impacting AAT results)?
- **Effective date**: Is a year-end 2022 effective date for the actuarial guideline reasonable, or should some guidance apply before that date?
2022 Proposed Charges

LIFE ACTUARIAL (A) TASK FORCE

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

Ongoing Support of NAIC Programs, Products and Services

1. The Life Actuarial (A) Task Force will:
   A. Work to keep reserve, reporting, and other actuarial-related requirements current. This includes principle-based reserving (PBR) and other requirements in the Valuation Manual, actuarial guidelines, and recommendations for appropriate actuarial reporting in blanks. Respond to charges from the Life Insurance and Annuities (A) Committee and referrals from other groups or committees, as appropriate.
   B. Report progress on all work to the Life Insurance and Annuities (A) Committee and provide updates to the Financial Condition (E) Committee on matters related to life insurance company solvency. This work includes the following:
      1. Work with the American Academy of Actuaries (Academy) and the Society of Actuaries (SOA) to develop new mortality tables for valuation and minimum nonforfeiture requirements, as appropriate, for life insurance and annuities.
      2. Provide recommendations for guidance and requirements for accelerated underwriting, as needed.
      3. Evaluate and provide recommendations regarding the VM-21, Requirements for Principle-Based Reserves for Variable Annuities/Actuarial Guideline XLIII—CARVM for Variable Annuities (AG 43) Standard Projection Amount, which may include continuing as a required floor or providing as disclosure. This evaluation is to be completed prior to year-end 2023.
      4. Work with the SOA on the annual development of the Generally Recognized Expense Table (GRET) factors.
      5. Provide recommendations and changes, as appropriate, to other reserve and nonforfeiture requirements to address issues and provide actuarial assistance and commentary to other NAIC committees relative to their work on actuarial matters.
      6. Work with the selected vendor to develop and implement the new economic scenario generator (ESG) for use in regulatory reserve and capital calculations.
      7. Monitor international developments regarding life and health insurance reserving, capital, and related topics. Compare and benchmark with PBR requirements.

2. The Variable Annuities Capital and Reserve (E/A) Subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force will:
   A. Monitor the impact of the changes to the variable annuities (VA) reserve framework and risk-based capital (RBC) calculation and determine if additional revisions need to be made.
   B. Develop and recommend appropriate changes, including those to improve accuracy and clarity of VA capital and reserve requirements.

3. The Experience Reporting (A) Subgroup will:
   A. Continue development of the experience reporting requirements within the Valuation Manual. Provide input, as appropriate, for the process regarding the experience reporting agent, data collection, and subsequent analysis and use of experience submitted.

4. The Indexed Universal Life (IUL) Illustration (A) Subgroup will:
   A. Monitor the results and practices of IUL illustrations following implementation of Actuarial Guideline XLIX-A—The Application of the Life Illustrations Model Regulation to Policies with Index-Based Interest to Policies Sold On or After December 14, 2020 (AG 49-A). Provide recommendations for consideration of changes to Life Insurance Illustrations Model Regulation (#582) to the Life Actuarial (A) Task Force, as needed.

5. The Longevity Risk (E/A) Subgroup of the Life Actuarial (A) Task Force and the Life Risk-Based Capital (E) Working Group will:
   A. Provide recommendations for recognizing longevity risk in statutory reserves and/or RBC, as appropriate.
6. The **Valuation Manual (VM)-22 (A) Subgroup** will:
   A. Recommend requirements, as appropriate, for non-variable (fixed) annuities in the accumulation and payout phases for consideration by the Life Actuarial (A) Task Force. Continue working with the Academy on a PBR methodology for non-variable annuities.

7. The **Guaranteed Issue (GI) Life Valuation (A) Subgroup** will:
   A. Provide recommendations regarding valuation requirements for GI life business, including any appropriate mortality table(s) for valuation as well as nonforfeiture.

8. The **Index-Linked Variable Annuity (A) Subgroup** will:
   A. Provide recommendations and changes, as appropriate, to nonforfeiture or interim value requirements related to index-linked variable annuities (ILVAs).

NAIC Support Staff: Reggie Mazyck/Jennifer Frasier
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

**Identification:**
PBR Staff of Texas Department of Insurance

**Title of the Issue:**

2. Three prescribed assumptions do not have clear requirements for VA contracts with no minimum guaranteed benefits in Additional Standard Projection Amount in VM-21 Section 6.C. These three prescribed assumptions are Partial Withdrawal, Account Value Depletion, and Other Voluntary Contract Termination.

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

VM-21 Section 6.B.3.a.v, VM-21 Section 6.C.4, VM-21 Section 6.C.10, VM-21 Section 6.C.11

January 1, 2021 NAIC *Valuation Manual*

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

See attached.

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

1. VM-21 requires the CSMP method for Additional Standard Projection Amount be applied to a seriatim in-force to capture the impact of model offices under a few deterministic scenarios. There is an incorrect section reference for the in force method required for the prescribed amounts calculation in the CSMP method.

2. VM-21 does not make clear what requirements should be used for VA contract with no minimum guaranteed benefit for the prescribed assumptions for partial withdrawal, account value depletion and other voluntary contract termination. The requirements for these three prescribed assumptions for VA contracts with no minimum guaranteed benefits should be added to VM-21 Section 6.C.

For Partial Withdrawal assumption, it is reasonable to set the partial withdrawal rate at 3.5% or greater for VA contract with no minimum benefit since the prescribed partial withdrawal rate is 3.5% for GMDB only without guaranteed growth in the benefit basis. For Account Value Depletion assumption, the termination is assumed when the Contract’s account value reaches zero. For Other Voluntary Contract Terminations assumption, the requirement should be clearly referred to Table 6.3 defined in Full Surrenders of Section 6.C.6.
VM-21 Section 6.B.3

3. Calculation Methodology

   a. CSMP Method:

      i. The company shall apply this method to a seriatim in-force.

      ii. Calculate the scenario reserve, as defined in VM-01 and discussed further in Section 4.B, for each of the prescribed market paths outlined in Section 6.B.6 using the same method and assumptions as those that the company uses to calculate scenario reserves for the purposes of determining the CTE70 (adjusted), \(^2\) as outlined in Section 9.C. These scenario reserves shall collectively be referred to as a Company Standard Projection Set.

      iii. Identify the market path from the Company Standard Projection Set such that the scenario reserve is closest to the CTE70 (adjusted), designated as Path A. This scenario reserve shall be referred to as Company Amount A.

      iv. Identify the following four market paths:

         - Two paths with the same starting interest rate as Path A, but equity shocks ±5% from that of Path A.

         - Two paths with the same equity fund returns as Path A, but the next higher and next lower interest rate shocks.

         From the four paths, identify Path B whose reserve value is:

         - If Company Amount A is lower than CTE70 (adjusted), the smallest reserve value that is greater than CTE70 (adjusted).

         - If Company Amount A is greater than CTE70 (adjusted), the greatest reserve value that is less than CTE70 (adjusted).

         If none of these paths satisfy the stated condition, discard the identified Path A, and redo steps (iii) and (iv) using the next closest scenario to CTE70 (adjusted) to be the new Path A in step (iii).

         For the path designated as Path B, the scenario reserve shall be referred to as Company Amount B.

   v. Recalculate the scenario reserves for Path A and Path B using the same method as outlined in step (ii) above, but substitute the assumptions prescribed in Section 6.C and use the modeled in force prescribed by Section 6.B.3.a.i2. These scenario reserves shall be referred to as Prescribed Amount A and Prescribed Amount B, respectively.

   vi. Calculate the Prescribed Projections Amount as:
Prescribed Projections Amount

\[ \text{Prescribed Projections Amount} = \text{Prescribed Amount A} + (\text{CTE70 (adjusted)} - \text{Company Amount A}) \times \left( \frac{\text{Prescribed Amount B} - \text{Prescribed Amount A}}{\text{Company Amount B} - \text{Company Amount A}} \right) \]

**VM-21 Section 6.C.4**
4. Partial Withdrawals

j. For contracts with no minimum guaranteed benefits, the partial withdrawal amount each year shall equal 3.5% of the Account Value.

jk. There may be instances where the company has certain data limitations, (e.g., with respect to policies that are not enrolled in an automatic withdrawal program but have exercised a non-excess withdrawal in the contract year immediately preceding the valuation date [Section 6.C.4.g and Section 6.C.4.i]). The company may employ an appropriate proxy method if it does not result in a material understatement of the reserve.

**VM-21 Section 6.C.10**
10. Account Value Depletions
The following assumptions shall be used when a contract’s Account Value reaches zero:

a. If the contract has a GMWB, the contract shall take partial withdrawals that are equal in amount each year to the guaranteed maximum annual withdrawal amount.

b. If the contract has a GMIB, the contract shall annuitize immediately. If the GMIB contractually terminates upon account value depletion, such termination provision is assumed to be voided in order to approximate the contract holder’s election to annuitize immediately before the depletion of the account value.

c. If the contract has any other guaranteed benefits, including a GMDB, the contract shall remain in-force. If the guaranteed benefits contractually terminate upon account value depletion, such termination provisions are assumed to be voided in order to approximate the contract holder’s retaining adequate Account Value to maintain the guaranteed benefits in-force. At the option of the company, fees associated with the contract and guaranteed benefits may continue to be charged and modeled as collected even if the account value has reached zero. While the contract must remain in-force, benefit features may still be terminated according to contractual terms other than account value depletion provisions.

d. If the contract has no minimum guaranteed benefits, the contract should be terminated according to contractual terms.
VM-21 Section 6.C.11

11. Other Voluntary Contract Terminations

For contracts that have other elective provisions that allow a contract holder to terminate the contract voluntarily, the termination rate shall be calculated based on the Standard Table for Full Surrenders as detailed above in Table 6.3 with the following adjustments:

a. If the contract holder is not yet eligible to terminate the contract under the elective provisions, the termination rate shall be zero.

b. After the contract holder becomes eligible to terminate the contract under the elective provisions, the termination rate shall be determined using the “Subsequent years” column of Table 6.3.

c. In using Table 6.3, the ITM of a contract’s guaranteed benefit shall be calculated based on the ratio of the guaranteed benefit’s GAPV to the termination value of the contract. The termination value of the contract shall be calculated as the GAPV of the payment stream that the contract holder is entitled to receive upon termination of the contract; if the contract holder has multiple options for the payment stream, the termination value shall be the highest GAPV of these options.

d. For GMWB or hybrid GMIB contracts, for all contract years in which a withdrawal is projected, the termination rate obtained from Table 6.3 shall be additionally multiplied by 60%.

For calculating the ITM of a hybrid GMIB, the guaranteed benefit’s GAPV shall be the larger of the Annuity GAPV or the Withdrawal GAPV.

e. For contracts with no minimum guaranteed benefits, ITM is 0%; for all contract years in which a withdrawal is projected, the termination rate obtained from Table 6.3 shall be the row in the table for ITM < 50% using the “Subsequent years” column of Table 6.3.
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form

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

   Joint submission by:
   -- Staff of Office of Principle-Based Reserving, California Department of Insurance
   -- Texas Department of Insurance

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


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

   See attached Appendix.

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

   See attached Appendix.

NAIC Staff Comments:

W:\National Meetings\2015\...\TF\LHA\
Appendix

ISSUE:

It has been observed that adding the prescribed mortality margins for some Life/LTC combination products cause modeled reserves to decrease rather than increase.

SECTION:


REDLINE:

(New) VM-20 Section 9.C.6.e

e. In the event that the prescribed mortality margins set forth above do not produce a reserve increase of adequate magnitude – and in particular when the prescribed margins produce a decrease in the reserve – the company shall derive and use margins that do produce an appropriately conservative result.

Guidance Note: This can occur, for example, when a rider -- such as a long-term care rider -- is being valued together with the base policy, pursuant to Section II, Subsection 6 of the Valuation Manual. Reductions to mortality rates, rather than additions, would potentially be needed in such cases. Such a product/rider combination would likely need to be in its own separate mortality segment. In the case of the product/rider combination, an adequate magnitude for a reserve increase can be thought of in terms of the size of reserve increase that would occur for the product using the tabular prescribed margins if the rider had not been present.

VM-20 Section 9.C.7.a

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

VM-20 Section 9.C.7.b.v

v. For each policy in a given mortality segment, from the start of the projection through policy duration E, the prudent estimate mortality assumptions are the company experience mortality rates (as defined in Section 9.C.2), plus the prescribed margin pursuant to Section 9.C.6.b, and further adjusted by any applicable additional margin changes pursuant to Section 9.C.6.d or Section 9.C.6.e.
(New) VM-31 Section 3.D.3.o

o. Adjustments to Prescribed Margins - Description and rationale for any adjustments made to prescribed mortality margins pursuant to VM-20 Section 9.C.6.d or 9.C.6.e.

REASONING:

We want to make sure that mortality margins always increase, rather than decreased, the modeled reserve.
The Life Actuarial (A) Task Force met Sept. 16, 2021. The following Task Force members participated: Cassie Brown, Chair, represented by Mike Boerner, Rachel Hemphill, and Karen Jiang (TX); Judith L. French, Vice Chair, represented by Peter Weber (OH); Lori K. Wing-Heier represented by Sharon Comstock (AK); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); Dana Popish Severinghaus represented by Bruce Sartain and Vincent Tsang (IL); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Rhonda Ahrens (NE); Marlene Caride represented by Kevin Clarkson (NJ); Adrienne A. Harris represented by Bill Carmello and Amanda Fenwick (NY); Glen Mulready represented by Andrew Schallhorn (OK); and Jonathan T. Pike represented by Tomasz Serbinowski (UT).

1. **Adopted the 2022 GRET**

Mr. Leung made a motion, seconded by Mr. Weber, to adopt the Society of Actuaries’ (SOA’s) 2022 Generally Recognized Expense Table (GRET) (Attachment Six-A). The motion passed unanimously.

2. **Exposed the SOA HMI 2021 Scale Recommendation**

Marianne Purushotham (SOA) presented the SOA Historical Mortality Improvement (HMI) 2021 scale recommendation (Attachment Six-B). She said since 2014, the SOA has applied a standard methodology to develop the HMI scale. The methodology averages a historical component and a forward-looking component to develop the scale, and it uses a smoothing process to eliminate volatility. The historical component is a short-term estimate of the mortality trend since the publication of the 2015 Valuation Basic Table (VBT). The forward-looking component is based on the U.S. Social Security Administration (SSA) Alt2 forecast of future improvements over the next 20 years. Ms. Purushotham noted that there is a difference in experience between the general population data used in the Alt2 forecast and insured population data. She said currently, because of the “noise” in the insured population data, the SOA chooses to use general population data from the SSA. She said in the future, the SOA will look at mortality within the general population by socio-economic group to better differentiate the data.

Ms. Purushotham discussed the graphs, comparing the smoothed and unsmoothed scales by gender for 2018 through 2021. She said the SOA recommends no change to the female scale and a decrease in the male scale for 2021. She recommended that individual companies reflect their expectations for COVID-19 impacts on short-term mortality as part of a temporary mortality adjustment.

Mr. Weber made a motion, seconded by Mr. Kupferman, to expose the SOA HMI 2021 scale recommendation, including the Microsoft Excel tables (Attachment Six-C), for a 21-day public comment period ending Oct. 6. The motion passed unanimously.

Having no further business, the Life Actuarial (A) Task Force adjourned.
TO: Reggie Mazyck, NAIC
FROM: Pete Miller, Experience Study Actuary, Society of Actuaries (SOA)
Tony Phipps, Chair, SOA Committee on Life Insurance Company Expenses
DATE: August 4, 2021
RE: 2022 Generally Recognized Expense Table (GRET) – SOA Analysis

Dear Mr. Mazyck:

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

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

APPROACH USED
The methodology for calculating the recommended GRET factors based on this data is similar to that followed the last several years. The methodology was last altered in 2015. The changes made at that time can be found in the recommendation letter sent to LATF on July 30, 2015.1

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

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

1 https://www.soa.org/Files/Research/Projects/research-2016-gret-recommendation.pdf
years to increase the response rate to the surveys of companies that submit Annual Statements in order to reduce the number of companies in the “Other” category would be most welcomed. The intention is to continue surveying the companies in future years to enable enhancement of this multiple distribution channel information.

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

THE RECOMMENDATION

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

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

**TABLE 1**

**PROPOSED 2022 GRET FACTORS, BASED ON AVERAGE OF 2019/2020 DATA**

<table>
<thead>
<tr>
<th>Description</th>
<th>Acquisition per Policy</th>
<th>Acquisition per Unit</th>
<th>Acquisition per Premium</th>
<th>Maintenance per Policy</th>
<th>Companies Included</th>
<th>Average Premium Per Policy Issued During Year</th>
<th>Average Face Amt (000) Per Policy Issued During Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>$183</td>
<td>$1.00</td>
<td>46%</td>
<td>$55</td>
<td>142</td>
<td>3,252</td>
<td>194</td>
</tr>
<tr>
<td>Career</td>
<td>212</td>
<td>1.20</td>
<td>53%</td>
<td>64</td>
<td>77</td>
<td>2,327</td>
<td>197</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>200</td>
<td>1.10</td>
<td>50%</td>
<td>60</td>
<td>23</td>
<td>875</td>
<td>72</td>
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<tr>
<td>Niche Marketing</td>
<td>151</td>
<td>0.90</td>
<td>37%</td>
<td>45</td>
<td>24</td>
<td>517</td>
<td>13</td>
</tr>
<tr>
<td>Other*</td>
<td>139</td>
<td>0.80</td>
<td>35%</td>
<td>42</td>
<td>109</td>
<td>786</td>
<td>70</td>
</tr>
</tbody>
</table>

* Includes companies that did not respond to this or prior year surveys 375

**TABLE 2**

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Acquisition per Policy</th>
<th>Acquisition per Unit</th>
<th>Acquisition per Premium</th>
<th>Maintenance per Policy</th>
<th>Companies Included</th>
<th>Average Premium Per Policy Issued During Year</th>
<th>Average Face Amt (000) Per Policy Issued During Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>$166</td>
<td>$0.90</td>
<td>42%</td>
<td>$50</td>
<td>121</td>
<td>2,916</td>
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<td>Career</td>
<td>214</td>
<td>1.20</td>
<td>54%</td>
<td>64</td>
<td>63</td>
<td>2,517</td>
<td>195</td>
</tr>
<tr>
<td>Direct Marketing</td>
<td>195</td>
<td>1.10</td>
<td>49%</td>
<td>59</td>
<td>15</td>
<td>2,933</td>
<td>119</td>
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<tr>
<td>Niche Marketing</td>
<td>137</td>
<td>0.80</td>
<td>34%</td>
<td>41</td>
<td>26</td>
<td>590</td>
<td>11</td>
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<tr>
<td>Other*</td>
<td>126</td>
<td>0.70</td>
<td>32%</td>
<td>38</td>
<td>67</td>
<td>836</td>
<td>29</td>
</tr>
</tbody>
</table>

* Includes companies that did not respond to this or prior year surveys 292
In previous recommendations, an effort was made to reduce volatility in the GRET factors from year-to-year by limiting the change in GRET factors between years to about ten percent of the prior value. The changes from the 2021 GRET were reviewed to ensure that a significant change was not made in this year’s GRET recommendation.

The Independent, Niche Marketing and Other distribution channel categories experienced a change greater than ten percent so the factors for this line were capped at the ten percent level (the Acquisition per unit factor changed somewhat more than 10% because of rounding) from the corresponding 2021 GRET values. The volatility occurred due to incorrect NAIC data for 2018 for some companies, which caused their actual to expected ratios to be considered outliers and they were not included in the calculation. This resulted in lower final 2021 GRET factors and subsequently the same for the 2022 recommendation. Over the next one to three years, the ten percent cap will allow this difference to be graded in so calculated GRET will be used for the final recommended GRET factors.

**USAGE OF THE GRET**

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

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

Kindest personal regards,

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

Tony Phipps, FSA, MAAA
Chair, SOA Committee on
Life Insurance Company Expenses
APPENDIX A -- DISTRIBUTION CHANNELS

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

1. **Independent** – Business written by a company that markets its insurance policies through an independent insurance agent or insurance broker not primarily affiliated with any one insurance company. These agencies or agents are not employed by the company and operate without an exclusive distribution contract with the company. These include most PPGA arrangements.

2. **Career** – Business written by a company that markets insurance and investment products through a sales force primarily affiliated with one insurance company. These companies recruit, finance, train, and often house financial professionals who are typically referred to as career agents or multi-line exclusive agents.

3. **Direct Marketing** – Business written by a company that markets its own insurance policies direct to the consumer through methods such as direct mail, print media, broadcast media, telemarketing, retail centers and kiosks, internet or other media. No direct field compensation is involved.

4. **Niche Marketers** – Business written by home service, pre-need, or final expense insurance companies as well as niche-market companies selling small face amount life products through a variety of distribution channels.

5. **Other** – Companies surveyed were only provided with the four options described above. Nonetheless since there were many companies for which we did not receive a response (or whose response in past years’ surveys confirmed an “other” categorization (see below), values for the “other” category are given in the tables in this memo. It was also included to indicate how many life insurance companies with no response (to this survey and prior surveys) and to indicate whether their exclusion has introduced a bias into the resulting values.
APPENDIX B – UNIT EXPENSE SEEDS

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

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

### 2006-2010 (AVERAGE) CLICE STUDIES:

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<tr>
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<th>Acquisition/ Policy</th>
<th>Acquisition/ Face Amount (000)</th>
<th>Acquisition/ Premium</th>
<th>Maintenance/ Policy</th>
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<td>Term</td>
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<tr>
<td>Unweighted Average</td>
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<td>57%</td>
<td>$76</td>
</tr>
<tr>
<td>Median</td>
<td>$196</td>
<td>$0.59</td>
<td>38%</td>
<td>$64</td>
</tr>
</tbody>
</table>

|          |                     |                                |                      |                     |
|----------|---------------------|--------------------------------|----------------------|                     |
| Permanent|                     |                                |                      |                     |
| Weighted Average | $167    | $1.43                          | 42%                  | $56                 |
| Unweighted Average | $303   | $1.57                          | 49%                  | $70                 |
| Median   | $158                | $1.30                          | 41%                  | $67                 |

### CURRENT UNIT EXPENSE SEEDS:

<table>
<thead>
<tr>
<th></th>
<th>Acquisition/ Policy</th>
<th>Acquisition/ Face Amount (000)</th>
<th>Acquisition/ Premium</th>
<th>Maintenance/ Policy</th>
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</thead>
<tbody>
<tr>
<td>All distribution channels</td>
<td>$200</td>
<td>$1.10</td>
<td>50%</td>
<td>$60</td>
</tr>
</tbody>
</table>
Historical Mortality Improvement Recommendation (VM-20)
2021 Scale Update

Mortality Improvements Life Work Group (MILWG) of the
Academy Life Experience Committee and SOA Preferred
Mortality Project Oversight Group (“Joint Committee”)

Agenda

- Review standard methodology used for Historical Mortality Improvement (HMI) scale development each year
- Review results of application of the methodology for 2021
- Recommendation for HMI scale for use with 2021 valuation under VM20
HMI Standard Methodology

- Most recent HMI data—last 10 years
- Source: Social Security Administration (SSA)
- Historical data only available through the end of the year that is 2 years prior to the current valuation year

- Most recent SSA Alt 2 forecast of future improvements over longer period (20 years)
- Alt 2 = intermediate projection from most recent SSA Trustees Report release

- Average of historical data and forecasted components
- With smoothing process applied

Historical Component:

10-Year Historical Average Annual Improvement

Male 10 Yr Historical Averages - SSA Data

Scale Year / Data Years:
- 2021 / 2009-2019
- 2020 / 2008-2018

Attained Age
Historical Component:
10-Year Historical Average Annual Improvement

Female 10 Yr Historical Averages - SSA Data

Scale Year / Data Years:
2021 / 2009-2019
2020 / 2008-2018
2018 / 2006-2016

Mortality Improvement Rates

Attained Age

--- 2021 Scale Year --- 2020 Scale Year --- 2019 Scale Year --- 2018 Scale Year

Unsmoothed Preliminary—Male
Comparison by Scale Year – 2021 Scale Revised

Males - Compare Unsmoothed Rates

Mortality Improvement Rates

Attained Age

--- 2021 Scale Year --- 2020 Scale Year --- 2019 Scale Year --- 2018 Scale Year
Unsmoothed Preliminary—Female
Comparison by Scale Year - 2021 Scale Revised

Smoothed Preliminary—Male
Comparison by Scale Year - 2021 Scale Revised
Smoothed Preliminary—Female
Comparison by Scale Year - 2021 Scale Revised

Females - Compare Smoothed Rates

Mortality Improvement Rates

Attained Age

F - 2021  F - 2020  F - 2019  F - 2018

Recommendation for Application of HMI Scale for 2021
Revised

Recommendation

- Use standard methodology for the published HMI scale for 2021
- Decrease the HMI scale for males and for females for 2021 based on the application of the standard methodology
- Recommend individual companies reflect their expectations around COVID-19 impacts for short-term mortality levels as part of a temporary mortality adjustment

Impact on the 12/31/21 Valuation

- Bring up to valuation date (standard Valuation Basic Table (VBT))
- Note: Companies start with different base mortality levels
  - Possibly higher mortality for the near term to reflect COVID-19
  - HMI scale would not attempt to adjust for COVID-19 as the exposure and the handling of deaths in the underlying company data will vary
Questions?

Contact Information

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Chair, Life MI Subgroup
mpurushotham@limra.com

Khloe Greenwood
Life Policy Analyst
American Academy of Actuaries
greenwood@actuary.org
## Historical Mortality Improvement Rates

To be used for VM20 Products  
2021 Recommended Scale

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<th>Attained Age</th>
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December 8, 2021

From: Seong-min Eom, Chair
Longevity Risk (E/A) Subgroup

To: Mike Boerner, Chair
The Life Actuarial (A) Task Force

Subject: The Report of Longevity Risk (E/A) Subgroup to the Life Actuarial (A) Task Force

The Longevity Risk (E/A) Subgroup has not met since the Summer National Meeting. A new Subgroup chair has been appointed. The Subgroup will coordinate with the PRT Mortality Drafting Group of the VM-22 (A) Subgroup to assess risks associated with pension risk transfer business.
December 8, 2021

From: Reggie Mazyck, NAIC Support Staff
Guaranteed Issue (GI) Life Valuation (A) Subgroup

To: Mike Boerner, Chair
The Life Actuarial (A) Task Force

Subject: The Report of Guaranteed Issue (GI) Life Valuation (A) Subgroup to the Life Actuarial (A) Task Force

The Guaranteed Issue (GI) Life Valuation (A) Subgroup has not met since the Summer National Meeting. It is awaiting the appointment of a new chair. Otherwise, it is in a dormant/monitoring mode given that there have been no new known studies of GI Life mortality that could prove useful in formulating a new prescriptive requirement for the reserves for GI Life products. One direction the subgroup could go is to continue consideration of how to adopt the GI Life table but require companies with credible experience to use a credibility weighted mortality whether their experience is lower or higher than the table.
Dec 8, 2021

From: Fred Andersen, Chair
The Experience Reporting (A) Subgroup

To: Mike Boerner, Chair
The Life Actuarial (A) Task Force

Subject: The Report of the Experience Reporting (A) Subgroup to the Life Actuarial (A) Task Force

The Experience Reporting (A) Subgroup has not met since the Summer National Meeting. Upcoming projects include monitoring the plans for collecting life insurance mortality and policyholder behavior data using the NAIC as the statistical agent, starting to develop mandatory reporting of variable annuity data, and continuing to work on evaluating actuarial aspects of accelerated underwriting.
Index-Linked Variable Annuity (A) Subgroup
Virtual Meeting
November 23, 2021

The Index-Linked Variable Annuity (A) Subgroup of the Life Actuarial (A) Task Force met Nov. 23, 2021. The following Subgroup members participated: Peter Weber, Chair (OH); Tomasz Serbinowski, Vice Chair (UT); Sarvjit Samra (CA); Vincent Tsang (IL); Derek Wallman (NE); Kevin Clarkson and David Wolf (NJ); Bill Carmello and Michael Cebula (NY); Mengting Kim and Mike Boerner (TX); and Craig Chupp (VA).

1. Exposed the Draft Actuarial Guideline for ILVAs

Mr. Weber said index-linked variable annuities (ILVAs) are filed as variable products. As such, they are exempt from nonforfeiture requirements, which are a source of consumer protection. He said the usual tradeoff available to variable product owners in lieu of nonforfeiture values is the availability of unitized separate account values at surrender. He said that the ILVA product does not have the safeguard of nonforfeiture, nor does it have unitized values. He said the proposed actuarial guideline (Attachment Ten-A) seeks to remedy this issue by providing guidance for how a non-unit-linked product can be considered to provide values that vary according to the investment experience of a separate account. He said the guideline clarifies the application of the Standard Nonforfeiture Law for Individual Deferred Annuities (#805) and the Variable Annuity Model Regulation (#250) to ILVAs to provide values that vary according to the investment experience of the assets in the underlying separate account, therefore allowing them to be considered variable annuities. Mr. Serbinowski provided an overview of the proposed guideline. He noted that the guideline is not a finished product but is intended to be a good starting point for discussion. He recommended that state insurance regulators review non-unitized products being filed as variable in their states to ensure that they are in conformance with the requirements of Model #250.

Wayne Mehlman (American Council of Life Insurers—ACLI) and Steve Roth (Committee of Annuity Insurers) said an industry drafting group has been developed to create a revised version of the proposed guideline. He said the aims of the revised version are to: 1) ensure that there are more choices and options for ILVA clients; 2) maintain the transparency of the interim or unitized value designs; 3) preserve the ability for carriers to use spread based rather than fee-based manufacturing model; and 4) allow flexibility in new product innovation and development. He said that industry believes the proposed guideline is currently too prescriptive and should be more principle-based.

The Subgroup agreed, without objection, to expose the proposed actuarial guideline for a 60-day public comment period ending Jan. 27, 2022.

Having no further business, the Index-Linked Variable Annuity (A) Subgroup adjourned.

https://naiconline.sharepoint.com/w:/r/sites/NAICSupportStaffHub/Member Meetings/Fall 2021/TF/LifeActuarial/ILVA/11_23/11_23 ILVA Minutes.docx
**Background**

Variable annuities are exempted from the scope of NAIC Model 805, Standard Nonforfeiture Law for Individual Deferred Annuities. The Model does not define the term "variable annuity". NAIC Model 250, Variable Annuity Model Regulation, provides requirements for nonforfeiture benefits. Model 250 also defines variable annuities as "contracts that provide for annuity benefits that vary according to the investment experience of a separate account."

Section 7B of the Model 250 provides that "to the extent that a variable annuity contract provides benefits that do not vary in accordance with the investment performance of a separate account" the contract shall satisfy the requirements of Model 805.

The application of the Model 250 to a traditional variable annuity with unit-linked values is straightforward. The unit-linked feature provides an automatic linkage between annuity values and the investment experience of a separate account. Daily values (market values of the separate account assets) are the basis of all the benefits, including surrender values.

Recently, a number of insurers introduced new, hybrid annuity products with periodic credits based on the performance of a specified portfolio of assets, typically through an index. These hybrid products typically are not unit-linked and do not invest in the assets whose performance forms the basis for the periodic credits.

There is no established terminology for these hybrid products. These products go by several names, including structured annuities, registered index-linked annuities, or index-linked variable annuities, among others. This guideline refers to them as index-linked variable annuities (ILVA).

The fact that ILVA products are not unit-linked means they don't have daily values determined by the market prices of the underlying assets. Instead, they provide interim values defined by contractual provisions. These interim values may or may not reflect the market values of the actual assets held by the insurer in support of the product guarantees.

Many ILVA products are registered with the SEC and claim to be exempt from model 805 as variable annuities. However, because they are not unit-linked, the question arises whether they provide values that vary according to the investment experience of a separate account, as required in Model 250.

The purpose of this guideline is to clarify the application of the Models 805 and 250 to those hybrid products. Specifically, the guideline provides conditions under which a non-unit-linked product can be considered to provide values that vary according to the
investment experience of a separate account, and therefore be considered a variable annuity under Model 250 and exempt from Model 805.

**Scope**

This guideline applies to any annuity contract claiming exemption from Model 805 on the basis that it is variable and that it is not unit-linked.

This guidance applies to index-linked crediting features that are provided through non-unitized separate account(s) that are built into policies or contracts (with or without unitized subaccounts) or added to such by rider, endorsement, or amendment. This guidance applies to both insulated and non-insulated separate account products.

This guideline does not apply to products supported by a general account and subject to the requirements of NAIC Model 805, Standard Nonforfeiture Law for Individual Deferred Annuities.

**Definitions**

“Hypothetical Portfolio” means hypothetical portfolio of fixed income assets and derivative assets designed to replicate an Index Option Value at the end of the Index Term.

“Interim value” means the value, attributable to one or more index options, used in determining the death benefit, withdrawal amount, annuitization amount or surrender value at any time other than the start date and end date of an index term.

“Index Strategy” means a method used to determine index credits with specified index or indices and cap, buffer, participation rate, spread, margin or other index crediting elements.

“Index Option Value” means the contract value or other well-defined base value in an index option at an index term start date or end date.

“Index Term” means the period of time from the term start date to the term end date over which an index change and index credit is determined.
Principles

This guideline is based on the following principles:

1. The Interim Value methodology must provide equity to both the contract holder and the company. Equity in this case, means that the Interim Values approximate the actual market values of the separate account assets backing the policies or contracts.

2. There exists a hypothetical portfolio containing fixed-income assets and derivatives that use values consistent with the underlying market prices of the hypothetical derivative assets at the time the index crediting elements are determined.

3. Such hypothetical portfolio must be designed to perfectly hedge the benefit guarantees at the end of the term.

4. The market value of such hypothetical portfolio is determinable based on the daily values of the hypothetical portfolio’s assets.

Text

Interim values must be based on the market value of the separate account assets supporting the guarantees in the contract. That determination may be based on the actual separate account assets or based on a hypothetical portfolio of supporting assets described herein.

The value of the Hypothetical Portfolio at any time is the sum of the Fixed-Income Asset Proxy value (with or without a market-value adjustment) and the Derivative Asset Proxy value.

“Fixed-Income Asset Proxy” represents a zero-coupon bond that accrues interest, simple or compound, over the Index Term and matures for a value equal to the initial Index Option Value.

“Derivative Asset Proxy” is a package of hypothetical derivative assets designed to hedge the risks associated with guaranteeing the Index Option Value.

The value of the Derivative Asset Proxy plus the value of the Fixed-Income Asset Proxy shall match the Index Option Value at the end of the Index Term as determined by the Index Strategy.

Assumptions used to value the Hypothetical Portfolio including yields, implied volatility, risk-free rate, and dividend yield:

1. Must be supported by market prices of the Fixed-Income Asset Proxy and Derivative Asset Proxy at the time index crediting elements are determined;
2. May be static throughout the Index Term or may be dynamic. If dynamic assumptions are used, the assumptions must be based on market prices of the Fixed-Income Asset Proxy and Derivative Asset Proxy at the time of valuation.

The initial value of the Fixed-Income Asset Proxy is equal to the initial Index Option Value less the initial value of the Derivative Asset Proxy. Drafting Note: The difference is expected to be small, as any profit provisions, spreads, and expenses should be reflected as explicit charges disclosed in the contract. Any explicit charges deducted at the beginning of the Index Term would decrease the Index Option Value for the purpose of the comparison to the Hypothetical Portfolio value. There may need to be a provision for recognition of periodic charges to be assessed over the Index Term in the comparison required above.

The company (or actuary) must describe the Hypothetical Portfolio and the assumptions used to calculate its value at any time. The product filing must quantify the maximum difference between the value of the Hypothetical Portfolio and the Index Option Value at the beginning of the Index Term. The actuary must justify and explain the source of any material differences.

Company must provide an actuary’s certification that provisions of this guideline are being met. <What, if any, details need to be provided in the cert or its support?>

**Effective Date**

Questions to commenters
The Index-Linked Variable Annuity (A) Subgroup of the Life Actuarial (A) Task Force met Sept. 23, 2021. The following Subgroup members participated: Peter Weber, Chair (OH); Tomasz Serbinowski, Vice Chair (UT); Sarvjit Samra (CA); Derek Wallman (NE); Kevin Clarkson and David Wolf (NJ); Bill Carmello (NY); and Mengting Kim (TX). Also participating were: Vincent Tsang (IL); David Sky (NH); and Mike Boerner (TX).

1. Discussed Establishing Interim Values for ILVAs

Mr. Weber discussed the list of options (Attachment Eleven-A) for the consideration of the Subgroup. Mr. Clarkson suggested that the Subgroup determine the order of importance for addressing the following items: 1) determining the definition of the product; 2) resolving the valuation and nonforfeiture issues; 3) deciding how closely the returns must come to matching the underlying index; and 4) the equity of the interim value provisions. Mr. Weber noted that valuation issues are outside of the scope of the Subgroup charges. He said he wants to focus on the Subgroup charge to provide recommendations for interim values.

Mr. Samra voiced support for basing any new guidance on state regulations currently in use. He asked if Mr. Weber’s survey of state regulations also included state-issued bulletins or notices companies could use as guidance. Mr. Weber responded that his survey, which was informal and conducted verbally, did not uncover any notices or bulletins. He said most states provided companies with a list of questions intended to promote disclosure.

Mr. Tsang said Illinois Regulation 1551 provides a definition for a variable contract, but it does not cover index-linked variable annuity (ILVA) products and other contracts that provide guarantees. Mr. Serbinowski said the ILVA may be covered if it is registered under the Securities Act of 1933. Mr. Weber suggested using the regulation as a template for developing a regulation that addresses interim values. Mr. Carmello said the New York State Department of Financial Services (NYSDFS) has a draft ILVA regulation that bases interim values on the market value of the segment guarantees or the prorated value based on the term of the guarantee. He said the buffer is included as part of the prorated value. He said the proration method is not perfect, but it has the advantage of being simple. Mr. Serbinowski said he favors developing an Actuarial Guideline that follows the path of the Illinois regulation, but it provides a slightly different interpretation of how benefits may follow the performance of the asset values. Mr. Carmello said the guideline should be applied to new issues only. Mr. Sky suggested notifying the commissioner of the intent to develop new requirements and recommending a moratorium on new ILVA product approvals. Mr. Carmello said it is probably too late for such a recommendation. Mr. Weber said he, Mr. Serbinowski, and a few others will begin work on the guideline.

Having no further business, the Index-Linked Variable Annuity (A) Subgroup adjourned.
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| Do nothing | • No impact to currently marketed products | • Not uniform and increased non-uniformity if states tighten standards on their own to address evolving designs  
• No minimum value provided  
• Evolving designs are less equitable to contract holder |
| Base guidance on a current states’ approach where such exists*. Or a blending of approaches | • Uniformity  
• Likely minimal effort to implement  
• Likely minimal impact on current marketed products | • Not well defined  
• Depends on the approach |
| Guidance for how these products can be considered variable (Compact approach) | • Uniformity  
• Potentially minimal impact on currently marketed products | • May be difficult to define |
| Modify model 805 and/or develop separate requirements for hybrid separate account products | • Uniformity | • Considerable effort  
• Such approach should be part of a more in-depth review and modification of the model beyond just ILVAs  
• Requires individual state adoption |
| Reject products as variable | • Regulatory framework exists but it must be strictly enforced | • Non-compliant products currently exist in market  
• Disrupts an important segment of the market between VAs and FIAS  
• Since many states will allow these products anyway, creates increased non-uniformity (this may be worse than “do nothing”) |

* Approaches shared through an informal state survey were aligned with but generally, less formal than the Illinois regulation’s expanded definition of “variable”. The states’ guidance included standard questions in review and disclosure requirements. Elements that could be incorporated into a recommended approach.
IL – Regulation 1551

Variable Contract means any policy or contract that provides for life insurance or annuity benefits that vary according to the investment experience of any separate account or accounts maintained by the insurer as to that policy or contract, as provided for in Section 245.21 of the Code; or any policy or contract that is registered under the Securities Act of 1933, as amended (15 USC 77a et seq.), and that provides for benefits that vary according to the performance of an index, when the funds are not guaranteed as to principal or a stated rate of interest and in which the supporting assets are held and reported in a noninsulated separate account in which changes in asset values substantially match changes in contractual benefits from inception of the contract.

What is a metric for “substantially match”? Could states accept actuary’s certification that they substantially match? Would a demonstration be required? What would a demonstration of that look like?
December 1, 2021

Mr. Mike Boerner
Chair, Life Actuarial (A) Task Force
National Association of Insurance Commissioners

Re: Amendment Proposal Form (APF) 2021-11

Dear Mr. Boerner,

On behalf of the Variable Annuity Reserves & Capital Work Group (VARCWG) of the American Academy of Actuaries,¹ I am pleased to provide comments on the proposed assumption disclosure requirements in APF 2021-11.

VARCWG believes that the proposed disclosures in VM-31 Section 3.F.13.d.ii and iii should consider unfloored conditional tail expectations (CTEs)—i.e., calculate the CTE without requiring that the scenario reserve for any scenario be no less than the cash surrender value. Quantifications before the cash surrender value floor are likely to provide a better understanding of the conservatism selected for the assumption.

It may also be possible to simplify the assumption margin analysis.

For example, one approach would be to simplify the assessment of individual risk factors in VM-31 Section 3.F.13.d.ii by using CTE 70 (adjusted) instead of CTE 70 (best efforts) and removing the CTE 98 requirement.

- Using CTE 70 (adjusted) for the assumption margin analysis is consistent with the use of CTE 70 (adjusted) to assess assumption outliers in the Standard Projection and in other disclosures.
- The CTE (adjusted) basis may make the analysis more tractable and/or less subject to estimation noise from simplifications for companies with a Clearly Defined Hedging Strategy (CDHS).

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
- The analogous disclosure requirement for VM-20 reserves uses only the Deterministic Reserve even if there are stochastic reserves.

- If desired, CTE 70 (adjusted) could be added to the VM-31 Section 3.F.13.d.iii aggregate margin disclosure requirements to connect the individual margin analysis to the aggregate CTE 70 and CTE 98 margin analysis.

Another approach would also remove the CTE 98 requirement from VM-31 Section 3.F.13.d.ii but allow actuaries to use either CTE (adjusted) or CTE (best efforts) for both VM-31 Section 3.F.13.d.ii and iii and disclose their selected basis and rationale. Both measures provide insights into assumption margins, and some actuaries may determine that one is more appropriate than the other based upon the underlying facts and circumstances.

Thank you for your consideration of these comments. Please contact Academy life policy analyst Khloe Greenwood (greenwood@actuary.org) with any questions.

Sincerely,
Connie Tang, MAAA, FSA, CERA, CFA
Chairperson, VARCWG
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

Identification:
PBR Staff of Texas Department of Insurance

Title of the Issue:
Add a section for other assumptions requirement in VM-21 which covers general guidance and requirements for assumptions, and expense assumptions.

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

VM-21 Section 1.C.2.b, VM-21 Section 12, VM-21 Section 13, VM-21 Section 1.B, VM-21 Section 10.A, VM-31 Section 3.F.3.d, VM-31 Section 3.F.13.d

January 1, 2021 NAIC Valuation Manual

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

See attached.

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

A new section is needed in VM-21 to provide general guidance and requirements for assumptions, similar to VM-20, to address assumption reporting issues identified in VM-21 PBR report reviews, e.g., some companies don’t discuss regular assumption reviews for any necessary updates. In addition, this section provides the specific requirements for assumptions that have not been covered in previous sections of VM-21, i.e., the expense assumptions. VM-21 is not very explicit about expenses (e.g., whether they are fully allocated or include one-time expenses). For VM-20, we have had some material impacts from how companies treat one-time expenses that may be multi-year but temporary. Companies could understate expenses if there is no adjustment for periodic or other recurrent expenses in expense study years where they do not occur. This APF is to make the VM-21 expense assumption requirement explicit and consistent with what is specified in VM-20 Section 9.E. The new section can also be used to cover any other assumptions requirements that need to be addressed in the future. The reporting requirement of the sensitivity testing and the impact of margin analysis is added to VM-31 to help regulators better understand how companies comply with the newly added assumption guidance and requirements.
VM-21 Section 1.C.2.b

a) Liability risks

i. Reinsurer default, impairment or rating downgrade known to have occurred before or on the valuation date.

ii. Mortality/longevity, persistency/lapse, partial withdrawal and premium payment risks.

iii. Utilization risk associated with guaranteed living benefits.

iv. Anticipated mortality trends based on observed patterns of mortality improvement or deterioration, where permitted.

v. Annuitization risks.

vi. Additional premium dump-ins (high interest rate guarantees in low interest rate environments).

vii. Applicable expense risks, including fluctuation in maintenance expenses directly attributable to the business, future commission expenses, and expense inflation/growth.

VM-21 Section 12 (new)

Section 12: Other Guidance and Requirements for Assumptions

A. Overview

This section provides guidance and requirements in general for setting prudent estimate assumptions when determining either the stochastic reserve or the reserve for any contracts determined using the Alternative Methodology. It also provides specific guidance and requirements for expense assumptions.

B. General Assumption Requirements

1. The company shall use prudent estimate assumptions for risk factors that are not stochastically modeled by applying margins to the anticipated experience assumptions if such risk factors have been categorized as material risks by following Section 1.B Principle 3 and requirements in Section 12.C.

2. The company shall establish the prudent estimate assumptions for risk factors in compliance with the requirements in Section 12 of Model #820 and must periodically review and update the assumptions as appropriate in accordance with these requirements.

3. The company shall model the following risk factors stochastically unless the company
elects the Alternative Methodology defined in Section 7:

a. Interest rate movements (i.e., Treasury interest rate curves).

b. Equity performance (e.g., Standard & Poor’s 500 index [S&P 500] returns and returns of other equity investments).

4. If the company elects to stochastically model risk factors in addition to the economic scenarios, the requirements in this section for determining prudent estimate assumptions for these risk factors do not apply.

Guidance Note: It is expected that companies will not stochastically model risk factors other than the economic scenarios, such as contract holder behavior or mortality, until VM-21 has more specific guidance and requirements available. Companies shall discuss with domiciliary regulators if they wish to stochastically model other risk factors.

5. The company shall use its own experience, if relevant and credible, to establish an anticipated experience assumption for any risk factor. To the extent that company experience is not available or credible, the company may use industry experience or other data to establish the anticipated experience assumption, making modifications as needed to reflect the circumstances of the company.

a. For risk factors (such as mortality) to which statistical credibility theory may be appropriately applied, the company shall establish anticipated experience assumptions for the risk factor by combining relevant company experience with industry experience data, tables or other applicable data in a manner that is consistent with credibility theory and accepted actuarial practice.

b. For risk factors (such as utilization of guaranteed living benefits) that do not lend themselves to the use of statistical credibility theory, and for risk factors (such as some of the lapse assumptions) to which statistical credibility theory can be appropriately applied but cannot currently be applied due to lack of industry data, the company shall establish anticipated experience assumptions in a manner that is consistent with accepted actuarial practice and that reflects any available relevant company experience, any available relevant industry experience, or any other experience data that are available and relevant. Such techniques include:

i. Adopting standard assumptions published by professional, industry or regulatory organizations to the extent they reflect any available relevant company experience or reasonable expectations.

ii. Applying factors to relevant industry experience tables or other relevant data to reflect any available relevant company experience and differences in expected...
experience from that underlying the base tables or data due to differences between the risk characteristics of the company experience and the risk characteristics of the experience underlying the base tables or data.

iii. Blending any available relevant company experience with any available relevant industry experience and/or other applicable data using weightings established in a manner that is consistent with accepted actuarial practice and that reflects the risk characteristics of the underlying contracts and/or company practices.

c. For risk factors that have limited or no experience or other applicable data to draw upon, the assumptions shall be established using sound actuarial judgment and the most relevant data available, if such data exists.

d. For any assumption that is set in accordance with the requirements of Section 12.B.5.c, the qualified actuary to whom responsibility for this group of contracts is assigned shall use sensitivity testing and disclose the analysis performed to ensure that the assumption is set at the conservative end of the plausible range.

e. The qualified actuary, to whom responsibility for this group of contracts is assigned, shall annually review relevant emerging experience for the purpose of assessing the appropriateness of the anticipated experience assumption. If the results of statistical or other testing indicate that previously anticipated experience for a given factor is inadequate, then the qualified actuary shall set a new, adequate, anticipated experience assumption for the factor.

6. The company shall sensitivity test risk factors that are not stochastically modeled and examine the impact on the stochastic reserve. The company shall update the sensitivity tests periodically as appropriate. The company may update the tests less frequently, but no less than every 3 years, when the tests show less sensitivity of the stochastic reserve to changes in the assumptions being tested or the experience is not changing rapidly. Providing there is no material impact on the results of the sensitivity testing, the company may perform sensitivity testing:

a. Using samples of the contracts in force rather than performing the entire valuation for each alternative assumption set.

b. Using data from prior periods.

Guidance Note: Sensitivity testing every risk factor on an annual basis is not required. For some risk factors, it may be reasonable, in lieu of sensitivity testing, to employ statistical measures for margins, such as adding one or more standard deviations to the anticipated experience assumption.
7. The company shall vary the prudent estimate assumptions from scenario to scenario within the stochastic reserve calculation in an appropriate manner to reflect the scenario-dependent risks.

C. Assumption Margins

The company shall include margins to provide for adverse deviations and estimation error in the prudent estimate assumption for each risk factor that is not stochastically modeled or prescribed, subject to the following:

1. The level of margin applied to the anticipated experience assumptions may be determined in aggregate or independently as discussed in Section 1.B Principle 3. It is not permissible to set a margin less toward the conservative end of the spectrum to recognize, in whole or in part, implicit or prescribed margins that are present, or are believed to be present, in other risk factors.

Risks that are stochastically modeled (e.g., interest rates, equity returns) or have prescribed margins or guardrails (e.g., assets, revenue sharing) shall be considered material risks. Other risks generally considered to be material include, but are not limited to, mortality, contract holder behavior, maintenance and overhead expenses, inflation and implied volatility. In some cases, the list of material risks may also include acquisition expenses, partial withdrawals, policy loans, annuitizations, account transfers and deposits, and/or option elections that contain an element of anti-selection.

2. The greater the uncertainty in the anticipated experience assumption, the larger the required margin, with the margin added or subtracted as needed to produce a larger modeled TAR than would otherwise result. For example, the company shall use a larger margin when:

   a. The experience data have less relevance or lower credibility.

   b. The experience data are of lower quality, such as incomplete, internally inconsistent or not current.

   c. There is doubt about the reliability of the anticipated experience assumption, such as, but not limited to, recent changes in circumstances or changes in company policies.

   d. There are constraints in the modeling that limit an effective reflection of the risk factor.

3. In complying with the sensitivity testing requirements in Section 12.B.6 above, greater analysis and more detailed justification are needed to determine the level of uncertainty when establishing margins for risk factors that produce greater sensitivity on the stochastic reserve.
4. A margin is permitted but not required for assumptions that do not represent material risks.

5. A margin should reflect the magnitude of fluctuations in historical experience of the company for the risk factor, as appropriate.

6. The company shall apply the method used to determine the margin consistently on each valuation date but is permitted to change the method from the prior year if the rationale for the change and the impact on the stochastic reserve is disclosed.

D. Expense Assumptions

1. General Prudent Estimate Expense Assumption Requirements

In determining prudent estimate expense assumptions, the company:

a. May spread certain information technology development costs and other capital expenditures over a reasonable number of years in accordance with accepted statutory accounting principles as defined in the Statements of Statutory Accounting Principles.

Guidance Note: Care should be taken with regard to the potential interaction with the inflation assumption below.

b. Shall assume that the company is a going concern.

c. Shall choose an appropriate expense basis that properly aligns the actual expense to the assumption. If values are not significant, they may be aggregated into a different base assumption.

Guidance Note: For example, death benefit expenses should be modeled with an expense assumption that is per death incurred.

d. Shall reflect the impact of inflation.

e. Shall not assume future expense improvements.

f. Shall not include assumptions for federal income taxes (and expenses paid to provide fraternal benefits in lieu of federal income taxes) and foreign income taxes.

g. Shall use assumptions that are consistent with other related assumptions.
h. Shall use fully allocated expenses.

Guidance Note: Expense assumptions should reflect the direct costs associated with the block of contracts being modeled, as well as indirect costs and overhead costs that have been allocated to the modeled contracts.

i. Shall allocate expenses using an allocation method that is consistent across company lines of business. Such allocation must be determined in a manner that is within the range of actuarial practice and methodology and consistent with applicable ASOPs. Allocations may not be done for the purpose of decreasing the stochastic reserve.

j. Shall reflect expense efficiencies that are derived and realized from the combination of blocks of business due to a business acquisition or merger in the expense assumption only when any future costs associated with achieving the efficiencies are also recognized.

Guidance Note: For example, the combining of two similar blocks of business on the same administrative system may yield some expense savings on a per unit basis, but any future cost of the system conversion should also be considered in the final assumption. If all costs for the conversion are in the past, then there would be no future expenses to reflect in the valuation.

k. Shall reflect the direct costs associated with the contracts being modeled, as well as an appropriate portion of indirect costs and overhead (i.e., expense assumptions representing fully allocated expenses should be used), including expenses categorized in the annual statement as “taxes, licenses and fees” (Exhibit 3 of the annual statement) in the expense assumption.

l. Shall include acquisition expenses associated with business in force as of the valuation date and significant non-recurring expenses expected to be incurred after the valuation date in the expense assumption.

m. For contracts sold under a new policy form or due to entry into a new product line, the company shall use expense factors that are consistent with the expense factors used to determine anticipated experience assumptions for contracts from an existing block of mature contracts taking into account:

   i. Any differences in the expected long-term expense levels between the block of new contacts and the block of mature contracts.

   ii. That all expenses must be fully allocated as required.
under Section 142.D6.1.a.i above.

2. Margins for Prudent Estimate Expense Assumptions

The company shall determine margins for expense assumptions following Section 12.C.

VM-21 Section 13

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

VM-21 Section 1.B

Principle 3: The implementation of a model involves decisions about the experience assumptions and the modeling techniques to be used in measuring the risks to which the company is exposed. Generally, assumptions are to be based on the conservative end of the confidence interval. The choice of a conservative estimate for each assumption may result in a distorted measure of the total risk. Conceptually, the choice of assumptions and the modeling decisions should be made so that the final result approximates what would be obtained for the stochastic reserve at the required CTE level if it were possible to calculate results over the joint distribution of all future outcomes. In applying this concept to the actual calculation of the stochastic reserve, the company should be guided by evolving practice and expanding knowledge base in the measurement and management of risk.

Guidance Note: The intent of Principle 3 is to describe the conceptual framework for setting assumptions. Section 10 provides the requirements and guidance for setting contract holder behavior assumptions and includes alternatives to this framework if the company is unable to fully apply this principle. More guidance and requirements for setting assumptions in general are provided in Section 12.

VM-21 Section 10.A

Section 10: Contract Holder Behavior Assumptions

A. General

Contract holder behavior assumptions encompass actions such as lapses, withdrawals, transfers, recurring deposits, benefit utilization, option election, etc. Contract holder behavior is difficult to predict accurately, and variance in behavior assumptions can significantly affect the results. In the absence of relevant and fully credible empirical data, the company should set behavior assumptions as guided by Principle 3 in Section 1.B and Section 12.

VM-31 Section 3.F.3.d

3. Liability Assumptions and Margins – A listing of the assumptions and margins used in the projections to determine the stochastic reserve, including a discussion of the source(s) and the rationale for each assumption:

a. Premiums and Subsequent Deposits – Description of premiums and subsequent deposits.
b. Interest Crediting Strategy – Description of the interest crediting strategy.

c. Commissions – Description of commissions, including any commission chargebacks.

d. Expenses Other than Commissions – Description and listing of insurance company expenses other than commissions, such as overhead, including:

i. Method used to allocate expenses to the contracts included in a principle-based valuation under VM-21 and a statement confirming that expenses have been fully allocated in accordance with VM-21 Section 12.D.1.h.

ii. Method used to apply the allocated expenses to model segments or sub-segments within the cash-flow model.

iii. Identification of types of costs that were spread, and for how many years, if any cost spreading was done pursuant to VM-21 Section 12.D.1.a.

ii.iv. Method used to determine margins.

VM-31 Section 3.F.13.c (new)

c. Sensitivity Tests – For each distinct product type for which margins were established:

i. List the specific sensitivity tests performed for each risk factor or combination of risk factors, rather than those discussed in Sections 3.D.3.h.ii. and 3.D.3.i.ii.

ii. Indicate whether the reserve was calculated based on the anticipated experience assumptions or prudent estimate assumptions for all other risk factors while performing the tests.

iii. Provide the numerical results of the sensitivity tests for both reserves and capital.

iv. Explain how the results of sensitivity tests were used or considered in developing assumptions.

VM-31 Section 3.F.13.d (new)

d. Impact of Margin

i. Company can perform the impact of margin analysis using off-cycle data. The analysis can be done less frequently than annual unless there is change or update in the margins, but not less frequently than every 3 years.
ii. Impact of Margins for Each Risk Factor – The impact of margins on the stochastic reserve for each risk factor, or group of risk factors, that has a material impact on the stochastic reserve, determined by subtracting (i) from (ii), expressed in both dollar amounts and percentages:

(1) The CTE70(best efforts), as outlined in VM-21 Section 9.C, but with the reserve calculated based on the anticipated experience assumption for the risk factor and prudent estimate assumptions for all other risk factors.

(2) The CTE70(best efforts), as outlined in VM-21 Section 9.C, for that group of contracts as reported.

(3) Repeat the impact analysis using the same method on CTE(98) levels.

Guidance Note: Pursuant to VM-21, margins must increase TAR, so the impact of each margin, as calculated above on CTE(98), must be positive.

iii. Aggregate Impact of Margins – the aggregate impact of all margins on the stochastic reserve for that group of contracts determined by subtracting (1) from (2), expressed in both dollar amounts and percentages:

(1) The CTE70(best efforts), as outlined in VM-21 Section 9.C, for that group of contracts, but with the reserve calculated based on anticipated experience assumptions for all risk factors prior to the addition of any margins.

(2) The CTE70(best efforts), as outlined in VM-21 Section 9.C, for that group of contracts as reported.

(3) Repeat the impact analysis using the same method on CTE(98) levels.

iv. Impact of Implicit Margins – For purposes of the disclosures required in 13.d.ii and 13.d.iii above:

(1) If the company believes the method used to determine anticipated experience assumptions includes an implicit margin, the company can adjust the anticipated experience assumptions to remove this implicit margin for this reporting purpose only. If any such adjustment is made, the company shall document the rationale and method used to determine the anticipated experience assumption.

(2) Since the company is not required to determine an anticipated experience assumption or a prudent estimate assumption for risk factors that are prescribed (i.e., interest rates movements, equity performance, default costs and net spreads on reinvestment assets), when determining the impact of margins, the prescribed assumption shall be deemed to be the prudent estimate assumption for the risk factor, and the company can elect to determine an anticipated experience assumption for the risk factor, based on the company's anticipated experience for the risk factor. If this is elected, the company shall document the rationale and method used to determine the anticipated experience assumption.
Brian Bayerle  
Senior Actuary  

December 1, 2021  

Mr. Mike Boerner  
Chair, NAIC Life Actuarial Task Force (LATF)  

Re: APF 2021-11  

Dear Mr. Boerner:  

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit the following comments on APF 2021-11.  

ACLI is supportive of regulatory requirements that ensure appropriate assumptions and margins, as well as disclosures that provide regulators useful insights into how a company has determined reserves. Industry is, however, concerned about further increases in reporting requirements that do not provide significant value to regulators. Therefore, although we support the majority of this APF, we are concerned about the inclusion of language regarding sensitivity testing in VM-21 Section 12.B.6. The margins on the assumptions are intended to account for the uncertainty around the assumptions, not the sensitivity of reserves to a given assumption; thus, it is unclear how this information assists regulators in assessing the reasonableness of the margin. The phrase "no material impact" also may be a source of confusion, as certain assumptions can display different sensitivities in different market conditions. Further, it is unclear how, if at all, the qualified actuary is intended to use the results of this sensitivity testing. For this reason, ACLI believes this requirement should be removed from APF 2021-11.  

The proposed requirements regarding sensitivity testing in this APF are like those found in VM-20. Consequently, the same comment above holds for VM-20; namely, that sensitivity tests appear to have little regulatory value concerning the determination of margins because sensitivity is different from uncertainty. Accordingly, ACLI believes that strong consideration should be given to removing the sensitivity testing requirements from VM-20 as well.  

In addition to the primary concern raised above, we have the following additional comments:  
• VM-21, Section 12.B.4 Guidance Note: The last sentence of the guidance note states that “Companies shall discuss...”, and we would like clarification if this language is intended as a requirement or a suggestion. If the latter, we would suggest changing to “Companies may shall discuss....”  

American Council of Life Insurers | 101 Constitution Ave, NW, Suite 700 | Washington, DC 20001-2133  

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States.

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• VM-21, Section 12.C.1: This language seems to require a conservative margin on every individual assumption without recognizing potential impacts from other margins. That appears to contradict Principle 3, which says, “The choice of a conservative estimate for each assumption may result in a distorted measure of the total risk.” Principle 3 implies that margins should be set to get to an appropriate overall level of conservatism.

• VM-31, Section 3.F.13.d.ii.3: The Guidance Note implies that TAR is equal to CTE(98), which is inaccurate. TAR is equal to reserves plus C-3 RBC, which will not be equal to CTE(98) due to the factors within the C-3 RBC formula.

We appreciate the consideration of our comments and look forward to discussing on a future call. Thank you.

Sincerely,

[Signature]

cc: Reggie Mazyck, NAIC
Life Actuarial (A) Task Force/ Health Actuarial (B) Task Force
Amendment Proposal Form*

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

   **Identification:**
   PBR Staff of Texas Department of Insurance

   **Title of the Issue:**
   Add a section for other assumptions requirement in VM-21 which covers general guidance and requirements for assumptions, and expense assumptions.

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

   VM-21 Section 1.C.2.b, VM-21 Section 12, VM-21 Section 13, VM-21 Section 1.B, VM-21 Section 10.A, VM-31 Section 3.F.3.d, VM-31 Section 3.F.13.d

   January 1, 2021 NAIC Valuation Manual

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

   See attached.

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

   A new section is needed in VM-21 to provide general guidance and requirements for assumptions, similar to VM-20, to address assumption reporting issues identified in VM-21 PBR report reviews, e.g., some companies don’t discuss regular assumption reviews for any necessary updates. In addition, this section provides the specific requirements for assumptions that have not been covered in previous sections of VM-21, i.e., the expense assumptions. VM-21 is not very explicit about expenses (e.g., whether they are fully allocated or include one-time expenses). For VM-20, we have had some material impacts from how companies treat one-time expenses that may be multi-year but temporary. Companies could understate expenses if there is no adjustment for periodic or other recurrent expenses in expense study years where they do not occur. This APF is to make the VM-21 expense assumption requirement explicit and consistent with what is specified in VM-20 Section 9.E. The new section can also be used to cover any other assumptions requirements that need to be addressed in the future. The reporting requirement of the sensitivity testing and the impact of margin analysis is added to VM-31 to help regulators better understand how companies comply with the newly added assumption guidance and requirements.
VM-21 Section 1.C.2.b

1. Liability risks
   a. Reinsurer default, impairment or rating downgrade known to have occurred before or on the valuation date.
   b. Mortality/longevity, persistency/lapse, partial withdrawal and premium payment risks.
   c. Utilization risk associated with guaranteed living benefits.
   d. Anticipated mortality trends based on observed patterns of mortality improvement or deterioration, where permitted.
   e. Annuitzation risks.
   f. Additional premium dump-ins (high interest rate guarantees in low interest rate environments).
   g. Applicable expense risks, including fluctuation in maintenance expenses directly attributable to the business, future commission expenses, and expense inflation/growth.

VM-21 Section 12 (new)

Section 12: Other Guidance and Requirements for Assumptions

A. Overview

This section provides guidance and requirements in general for setting prudent estimate assumptions when determining either the stochastic reserve or the reserve for any contracts determined using the Alternative Methodology. It also provides specific guidance and requirements for expense assumptions.

B. General Assumption Requirements

1. The company shall use prudent estimate assumptions for risk factors that are not stochastically modeled by applying margins to the anticipated experience assumptions if such risk factors have been categorized as material risks by following Section 1.B Principle 3 and requirements in Section 12.C.

2. The company shall establish the prudent estimate assumptions for risk factors in compliance with the requirements in Section 12 of Model #820 and must periodically review and update the assumptions as appropriate in accordance with these requirements.

3. The company shall model the following risk factors stochastically unless the company
elects the Alternative Methodology defined in Section 7:

a. Interest rate movements (i.e., Treasury interest rate curves).

b. Equity performance (e.g., Standard & Poor’s 500 index [S&P 500] returns and returns of other equity investments).

4. If the company elects to stochastically model risk factors in addition to the economic scenarios, the requirements in this section for determining prudent estimate assumptions for these risk factors do not apply.

It is expected that companies will not stochastically model risk factors other than the economic scenarios, such as contract holder behavior or mortality, until VM-21 has more specific guidance and requirements available. Companies shall discuss with domiciliary regulators if they wish to stochastically model other risk factors.

5. The company shall use its own experience, if relevant and credible, to establish an anticipated experience assumption for any risk factor. To the extent that company experience is not available or credible, the company may use industry experience or other data to establish the anticipated experience assumption, making modifications as needed to reflect the circumstances of the company.

a. For risk factors (such as mortality) to which statistical credibility theory may be appropriately applied, the company shall establish anticipated experience assumptions for the risk factor by combining relevant company experience with industry experience data, tables or other applicable data in a manner that is consistent with credibility theory and accepted actuarial practice.

b. For risk factors (such as utilization of guaranteed living benefits) that do not lend themselves to the use of statistical credibility theory, and for risk factors (such as some of the lapse assumptions) to which statistical credibility theory can be appropriately applied but cannot currently be applied due to lack of industry data, the company shall establish anticipated experience assumptions in a manner that is consistent with accepted actuarial practice and that reflects any available relevant company experience, any available relevant industry experience, or any other experience data that are available and relevant. Such techniques include:

i. Adopting standard assumptions published by professional, industry or regulatory organizations to the extent they reflect any available relevant company experience or reasonable expectations.

ii. Applying factors to relevant industry experience tables or other relevant data to reflect any available relevant company experience and differences in expected
experience from that underlying the base tables or data due to differences between the risk characteristics of the company experience and the risk characteristics of the experience underlying the base tables or data.

iii. Blending any available relevant company experience with any available relevant industry experience and/or other applicable data using weightings established in a manner that is consistent with accepted actuarial practice and that reflects the risk characteristics of the underlying contracts and/or company practices.

c. For risk factors that have limited or no experience or other applicable data to draw upon, the assumptions shall be established using sound actuarial judgement and the most relevant data available, if such data exists.

d. For any assumption that is set in accordance with the requirements of Section 12.B.5.c, the qualified actuary to whom responsibility for this group of contracts is assigned shall use sensitivity testing and disclose the analysis performed to ensure that the assumption is set at the conservative end of the plausible range.

e. The qualified actuary to whom responsibility for this group of contracts is assigned, shall annually review relevant emerging experience for the purpose of assessing the appropriateness of the anticipated experience assumption. If the results of statistical or other testing indicate that previously anticipated experience for a given factor is inadequate, then the qualified actuary shall set a new, adequate, anticipated experience assumption for the factor.

6. The company shall sensitivity test material risk factors that are not stochastically modeled and examine the impact on the stochastic reserve. The company shall update the sensitivity tests periodically as appropriate. The company may update the tests less frequently, but no less than every 3 years, when the tests show less sensitivity of the stochastic reserve to changes in the assumptions being tested or the experience is not changing rapidly. Providing there is no material impact on the results of the sensitivity testing, the company may perform sensitivity testing:

a. Using samples of the contracts in force rather than performing the entire valuation for each alternative assumption set.

b. Using data from prior periods.

Guidance Note: Sensitivity testing every risk factor on an annual basis is not required. For some risk factors, it may be reasonable, in lieu of sensitivity testing, to employ statistical measures for margins, such as adding one or more standard deviations to the anticipated experience assumption.
7. The company shall vary the prudent estimate assumptions from scenario to scenario within the stochastic reserve calculation in an appropriate manner to reflect the scenario-dependent risks.

C. Assumption Margins

The company shall include margins to provide for adverse deviations and estimation error in the prudent estimate assumptions for each risk factor that are not stochastically modeled or prescribed, subject to the following:

1. The level of margin applied to the anticipated experience assumptions may be determined in aggregate or independently as discussed in Section 1.B Principle 3. It is not permissible to set a margin less toward the conservative end of the spectrum to recognize, in whole or in part, implicit or prescribed margins that are present, or are believed to be present, in other risk factors.

Risks that are stochastically modeled (e.g., interest rates, equity returns) or have prescribed margins or guardrails (e.g., assets, revenue sharing) shall be considered material risks. Other risks generally considered to be material include, but are not limited to, mortality, contract holder behavior, maintenance and overhead expenses, inflation and implied volatility. In some cases, the list of material risks may also include acquisition expenses, partial withdrawals, policy loans, annuitizations, account transfers and deposits, and/or option elections that contain an element of anti-selection.

2. The greater the uncertainty in the anticipated experience assumption, the larger the required margin, with the margin added or subtracted as needed to produce a larger modeled TAR than would otherwise result. For example, the company shall use a larger margin when:
   a. The experience data have less relevance or lower credibility.
   b. The experience data are of lower quality, such as incomplete, internally inconsistent or not current.
   c. There is doubt about the reliability of the anticipated experience assumption, such as, but not limited to, recent changes in circumstances or changes in company policies.
   d. There are constraints in the modeling that limit an effective reflection of the risk factor.

3. In complying with the sensitivity testing requirements in Section 12.B.6 above, greater analysis and more detailed justification are needed to determine the level of uncertainty when establishing margins for risk factors that produce greater sensitivity on the stochastic reserve.
4. A margin is permitted but not required for assumptions that do not represent material risks.

5. A margin should reflect the magnitude of fluctuations in historical experience of the company for the risk factor, as appropriate.

6. The company shall apply the method used to determine the margin consistently on each valuation date but is permitted to change the method from the prior year if the rationale for the change and the impact on the stochastic reserve is disclosed.

D. Expense Assumptions

1. General Prudent Estimate Expense Assumption Requirements

   In determining prudent estimate expense assumptions, the company:

   a. May spread certain information technology development costs and other capital expenditures over a reasonable number of years in accordance with accepted statutory accounting principles as defined in the Statements of Statutory Accounting Principles.

   b. Shall assume that the company is a going concern.

   c. Shall choose an appropriate expense basis that properly aligns the actual expense to the assumption. If values are not significant, they may be aggregated into a different base assumption.

   d. Shall reflect the impact of inflation.

   e. Shall not assume future expense improvements.

   f. Shall not include assumptions for federal income taxes (and expenses paid to provide fraternal benefits in lieu of federal income taxes) and foreign income taxes.

   g. Shall use assumptions that are consistent with other related assumptions.

Guidance Note: Care should be taken with regard to the potential interaction with the inflation assumption below.

Guidance Note: For example, death benefit expenses should be modeled with an expense assumption that is per death incurred.
h. Shall use fully allocated expenses.

**Guidance Note:** Expense assumptions should reflect the direct costs associated with the block of contracts being modeled, as well as indirect costs and overhead costs that have been allocated to the modeled contracts.

i. Shall allocate expenses using an allocation method that is consistent across company lines of business. Such allocation must be determined in a manner that is within the range of actuarial practice and methodology and consistent with applicable ASOPs. Allocations may not be done for the purpose of decreasing the stochastic reserve.

**Guidance Note:** For example, the combining of two similar blocks of business on the same administrative system may yield some expense savings on a per unit basis, but any future cost of the system conversion should also be considered in the final assumption. If all costs for the conversion are in the past, then there would be no future expenses to reflect in the valuation.

j. Shall reflect expense efficiencies that are derived and realized from the combination of blocks of business due to a business acquisition or merger in the expense assumption only when any future costs associated with achieving the efficiencies are also recognized.

k. Shall reflect the direct costs associated with the contracts being modeled, as well as an appropriate portion of indirect costs and overhead (i.e., expense assumptions representing fully allocated expenses should be used), including expenses categorized in the annual statement as “taxes, licenses and fees” (Exhibit 3 of the annual statement) in the expense assumption.

l. Shall include acquisition expenses associated with business in force as of the valuation date and significant non-recurring expenses expected to be incurred after the valuation date in the expense assumption.

m. For contracts sold under a new policy form or due to entry into a new product line, the company shall use expense factors that are consistent with the expense factors used to determine anticipated experience assumptions for contracts from an existing block of mature contracts taking into account:

   i. Any differences in the expected long-term expense levels between the block of new contacts and the block of mature contracts.

   ii. That all expenses must be fully allocated as required.
under Section 12.ED.1.b above.

2. Margins for Prudent Estimate Expense Assumptions

The company shall determine margins for expense assumptions following Section 12.C.

VM-21 Section 13

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

VM-21 Section 1.B

Principle 3: The implementation of a model involves decisions about the experience assumptions and the modeling techniques to be used in measuring the risks to which the company is exposed. Generally, assumptions are to be based on the conservative end of the confidence interval. The choice of a conservative estimate for each assumption may result in a distorted measure of the total risk. Conceptually, the choice of assumptions and the modeling decisions should be made so that the final result approximates what would be obtained for the stochastic reserve at the required CTE level if it were possible to calculate results over the joint distribution of all future outcomes. In applying this concept to the actual calculation of the stochastic reserve, the company should be guided by evolving practice and expanding knowledge base in the measurement and management of risk.

Guidance Note: The intent of Principle 3 is to describe the conceptual framework for setting assumptions. Section 10 provides the requirements and guidance for setting contract holder behavior assumptions and includes alternatives to this framework if the company is unable to fully apply this principle. More guidance and requirements for setting assumptions in general are provided in Section 12.

VM-21 Section 10.A

Section 10: Contract Holder Behavior Assumptions

A. General

Contract holder behavior assumptions encompass actions such as lapses, withdrawals, transfers, recurring deposits, benefit utilization, option election, etc. Contract holder behavior is difficult to predict accurately, and variance in behavior assumptions can significantly affect the results. In the absence of relevant and fully credible empirical data, the company should set behavior assumptions as guided by Principle 3 in Section 1.B and Section 12.

VM-31 Section 3.F.3.d

3. Liability Assumptions and Margins – A listing of the assumptions and margins used in the projections to determine the stochastic reserve, including a discussion of the source(s) and the rationale for each assumption:

a. Premiums and Subsequent Deposits – Description of premiums and subsequent deposits.
b. **Interest Crediting Strategy** – Description of the interest crediting strategy.

c. **Commissions** – Description of commissions, including any commission chargebacks.

d. **Expenses Other than Commissions** – Description and listing of insurance company expenses other than commissions, such as overhead, including:

   i. Method used to allocate expenses to the contracts included in a principle-based valuation under VM-21 and a statement confirming that expenses have been fully allocated in accordance with VM-21 Section 12.D.1.h.

   ii. Method used to apply the allocated expenses to model segments or sub-segments within the cash-flow model.

   iii. Identification of types of costs that were spread, and for how many years, if any cost spreading was done pursuant to VM-21 Section 12.D.1.a.

   iv. Method used to determine margins.

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**VM-31 Section 3.F.13.c (new)**

**c. Sensitivity Tests**  
For each distinct product type for which margins were established:

   i. List the specific sensitivity tests performed for each risk factor or combination of risk factors other than those discussed in Section 3.F.3.h.vi and 3.F.3.i.ii.

   ii. Indicate whether the reserve was calculated based on the anticipated experience assumptions or prudent estimate assumptions for all other risk factors while performing the tests.

   iii. Provide the numerical results of the sensitivity tests for both reserves and capital.

   iv. Explain how the results of sensitivity tests were used or considered in developing assumptions.

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**VM-31 Section 3.F.13.d (new)**

d. **Impact of Margin**

   i. Company can perform the impact of margin analysis using off-cycle data. The analysis can be done less frequently than annual unless there is change or update in the margins, but not less frequently than every 3 years.

   ii. Impact of Margins for Each Risk Factor – The impact of margins on the stochastic reserve for each risk factor, or group of risk factors, that has a material impact on the stochastic reserve, determined...
by subtracting (i) from (ii), expressed in both dollar amounts and percentages. For the purposes of this analysis, calculate the CTE without requiring that the scenario reserve for any scenario be no less than the cash surrender value:

(1) The CTE70(best efforts), as outlined in VM-21 Section 9.C, but with the reserve calculated based on the anticipated experience assumption for the risk factor and prudent estimate assumptions for all other risk factors.

(2) The CTE70(best efforts), as outlined in VM-21 Section 9.C, for that group of contracts as reported.

(3) Repeat the impact analysis using the same method on CTE(98) levels.

iii. Aggregate Impact of Margins – the aggregate impact of all margins on the stochastic reserve for that group of contracts determined by subtracting (1) from (2), expressed in both dollar amounts and percentages. For the purposes of this analysis, calculate the CTE without requiring that the scenario reserve for any scenario be no less than the cash surrender value:

(1) The CTE70(best efforts), as outlined in VM-21 Section 9.C, for that group of contracts, but with the reserve calculated based on anticipated experience assumptions for all risk factors prior to the addition of any margins.

(2) The CTE70(best efforts), as outlined in VM-21 Section 9.C, for that group of contracts as reported.

(3) Repeat the impact analysis using the same method on CTE(98) levels.

iv. Impact of Implicit Margins – For purposes of the disclosures required in 13.d.ii and 13.d.iii above:

(1) If the company believes the method used to determine anticipated experience assumptions includes an implicit margin, the company can adjust the anticipated experience assumptions to remove this implicit margin for this reporting purpose only. If any such adjustment is made, the company shall document the rationale and method used to determine the anticipated experience assumption.

(2) Since the company is not required to determine an anticipated experience assumption or a prudent estimate assumption for risk factors that are prescribed (i.e., interest rates movements, equity performance, default costs and net spreads on reinvestment assets), when determining the impact of margins, the prescribed assumption shall be deemed to be the prudent estimate assumption for the risk factor, and the company can elect to determine an anticipated experience assumption for the risk factor, based on the company’s anticipated experience for the risk factor. If this is elected, the company shall document the rationale and method used to determine the anticipated experience assumption.
NAIC ESG Update
NAIC National Meeting - Fall 2021

Scott O’Neal, FSA, MAAA - NAIC Life Examination Actuary
Dan Finn, FCAS, ASA - Managing Director at Conning

December 8, 2021

Agenda

1. Treasury Model Calibration Update
2. Key Decisions for Equity Model
3. Key Decisions for Corporate Model
Treasury Model Calibration Update

- Conning has developed a new calibration of the GEMS® Treasury model according to the acceptance criteria defined by the ESG Drafting Group (see Appendix 1).
- NAIC Staff and Conning are analyzing the Treasury scenarios from the new calibration to ensure that they meet the most important acceptance criteria while making appropriate tradeoffs, where necessary.
- The analysis of the scenarios is expected to be completed shortly to be presented at an upcoming ESG Drafting Group in December for additional discussion.
- The ESG Drafting Group may request tweaks to the Treasury scenarios upon review.
- After the ESG Drafting Group approves the scenarios, a discussion of the Treasury scenarios will occur on a public Life Actuarial (A) Task Force (LATF) and Life Risk-Based Capital (E) Working Group (LRBC WG) meeting.

Key Decisions for Equity Model:
Relationship between equities and Treasury rates

<table>
<thead>
<tr>
<th>Theoretical and Historical Relationship</th>
<th>Modeling Considerations</th>
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<tr>
<td>The relationship between equities and Treasury rates, commonly referred to as the “Equity Risk Premium”, reflects the additional return investors demand to invest in risky equity assets over the risk-free return offered by U.S. Treasuries.</td>
<td>As currently configured, the GEMS® equity model contains a linkage to Treasury rates in both the process governing equity returns as well as the dividend process.</td>
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<tr>
<td>It is difficult to see strong relationships in historical data between equities and Treasuries because the equity market is so volatile.</td>
<td>There are a number of ways that the relationship between equities and interest rates could be defined in the model, including a formulaic linkage, correlation factors, and linking long-term equity targets to long-term interest rate targets. Alternatively, the equity returns could be set to be independent of the Treasury rates.</td>
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<tr>
<td>The idea of an “Equity Risk Premium” is consistent with a number of theoretical concepts, including the Capital Asset Pricing Model (CAPM) and the Sharpe Ratio</td>
<td>Altering GEMS® existing equity/Treasury linkage by specifying an alternative relationship between equities and treasuries or assuming independence would require a currently unknown amount of development time and effort.</td>
</tr>
</tbody>
</table>
Key Decisions for Equity Model: Other Considerations

Risk/return relationship for and between different equity indices

- The GEMS® equity model will produce returns for a variety of U.S. and international funds.
- Typically, it is reasonable to assume that there is a relationship with expected return and volatility, such that "it would generally be inappropriate to assume that a market or fund consistently "outperforms" (lower risk, higher expected return relative to the efficient frontier) over the long term." (VM-21 Section B.C.4)
- Recent historical data (since 1987) for the International Diversified Equity fund (MSCI EAFE) has shown underperformance on a risk-adjusted basis relative to the Diversified Large Cap U.S. Equity fund (S&P 500). However, an evaluation of the longer historical record has shown both periods of under- and over-performance for the International Diversified Equity fund.

How should equity rates respond to changes in initial market conditions

- Changes to recent and/or initial market conditions such as equity returns, equity volatility, and Treasury rates can influence future equity returns. For example, the Chicago Board Options Exchange Volatility Index (VIX) reflects the market's estimate of future volatility. When the VIX is high, there tends to be more volatility in the short term.
- Some subject-matter experts from the ESG Drafting Group have suggested that initial/recent market conditions should not impact equity returns beyond the near term (~six years) with most of the impacts from initial conditions experienced in the first two years.

Key Decisions for Corporate Model

Corporate Model Complexity

- The GEMS® corporate model has the capability to produce bond fund returns that reflect dynamic spreads, credit rating transitions, and defaults.
- Bond fund returns produced by the ESG will be used to model policyholder separate account investments in bond funds and general account investments in bond funds where applicable.
- Regulators will have to weigh the benefits of a complex model that is able to capture the key dynamics that drive bond fund returns versus the desire for a simplified model.
- It will be a development effort for Conning to produce a new simplified corporate model if that is the direction chosen by regulators.
### Appendix 1: Treasury Model Acceptance Criteria

<table>
<thead>
<tr>
<th>Item</th>
<th>Category</th>
<th>Suggested Direction for Next Iteration</th>
</tr>
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</table>
| 1.   | Low For Long | 10 and 30-year geometric average of 20yr UST below current level  
|      |           | a) 10-year threshold: 10%  
|      |           | b) 30-year threshold: 5%  
| 2.   | Prevalence of High Rates, Upper Bound on Treasury Rates | a) The scenario set should reasonably reflect history, with some allowance for more extreme high and low interest rate environments  
|      |           | b) Upper Bound:  
|      |           | i. [20%] is >= [99%]-tile on the 3M yield fan chart, and no more than [5%] of scenarios have 3M yields that go above [20%] in the first 30 years  
|      |           | ii. [20%] is >= [99%]-tile on the 10Y yield fan chart, and no more than [5%] of scenarios have 10Y yields that go above [20%] in the first 30 years  
| 3.   | Lower Bound on Negative Interest Rates, Arbitrage Free Considerations | Apply the following guidance for negative rates:  
|      |           | a) All maturities could experience negative interest rates  
|      |           | b) Interest rates may remain negative for multi-year time periods  
|      |           | c) Rates should generally not be lower than -1.5%  
|      |           | A floor will likely be employed but the exact form of the floor will be determined later  
| 4.   | Initial Yield Curve Fit, Yield Curve Shapes in Projection, and Steady State Yield Curve Shape | a) Review initial actual vs. fitted spot curve differences for a sampling of 5 dates representing different shapes and rate levels for the entire curve and review fitted curves qualitatively to confirm they stylistically mimic the different actual yield curve shapes  
|      |           | b) The frequency of different yield curve shapes in early durations should be reasonable considering the shape of the starting yield curve (e.g. a flatter yield curve leads to more inversions).  
|      |           | c) The steady state curve has normal shape (not inverted for short maturities, longer vs shorter maturities, or between long maturities)  
| 5.   | Realized short and long maturity volatility at different interest rate levels | a) No Criteria for realized short and long maturity volatility at different interest rate levels  

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Life Actuarial (A) Task Force

Modeling of complex assets in asset adequacy testing

December 8, 2021
Webex

Drivers of project

- Rapid entry of private equity firms into life insurer
  - Owners of life insurers
  - Acquirers of fixed annuity blocks
- Valuation Analysis (E) Working Group charge
  - Identify concerns re: life insurers’ asset adequacy testing (AAT)
- MN Department, coordinating with VAWG, collected information from 27 companies representing 17 groups
  - Details on AAT, including modeling of complex assets
  - Scope: one or more of: connected to private equity, large fixed annuity exposure, complex assets
  - Company-specific information is confidential, per SVL
Information collected

- Richness of liability guarantees
  - Implying pressure to attain yield to support the liabilities
- Non-traditional assets, amount and valuation of
  - Including CLOs, ABS, BA assets
- Assumed net yields on existing and reinvestment assets
- Investment manager, arrangement, expertise, fees
- Other actuarial assumptions: lapse, borrowing
- Reinsurance ceded

Findings

- Sampling of responses
- If investment assumptions are too optimistic:
  - Inappropriately signal adequacy of formula reserves
  - Additional AAT reserves won't be held
  - Understated reserves
  - Inflated surplus
  - Inflated RBC ratios
  - Money leaving the insurer under inappropriate circumstances
    - e.g., through shareholder dividends
  - Claims-paying ability in jeopardy
Findings (in some cases) and risks

- Inflated net yields
  - Simplistic modeling - similar level of defaults assumed for higher-yielding complex assets as for similarly-rated corporate bonds

- Internal modeling of asset values
  - When no CUSIP and no deep secondary market
  - Risk of asset values being overstated is high

- CLO performance
  - Generally performed well in recent years
  - Some assume this high performance will continue for the length of the projection

- Investment manager relationships and expenses
  - Is an inappropriate amount of money leaving the insurer?
  - In some cases, AAT modeling of investment expenses appears simplistic

Other findings

- Creation of structured assets
  - Packaging of underlying collateral, selling lower tranches
  - Ensure modeling captures tail risk and realistic cash flows

- Offshore / affiliated reinsurance
  - To address perceived reserve redundancy, tax favorability, and increasing RBC ratios

- Trend towards less liquid assets
  - To attain high yield, recognizing low liquidity of some liabilities
  - Ensure appropriate modeling in scenarios where asset sale needed
LATF Exposure – Sept 2021

- Findings and rapid increase in private equity / complex asset / life insurer activity -> need for action
- Action item: development of actuarial guideline, focused on modeling of complex assets
- Comment period re:
  - Product scope
  - Size scope
  - Focus on constraints / standards of documentation
  - Effective date

Comments: Scope

- Activity beyond fixed annuities has occurred
- Potential consensus is all liabilities with significant investment risk should be in the scope
- Exemption or phase in for some cases?
  - Exemption by size of insurer may not be appropriate
    - Even some smaller insurers are getting more aggressive with investments
  - Perhaps exemption if complex assets are a small portion of the portfolio
  - Need to focus on definition of complex assets if exemption put in place
Comments: Establishment of Constraints

- Establishing constraints on asset assumptions - Pros
  - Needed to prevent further optimism in assumptions
  - Discourage race to the bottom (re: minimizing reflection of risk associated with high returns)
  - Level playing field
  - Consistent with moderately adverse condition requirement
  - VM-20 already has constraints on net yields
    - Why would other blocks be treated differently?

- Establishing constraints on asset assumptions - Cons
  - Difficult to establish a one-size-fits-all constraint without being too restrictive
  - Analysis of risk/reward relationship is key, will vary by situation
  - Additional documentation will help in the understanding of the modeling

Comments: Effective date

- YE 2021 is too early for an AG adoption
  - However, insurers should be on notice – expect robust support for assumptions
  - Particularly those that can be viewed as optimistic

- YE 2022 target for AG adoption
  - Perhaps narrower scope for 2022, broader scope for 2023
Potential AG AAT goals

- Uniform guidance for support of asset-related AAT assumptions
- Help ensure reserve adequacy and claims-paying ability in moderately adverse conditions
  - Including conditions negatively impacting complex asset cash flows
- Clarify how margins for uncertainty are established such that the greater the uncertainty the larger the margin and resulting reserve
  - If modeling of asset risk is simplistic, add margin
- Recognize that higher gross returns are, to some extent, associated with higher risk
  - Assumptions should fit reasonably within the risk-return spectrum

Potential AG AAT goals

- Require sensitivity testing of complex asset returns;
- Identify expectations in practice regarding the valuation of complex assets
- Require additional documentation of investment fee income relationships with affiliated / close entities
Next steps

- Draft Actuarial Guideline, considering comments
- Refine AG draft in early 2022
Brian Bayerle  
Senior Actuary  

December 1, 2021  

Mr. Mike Boerner  
Chair, NAIC Life Actuarial Task Force (LATF)  

Mr. Fred Andersen  
Chief Life Actuary, Minnesota Department of Commerce  

Re: Proposed Actuarial Guideline on Complex Assets in Asset Adequacy Testing  

Dear Messrs. Boerner and Andersen:  

The American Council of Life Insurers (ACLI) appreciates the opportunity to submit the following comments on the proposed Actuarial Guideline to address the modeling of complex assets in Asset Adequacy Testing (AAT).  

ACLI encourages the task force to provide a clear, concise, public statement of the regulatory concern that would guide drafting efforts and facilitate the assessment of any proposed solutions. Based on public comments to date, ACLI understands that regulators are concerned about assumed projected yields, used in the context of asset adequacy testing, for certain complex and high-yielding assets that some companies have used to back in-force blocks of fixed annuities.  

Given our current understanding, we believe that a prudent initial approach involves developing additional disclosures in VM-30 instead of the proposed Actuarial Guideline. For example, disclosures could include details of the assets, describe characteristics including credit and liquidity, and explain modeling practices, including the development of projected returns. Such disclosures would also provide consistency across the states. ACLI welcomes the opportunity to assist in the development of appropriate and meaningful disclosures.  

We believe that disclosure is preferable to an actuarial guideline at this stage for several reasons. First, we believe well-designed disclosures provide regulators with greater insight and allow for productive discussions between regulators and appointed actuaries. Second, enhanced disclosures encourage appointed actuaries to devote additional attention and provide additional support and justification to modeling practices. Finally, disclosures inform the development of subsequent measures, if any are necessary.
We have the following specific comments regarding the exposed questions:

**Product scope:** Should the focus be on assets supporting fixed annuities or assets supporting all life insurer liabilities subject to AAT?

**ACLI response:** If regulators are concerned about the modeling of certain categories of assets, then the material use of assets to back any line of business is more relevant than the fact that such assets are being used to back any particular product line. Additionally, AAT is by definition based on a holistic view of each company’s balance sheet and is not specific to a particular line of business such as fixed annuities.

**Size scope:** Should only life insurers or blocks exceeding a certain size threshold be subject to the actuarial guideline?

**ACLI response:** We believe that it is appropriate to develop size/materiality thresholds for both the size of the block and the material use of complex/high-yielding assets. Immaterial exposures should be exempt from any new requirements.

**Constraints or documentation:** Should the Actuarial Guideline focus on establishing constraints related to the modeling of complex or high gross yield assets (impacting AAT results) or providing detailed documentation and sensitivity testing on the modeling of such assets (potentially not impacting AAT results)?

**ACLI response:** Given our current understanding of the concern, ACLI believes regulators should focus on detailed documentation and disclosures around the use of such assets as discussed above. Our thinking may evolve as we better understand the concerns of the regulators.

**Effective date:** Is a year-end 2022 effective date for the Actuarial Guideline reasonable, or should some guidance apply before that date?

**ACLI response:** Given our current understanding of the regulatory concern, we believe it is most appropriate to develop appropriate disclosures in VM-30, which would complement the existing documentation requirements already in VM-30. Given the lead time required for changes to the Valuation Manual, revised requirements would be effective for the 2023 Valuation Manual. If regulators believe the disclosures are necessary sooner, the task force can release guidance along with the adoption of the APF. Additionally, state regulators can request a variety of additional information from carriers using existing authority.

We appreciate the consideration of our comments and look forward to discussing on a future call. Thank you.
Sincerely,

[Signature]

cc: Reggie Mazyck, NAIC
Memo

To: Mike Boerner, Chair, Life Actuarial Task Force
From: Tricia Matson, Partner and Ed Toy, Director
Date: November 18, 2021
Subject: RRC comments regarding AG on complex assets

Background
The Life Actuarial Task Force (LATF) issued a request for feedback related to the concept of an actuarial guideline (AG) focusing on modeling of complex or high-yielding assets in asset adequacy testing (AAT). This request relates to the increasing use of complex investments to back reserves, and the importance of appropriately capturing the risks associated with those assets in AAT. RRC appreciates the opportunity to offer our comments. Should you have any questions, we would be glad to discuss our comments with you and the LATF members.

RRC Comments

- Overall comments:
  - We applaud these efforts. There are many unique risks associated with some of the invested assets that are increasingly being used to back insurance liabilities. As noted, many of these invested assets present unique challenges due to their complexity, but they also often represent assets that are opaque, are highly volatile from a fair value standpoint and are illiquid. While these complex investments can provide benefits to the insurer and the policyholder (typically in the form of higher yields), it is critical that the reserves (and capital) supporting the business appropriately take the additional risk exposures into account.
  - We support doing this in the near term via an Actuarial Guideline. We would also encourage LATF and the NAIC to consider how to incorporate guidance more directly into the valuation manual and into the risk-based capital formula.
  - We believe that current guidance to Appointed Actuaries (in Actuarial Standards of Practice that apply to AAT) already require appropriate inclusion of asset risks in AAT; however, more specific guidance in the form of an AG may be helpful to Appointed Actuaries and may improve consistency of industry practice and policyholder protection.

- Regarding Product Scope (Should the focus be on assets supporting fixed annuities or assets supporting all life insurer liabilities subject to AAT?)
  - We believe the scope should include all products.
  - We see use of complex investments backing life insurance and long term care, and see no reason why the associated risks should be considered in fixed annuity reserves but not other types of products.
• Regarding Size Scope (Should only life insurers or blocks exceeding a certain size threshold be subject to the actuarial guideline?)
  o We do not think the size of the insurer or the block should impact application of the guidance. If an insurer is willing to take the risk, we believe the insurer should be able to appropriately understand the unique nature of some of these assets and reserve for the risk.
  o That said, if complex assets are less than some defined immaterial percentage of the total assets backing the reserves or are very short duration in nature, limiting application of the guidance might be appropriate.

• Regarding Constraints or Documentation (Should the actuarial guideline focus on establishing constraints related to the modeling of complex or high gross yield assets (impacting AAT results) or providing detailed documentation and sensitivity testing on the modeling of such assets (potentially not impacting AAT results)?)
  o We believe that a higher risk profile for any invested assets should result in additional provision for risk in the reserve analysis, and therefore we favor a “constraints” approach. We also believe that this approach is aligned with existing guidance, which requires that reserves cover moderately adverse conditions.
  o In addition to specific constraints, inclusion of explicit disclosure requirements and/or sensitivity tests may also be helpful. For example, many of the “newer” investments do not have as much historical data for use in setting assumptions regarding investment yield, cash flow profile, default or prepayment, thereby making both provisions for adverse deviation and sensitivity testing important. The availability of reliable data may also be informative in determining what would be appropriately considered “moderately adverse”.

• Regarding Effective Date (Is a year-end 2022 effective date for the actuarial guideline reasonable, or should some guidance apply before that date?)
  o Since there is current guidance (albeit not necessarily prescriptive) in ASOPs, and new guidance should generally be implemented with sufficient notice so that companies can make good faith efforts to comply, we believe that year-end 2022 is sufficient.
  o We also recognize that to develop, vet, and adopt good guidance on this complex topic takes time, so it may also make sense to adopt interim guidance for year-end 2022, and further enhance that guidance for subsequent year ends.
Life Actuarial (A) Task Force
Exposure Draft
Please send comments to Reggie Mazyck (RMazyck@NAIC.Org) by close of business December 1

Consider concept of an actuarial guideline focusing on modeling of complex or high-yielding assets in asset adequacy testing.

Development of an actuarial guideline focusing on modeling of complex or high-yielding assets in asset adequacy testing (AAT), with particular interest in receiving feedback on the following issues:

- **Product scope**: Should the focus be on assets supporting fixed annuities or assets supporting all life insurer liabilities subject to AAT?
  Investing in complex and/or high-yielding assets is not a stand-alone issue for fixed annuity products. Providing guideline for all life insurer liabilities subject to AAT is not expected to dilute the focus for assets supporting fixed annuities.

- **Size scope**: Should only life insurers or blocks exceeding a certain size threshold be subject to the actuarial guideline?
  When the actuarial guideline is specifically applied to assets, it should not be limited to certain size of business. Smaller companies asset assumptions should follow the same guideline as it applies to larger companies.

- **Constraints or documentation**: Should the actuarial guideline focus on establishing constraints related to the modeling of complex or high gross yield assets (impacting AAT results) or providing detailed documentation and sensitivity testing on the modeling of such assets (potentially not impacting AAT results)?
  The actuarial guideline should focus on establishing constraints related to the modeling of complex or high gross yield assets (impacting AAT results), which should include detailed documentation, and supplemental sensitivity tests. The regulating actuary who review the actuarial memorandum may not have adequate experience in assessing the risk underlying these complex/high yielding assets. Simply relying on documentation and sensitivity test does not give sufficient support for regulators to review and challenge the assumptions used.

- **Effective date**: Is a year-end 2022 effective date for the actuarial guideline reasonable, or should some guidance apply before that date?
  Year-end 2022 effective date for the actuarial guideline appears reasonable. Providing guidance before that date would imply year-end 2021 effectiveness, which would seem too rush and not much time for industry to react.

In addition, I wonder if LATF would be interested in expanding the scope to cover all assets including the non-callable corporate bonds with regularly updated assumptions for PBR purposes. These should cover
a) if reinvestment strategy should be consistent with the company’s investment strategy for the relevant block of business.
b) If default assumptions should be allowed to be less than Table A less margin.
Life Actuarial (A) Task Force
Exposure Draft
Please send comments to Reggie Mazyck (RMazyck@NAIC.Org) by close of business December 1

c) If current spreads and ultimate spread should be allowed to be higher than the VM-20 spreads as published in Table F and Table G for Current Benchmark Spreads and Table H & Table I for Long Term Spreads.
d) If a grading period is used to bridge current spread and ultimate spread, what range of grading period would be considered acceptable in light of the four year prescribed in VM-20.
DATE: December 1, 2021
FROM: Aaron Sarfatti, Chief Risk Officer
SUBJECT: Equitable Comments on the concept of developing an Actuarial Guideline on modeling complex or high-yielding assets in Asset Adequacy Testing (AAT).

Equitable appreciates the opportunity to comment on the concept of developing an Actuarial Guideline on modeling of complex or high-yielding assets in Asset Adequacy Testing (AAT). We support an Actuarial Guideline to govern spread recognition as a first step in a necessary broader effort to establish consistent national standards for AAT. Our viewpoints are summarized in the table below:

<table>
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<tr>
<th>Question</th>
<th>Recommendation</th>
<th>Rationale</th>
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| Should the AG constrain spreads or require enhanced documentation?       | Constrained via guardrails   | • Spread forecasts are inherently subjective; guardrails govern against “unbridled optimism” in judgments  
|                                                                          |                              | • Guardrails simplify governance and improve comparability across firms (within and across states)  
|                                                                          |                              | • Documenting subjective forecasts in detail is a low value activity for both regulators and industry |
| When should be the effective date?                                       | Year-end 2022                | • Design of a simple guardrail is readily achievable  
|                                                                          |                              | • Field testing of impact should be straightforward and readily estimable by firms (e.g. DV01 estimate) |
| What other reforms to AAT should be pursued?1                           | Introduce an aggregate investment spread cap equal to the “A-rated” corporate bond spread + a modest illiquidity premium | • Subjectivity and inconsistency in spread recognition applies to all investment classes  
|                                                                          | Harmonize capital markets scenarios (interest rates, equity returns) | • Aggregate spread cap best ensures resilience of reserves to “above market” spread recognition  
|                                                                          |                              | • “A rated” bond spread is the emergent standard for spread recognition in other public accounting and regulatory regimes (FASB, IAIS, VM-22, etc.)  
|                                                                          |                              | • Illiquidity allowance reflects “benefit of doubt” for superior spread generation through private credit |

For background, Equitable views the life insurance industry and regulatory system as having arrived at a critical juncture that calls for increased reliance on a robust AAT framework:

- Sustained low interest rates has manifested in a material gap between the (i) market yields at which firms can reinvest maturing investments and (ii) Stat Valuation Rates that drive reserves.
- Consequently, the life industry has begun to increase investment risk concentrations both directly and through reinsurance, with structured securities a common tool for increasing yields; industry surveys have further shown that actuarial judgments regarding what constitutes “moderately adverse” future interest rate scenarios are further diverging in consistency - in particular, whether the continuation of prevailing market yields qualifies as moderately adverse
- The result is a rising reliance on AAT as the *de facto* reserving standard for many life insurers, which today is inconsistent in its governance of high sensitivity input judgments such as the projected recognition of investment spreads, among other factors
- Moreover, the prevalence of market-based regulatory regimes is increasing internationally, and there are growing calls for the NAIC Model Law and RBC system to demonstrate substantive equivalence with such regimes to avoid the imposition of supplemental regimes on select firms.

These combined factors increase the imperative to enact standards that boost comparability across firms, necessary to ensure the resilience of reserves in a low interest rate environment. Maintaining the current AAT framework, with its inconsistency across firms and non-standard use of inputs that are common to all financial markets (e.g. US Treasury rates), is no longer in the best interests of the US regulator community. A broader-based reform of AAT as recommended represents the most pragmatic way both to introduce necessary consistency across firms and on common market factors, as well as demonstrate substantive equivalence with international regimes that staves off the imposition of supplementary regulatory regimes (like the International Capital Standard) that could challenge industry capital management.2

So, in summary, Equitable fully supports the plan to create a formal Actuarial Guideline to ensure companies do not assume complex assets generate high gross returns with little deduction for risk – but also to encourage regulators to consider this as simply the first step in a broader reform necessary to harmonize AAT across firms irrespective of their state of domicile.

Below are our thoughts on specific items requested for comment in the exposure; on the questions of product and size scope, our views are appropriately captured in the ACLI comment letter. We note that the exposure was limited and so would appreciate any additional information that can be shared to help us better address and understand regulator concerns.

**Constraint or Documentation:**

*Question*: Should the actuarial guideline focus on establishing constraints related to the modeling of complex or high gross yield assets (impacting AAT results) or providing detailed documentation and sensitivity testing on the modeling of such assets (potentially not impacting AAT results)?

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2 See IAIS HLP1, a requirement for reciprocal regimes (including the US-proposed Aggregation Method) to demonstrate consistent movements in reserves and capital with the market-based ICS design.
**Equitable Perspective:** Equitable believes that formal guidance should establish guardrails related to the modeling of complex or high yielding assets. Imposing a constraint rather than a documentation requirement would provide the issue with the appropriate focus. We note that in the current low interest rate environment, AAT requirements frequently become the de facto reserve requirement, validating the importance of this topic and need for formal guardrails.

Equitable suggests a credit spread cap of a single-“A-“corporate bond spread plus a modest illiquidity premium as a potential guardrail for such complex assets. We firmly believe that companies should not be incentivized and rewarded for taking on higher investment risk without a commensurate reserve increase, and this guardrail would ensure that reserves are appropriately risk adjusted. We note that the single-A curve is widely recognized in the insurance industry as an appropriate measure of fair value (e.g., GAAP LDTI, VM22, etc.), and we believe that adding a modest illiquidity premium is appropriate to reflect the ability of insurers to realize such a premium given the long-dated nature of their liabilities.

Credit spread limits are an important part of a principle-based reserving framework. Such limits ensure reserves do not rely on excessive amounts of credit spread in excess of industry investment and pricing practices. As an example of the significance of spread assumptions within AAT reserves, we examined the market value AAT requirement of a 20-year guaranteed investment contract (GIC) liability as of December 2020. The chart below shows the results, namely that the market value of liabilities significantly decreases as the assumed asset spread increases. While a portion of this risk is contemplated in the Risk-Based Capital framework, the C-1 charges are not significant enough to offset the impacts on reserves shown below at higher spread levels. Assuming elevated spreads can cause insurers to hold insufficient AAT reserves, thereby impairing their claims-paying ability.

If the guideline is not retained for reserving, we propose that it be retained for dividend setting practices. This will result in companies retaining necessary capital, instead of paying dividends, to pay for future policyholder obligations.

**Additional Equitable Perspective on AAT:**
In addition to the potential introduction of guardrails on the spreads of complex or high yielding assets assumed in cash flow testing discussed above and contemplated in the NAIC exposure, Equitable posits that broader AAT reform within the NAIC regulatory framework is necessary. In particular, this includes some basic standardization of the interest rate scenario(s) tested in AAT and an aggregate guardrail on spread recognition across all asset classes. As noted above, in the current interest rate environment AAT requirements frequently become the binding reserve requirement, thus necessitating the need for some guardrails on the most important inputs into the AAT calculation.
**Effective Date:**

*Question:* Is a year-end 2022 effective date for the actuarial guideline reasonable, or should some guidance apply before that date?

*Equitable Perspective:* Equitable supports a year-end 2022 goal for an Actuarial Guideline.

Equitable appreciates the opportunity to comment on this exposed proposal and we look forward to working with regulators to reach an appropriate framework for modeling of complex assets within the Asset Adequacy Testing framework. We are available to discuss our comments further as desired.

Sincerely,

[Signature]

Aaron Sarfatti, ASA

Chief Risk Officer, Equitable
December 2, 2021

Mr. Mike Boerner
Chair, Life Actuarial (A) Task Force
National Association of Insurance Commissioners

Re: Consider concept of an actuarial guideline on asset adequacy testing focusing on modeling of complex or high-yielding assets

Dear Mr. Boerner,

The American Academy of Actuaries’\(^1\) Life Practice Council (LPC) has formed an ad hoc task force\(^2\) to provide comment on the exposure of LATF’s proposal on consideration of a conceptional actuarial guideline on asset adequacy testing (AAT) with a comment period ending December 1.

Before we respond to the specific questions that were included in the exposure, we would like to note that the ad hoc task force was unable to form an opinion on many of the issues raised because we did not have a clear understanding of the specific practices giving rise to regulators’ concerns.

We would also like to note that several Actuarial Standards of Practice (ASOPs) currently exist for actuaries when modeling complex or high-yielding assets in AAT. Specifically, the actuary should:

- Identify the assets chosen for the analysis (ASOP No. 7);
- Consider any known factors that are likely to have a material effect on asset cash flows and/or the insurer’s investment strategy (ASOP No. 7);
- Choose assets that are appropriate for the analysis (ASOP No. 22);
- Use assumptions that are appropriate for the analysis (ASOP No. 22);
- Document the assumptions used and provide supporting rationale for the appropriateness of the assumptions (ASOP No. 22);
- Disclose the assets chosen and provide supporting rationale for the appropriateness of the assets (ASOP No. 22\(^3\));
- Review data for reasonableness, consistency and limitations, and provide appropriate disclosures (ASOP No. 23);

\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

\(^2\) The members of the ad hoc task force are listed at the end of this comment letter.

\(^3\) Version that will be effective June 1, 2022.
• Identify the methods, procedures, assumptions and data used with sufficient clarity as to allow for an objective appraisal of the reasonableness of the actuary’s work (ASOP No. 41);
• Confirm that the selected model reasonably meets the intended purpose (ASOP No. 56);
• Make reasonable efforts to confirm that the model structure, data, assumptions, governance and controls, and model testing and output validation are consistent with the intended purpose (ASOP No. 56); and
• Understand important aspects of the model being used, as well as known weaknesses and limitations (ASOP No. 56).

Nevertheless, we recognize that there may be differences among actuaries in this evolving area, and a regulatory effort to promote more transparency around actuarial practices and uniformity in the related disclosures would be a positive step. For such an effort, we note that revisions to VM-30 may be preferable to a new actuarial guideline because VM-30 contains the Actuarial Opinion and Memorandum Regulation (AOMR) requirements for AAT.

With those comments in mind, responses to the specific questions that were included in the exposure are provided below.

**Product scope: Should the focus be on assets supporting fixed annuities or assets supporting all life insurer liabilities subject to AAT?**

We believe the focus should be on assets supporting all liabilities subject to AAT because considerations and best practices for the modeling of the assets would be applicable regardless of the liabilities supported by those assets.

**Size scope: Should only life insurers or blocks exceeding a certain size threshold be subject to the actuarial guideline?**

We believe an appropriate threshold would be based on the materiality of the assets to the AAT because a small exposure can be material to the AAT. Thus, all insurers or blocks with a material percentage of these assets should be subject to the requirements, regardless the size of the insurer or block.

**Constraints or documentation: Should the actuarial guideline focus on establishing constraints related to the modeling of complex or high gross yield assets (impacting AAT results) or providing detailed documentation and sensitivity testing on the modeling of such assets (potentially not impacting AAT results)?**

As stated above, a regulatory effort that is focused on disclosures would be beneficial. Such disclosures would promote more transparency and uniformity and could stimulate more robust actuarial analysis in support of the disclosures.
We are unable to comment on the establishment of constraints because we do not have a clear understanding of the specific practices giving rise to the regulators’ concerns. We would be pleased to provide comments on such an approach if LATF outlines specific concerns.

**Effective date:** *Is a year-end 2022 effective date for the actuarial guideline reasonable, or should some guidance apply before that date?*

A year-end 2022 effective date seems reasonable if LATF establishes disclosure requirements; however, more time may be needed for implementation if LATF establishes constraints.

In summary, we note that several ASOPs apply to the actuary when modeling complex or high-yielding assets in AAT, and a regulatory effort that brings more transparency to these practices would be a positive development. Such an effort should apply to the assets regardless of the liabilities they support and should apply to assets that are material to the AAT. Focusing on disclosure requirements would promote more transparency and uniformity of the disclosures and could stimulate more robust actuarial analysis in support of the disclosures.

Thank you for your consideration of these comments. Please contact Academy life policy analyst, Khloe Greenwood ([greenwood@actuary.org](mailto:greenwood@actuary.org)), with any questions.

Jason Kehrberg, MAAA, FSA  
Chair, Ad Hoc Task Force of the Life Practice Council

Nancy Bennett, MAAA, FSA  
Laura Hanson, MAAA, FSA  
Len Mangini, MAAA, FSA  
Tricia Matson, MAAA, FSA  
John Miller, MAAA, FSA  
Craig Morrow, MAAA, FSA  
Link Richardson, MAAA, FSA  
Ben Slutsker, MAAA, FSA  
Mike Ward, MAAA, FSA
Consider concept of an actuarial guideline focusing on modeling of complex or high-yielding assets in asset adequacy testing.

Submitted by David Yetter - NCDOI

Development of an actuarial guideline focusing on modeling of complex or high-yielding assets in asset adequacy testing (AAT), with particular interest in receiving feedback on the following issues:

- **Product scope**: Should the focus be on assets supporting fixed annuities or assets supporting all life insurer liabilities subject to AAT? NC would prefer the focus to be on assets supporting all life insurer liabilities. There are concerns that if the focus was only looking at just assets supporting annuities, companies could just move/switch assets.

- **Size scope**: Should only life insurers or blocks exceeding a certain size threshold be subject to the actuarial guideline? We would be more concerned with the percentage of the liability the asset (or assets) is supporting. In other words, if the high-yielding assets are supporting 50% of the block, we should be concerned. If the high-yielding assets are supporting 0.5%, it’s probably not worth including.

- **Constraints or documentation**: Should the actuarial guideline focus on establishing constraints related to the modeling of complex or high gross yield assets (impacting AAT results) or providing detailed documentation and sensitivity testing on the modeling of such assets (potentially not impacting AAT results)? NC would rather see detailed documentation and sensitivity testing on the modeling. The company, hopefully, understands the asset much better than anyone else. There should not be constraints on modeling new or unique assets. By having the company provide detailed documentation, the regulator can decide what factors could affect the value of that asset.

- **Effective date**: Is a year-end 2022 effective date for the actuarial guideline reasonable, or should some guidance apply before that date?
Life Actuarial (A) Task Force
Exposure Draft

Please send comments to Reggie Mazyck (RMazyck@NAIC.Org) by close of business December 1

Consider concept of an actuarial guideline focusing on modeling of complex or high-yielding assets in asset adequacy testing.

Development of an actuarial guideline focusing on modeling of complex or high-yielding assets in asset adequacy testing (AAT), with particular interest in receiving feedback on the following issues:

- **Product scope:** Should the focus be on assets supporting fixed annuities or assets supporting all life insurer liabilities subject to AAT?

  I believe this approach should apply to both fixed annuities and to life insurance liabilities. The performance of the ALT assets is not linked to the liabilities, so the approach to modeling the assets should be consistent by product line.

- **Size scope:** Should only life insurers or blocks exceeding a certain size threshold be subject to the actuarial guideline?

  I would link the size of the block would not matter. The approach to modeling these assets should be appropriate and consistent across all life insurers.

- **Constraints or documentation:** Should the actuarial guideline focus on establishing constraints related to the modeling of complex or high gross yield assets (impacting AAT results) or providing detailed documentation and sensitivity testing on the modeling of such assets (potentially not impacting AAT results)?

  I am not sure what constraints would mean. Does this suggest that the approach can be aggressive, but the guideline will limit the aggressiveness? I have discussed CFT analysis with other actuaries that use ALTS for CFT. Their comments seem to fall under two buckets (both of which are concerning):

  o The ALTS are only 5% of the portfolio, so it was immaterial. If the ALTs are assumed to earn 12% and this replaces assets earning 3%, then the impact is an extra 45bps of return. It seems difficult to argue immateriality.

  o The ALTS are expected to have a 12% return, so the appointed actuary uses 8% to be “conservative” and model as a bond. We are talking about assets that could have an annual return distribution from -30% to +30%. It also has cash flows that are dissimilar from other asset types (pledged capital, contributions, distributions). The NII is not realized until distributions occur. The analysis needs to recognize the asset cash flows and NII pattern used to support the liability cash flows.

  It seems like the AG should require detailed documentation on the ALT modeling approach. In addition, ALTS are one of the most volatile asset types used by Life insurers. It seems like the AG should require the analysis to capture the volatility of the asset type. Some of the requirements to consider include:

  o The analysis should capture the cash flows of the asset type. This would include contributions, distributions, and total returns.
Life Actuarial (A) Task Force
Exposure Draft
Please send comments to Reggie Mazyck (RMazyck@NAIC.Org)
by close of business December 1

- The analysis should capture the distributions of the outcomes from the
  A/L analysis. This may require stochastic analysis that captures the
  distribution of results for the ALTs and for the other assets supporting
  the liabilities. It could use the NY7 scenarios and run number of paths of
  stochastic asset spreads, defaults (migrations), and equity returns for
  each scenario. It seems like reserve sufficiency is an 85th percentile
  measure, so a focus at the 85th percentile seems reasonable to consider.
  (I would suggest Conning could provide these paths for each NY
  scenario)
- The requirements should consider the illiquidity of the asset type. The
  analysis shouldn’t be allowed to disinvest an asset type that is illiquid.

(This approach is difficult to implement, but the volatility of the asset class requires this
level of detail. If the appointed actuary is going to use these asset types to support CFT,
then the analysis requires this level of thoroughness. I would pose this question: How
would the appointed actuary know the assets are adequate to support the liabilities
without this type of analysis?)

- **Effective date**: Is a year-end 2022 effective date for the actuarial guideline
  reasonable, or should some guidance apply before that date?
EOY 2022 seems appropriate if a documentation approach is used. The industry would
need time to implement.
Comment on the Actuarial Guideline for AAT Exposure
Received 9/30/21
Submitter: Anonymous

I. My main suggestion would be to be broader in how you look at and write things up (rather than focusing on a specific asset such as CLOs).

II. Areas of investment-related risk likely not captured in credit ratings include:
   1. Liquidity
   2. Volatility of returns
   3. Volatility of fair market valuation
   4. Difficulty in assessing fair market valuation

Life insurers have largely been trying to get more yield by going farther out on the spectrum for one or all of those risks. Guidance could include adjustments related to those risks.
Update on Mortality Experience Data Collection

Pat Allison, FSA, MAAA
December 8, 2021

Agenda

- Current Data Collection Timeline
- NAIC Data Review Process and Status
- Recommended Deadline Extension
2021 Experience Data Collection Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/7/21</td>
<td>NAIC notified companies that they could begin submitting data for the 2018 and 2019 observation years. A total of 110 companies, representing 87.5% of industry claims, are subject to the mortality experience data collection.</td>
</tr>
<tr>
<td>9/30/21</td>
<td>Deadline for initial submissions. A complete submission includes 2 years of data submitted using the Regulatory Data Collection (RDC) tool as well as Control Totals, Reconciliation to Exhibit of Life Insurance, and VM-51 Appendix Questionnaires.</td>
</tr>
<tr>
<td>12/31/21</td>
<td>Deadline for companies to make corrections to data submissions.</td>
</tr>
<tr>
<td>5/31/22</td>
<td>NAIC to submit aggregate experience data to SOA.</td>
</tr>
</tbody>
</table>

Data Review Process and Status

1. Data submissions - RDC Tool gives immediate feedback on form and format data exceptions (Example of a data exception: Smoker Status has an invalid code)
   Status: 100 companies have submitted their data for the 2018 and 2019 observation years. The remaining 10 companies have uploaded their data but have not yet submitted it.

2. Control Totals and Reconciliation to Annual Statement – These serve as an inclusion controls, ensuring that all records intended to be submitted were received, and that only business in scope was submitted.
   Status: The NAIC is having ongoing communication with companies regarding any control totals and reconciliations that do not match the data submission.

3. VM-51 Appendix Questionnaires – Preferred Class Structure Questionnaires, Mortality Claims Questionnaire, Additional Plan Code Form
   Status: Most companies have completed these.
Data Review Process and Status (continued)

4. Rules-Based Data Validation - includes all RDC checks, plus more complex data validations (e.g., year-over-year data comparisons) added by NAIC actuarial staff. A list of the validations can be found on the NAIC website (https://content.naic.org/pbr_data.htm - Scroll down to VM-50 / VM-51 Experience Reporting). A company will need to meet a minimum threshold of acceptable data in order to be included in the aggregate file to be sent to the SOA.

Status: Initial data submissions range from 0% - 100% acceptable.

- Small companies tend to have higher percentages of acceptable data. Large companies are generally more complex. There are often many product types, multiple admin systems, and sometimes coordination is required with 3rd party administrators.
- Common reasons for lower acceptance percentages include:
  - Face Amount is missing, zero, or negative.
  - Inconsistencies in year-over-year data (e.g., changes in issue age, smoker status, or number of classes in preferred class structure)

---

Data Review Process (continued)

5. Field Distribution Review - checks data reasonability in accordance with VM-50 Section 4.B.8. To do this, the NAIC created approximately 150 charts and tables in Tableau to help identify potential systematic errors, unusual or unlikely reporting patterns in the data, etc. Note: Data corrections may be needed even if review step #4 indicates that 100% of the data passes the rules-based tests.

Status: Typically, companies are receiving at least 60 comments/questions for which a written response is required.

- Common questions are regarding:
  - Small face amounts (<$5,000) – These may represent paid-up additions in some cases.
  - Preferred classes – There is confusion on how to code preferred and standard classes.
  - Underwriting type – Many companies have coded a high percentage of records as Unknown, Not Underwritten, or Underwritten with unknown fluid collection.
  - Terminations – These appear low for some companies.
  - Unlikely gender and smoker status concentrations (e.g., plan codes with 100% females)

- Note: There may be reasonable explanations for apparent data anomalies. In this case, the NAIC will keep track of company responses so that questions are not repeated in future years.
Recommendation for Deadline Extension

- The VM-51 deadline for corrected data submissions is 12/31/21.
- NAIC staff recommends a deadline extension to 3/31/22 to allow companies more time to review NAIC feedback, provide responses, and make corrections as needed.
  - It is anticipated that companies may need to submit more than one corrected file. We encourage companies to resubmit as soon as they feel they have addressed the data exceptions and questions from the data validation and field distribution review.
- A deadline extension is not expected to delay delivery of aggregated data to the SOA by 5/31/22.
Future Mortality Improvement Scale Development (VM-20)
UPDATE

Mortality Improvements Life Work Group (MILWG) of the Academy Life Experience Committee and SOA Preferred Mortality Project Oversight Group (“Joint Committee”)

RECAP: Individual Life Insurance Future Mortality Improvement (FMI) for VM-20 Products

GOAL: To allow a prudent level of future mortality improvement (FMI) for VM-20 products beginning with the 2022 valuation manual

- FMI scale will be developed, updated and made available to practitioners annually
- Updates will be limited to a threshold of materiality for making a change
- Two versions of the scale will be published: Basic (“Best Estimate”) and Loaded (“with margin”)
- Period of scale application: 20 years
- Varies only by gender and attained age
Topics for Presentation

- 2022 scale development plan
- Issues to be addressed in 2022 recommendation
- Next steps/future considerations

### 2022 MI Scale Development Plan (VM-20)

<table>
<thead>
<tr>
<th><strong>2022 MI Scale Development</strong></th>
<th><strong>Timeline</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Receive 2020 data from CMS and SOA creates preliminary estimate for 2020</td>
<td>2/28/2022</td>
</tr>
<tr>
<td>2. Determine preliminary 2022 HMI and FMI Scales by applying approved methodology to SOA 2020 estimate</td>
<td>3/31/2022</td>
</tr>
<tr>
<td>3. Develop recommendation for reflecting COVID impact</td>
<td>5/1/2022</td>
</tr>
<tr>
<td>4. Determine method for smoothing (FMI)</td>
<td>6/1/2022</td>
</tr>
<tr>
<td>5. Finalize approach for application of margin</td>
<td>6/1/2022</td>
</tr>
<tr>
<td>6. Develop revised version of 2022 HMI and FMI scales - apply COVID, smoothing, and margin adjustments</td>
<td>6/15/2022</td>
</tr>
<tr>
<td>8. Develop final recommendation for HMI and FMI scales for 2022 (basic and loaded versions) and present to IATF for exposure</td>
<td>6/30/2022</td>
</tr>
<tr>
<td>9. Receive SSA mortality improvement data (final SOA estimates for 2022)</td>
<td>8/15/2022</td>
</tr>
<tr>
<td>10. Respond to exposure comments obtain IATF approval of 2022 HMI and FMI scales - both basic and loaded versions</td>
<td>9/15/2022</td>
</tr>
<tr>
<td>11. Publish 2022 HMI and FMI scales on SOA website</td>
<td>9/30/2022</td>
</tr>
</tbody>
</table>
Issues to be Addressed in 2022 Scale Recommendation

- COVID-19 impacts
- Smoothing method
- Margin application

Issues to be Addressed in 2022 Scale Recommendation
COVID-19 Impacts

- Quantification of COVID-19 impact
  - Data sources
  - Short vs medium vs longer term impacts
  - Return to improvement over time or continued deterioration
  - Insured vs general population impacts
  - Differences in COVID-19 impact/adjustment approaches by company

- Approach for reflecting impacts
  - Direct adjustment or reflected in margins
  - Consistency across product lines ("Think Tank Group" recommendations)
Issues to be Addressed in 2022 Scale Recommendation Smoothing Method

- Unsmoothed historical estimates vary materially by age
- Consider reflecting larger differences in smoothed rates for FMI recommendation
- Consider implications to HMI smoothing for 2022
Issues to be Addressed in 2022 Scale Recommendation Margin Application

- Apply any adjustments for COVID-19 impacts as determined by subgroup work
- Specify approach for application where FMI rates are zero, near zero or negative

Next Steps and future considerations

- Threshold of materiality for making a change in a given year
- Impacts of opioid epidemic
- Obesity impacts
- Mental health impacts
- Slowdown in cardiovascular mortality improvement
- Smoker status impacts
- Socioeconomic differences (between general and insured population beyond COVID-19 impacts)
Questions?

Contact Information

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Khloe Greenwood
Life Policy Analyst
American Academy of Actuaries
greenwood@actuary.org
Appendix

FMI Scale Development—Methodology Review

- Best estimate FMI grades from the historical basis to a long-term MI rate (“LTMIR”) at 10 years
- Remains level from 10 to 15 years
- Grades to no additional improvement at 20 years
- Separate exercise for initial published scale to consider COVID-19 impacts
Sample Best Estimate FMI Rates
Unsmoothed—Male—2020 Valuation

Example Best Estimate FMI Rates
Unsmoothed—Female—2020 Valuation
2020 Smoothed Best Estimate FMI Rates

Margin Recommendation

MARGIN ON THEINCREMENTALMORTALITY IMPROVEMENT SCALE
- Margin will be included for all companies
  - Companies may use a more conservative MI scale but not less conservative
  - Margin will take the form of a flat % reduction in the best estimate MI scale
    - Recommendation for 25% flat reduction
Considerations in Margin Recommendation

- 25% reduction in best estimate scale is a material cushion to reserve impact

- Conservatism in best estimate MI scale
  - Not explicitly included
  - Methodology has some conservatism—i.e., limiting cumulative improvements to 20 years

- Ability to change best estimate MI scale each year
  - No lock in of assumptions under VM-20
  - Corrections can be made if trends change
SOCIETY OF ACTUARIES
RESEARCH UPDATE TO LATF
December 8, 2021
R. DALE HALL, FSA, MAAA, CERA, CFA
Managing Director of Research

U.S. Post-Level Term Lapse and Mortality Predictive Modeling Report
U.S. Post Level Term Lapse and Mortality

• Previous PLT report published in 2014
  • Included data from 37 companies
  • 317,000 policy years in duration 11
  • Did not include significant predictive modeling
• Current study began in January, 2019
  • Included data from 25 companies
  • 737,000 policy years in duration 11
  • Enough experience to:
    • Compare graded vs jump to ART premium experience
    • Analyze PLT experience for 15-year LT policies

U.S. Post Level Term Lapse and Mortality

• Key findings
  • Shock lapse at the end of the term is the pivotal variable
  • Other variables have greater impact for lower premium increases (esp. up to 3x premium increases)
  • Lapses in each duration are higher if the shock lapse is higher
  • For graded, subsequent premium jumps in the PLT period were an important driver of lapsation
  • Mortality deterioration in PLT was higher for higher shock lapses
  • For higher shock lapse ranges, the mortality deterioration wore off quickly; this was not the case for graded or low shock lapses
U.S. Post Level Term Lapse and Mortality

• Modeling approach
  • Use Generalized Linear Regression to build a model for the shock lapse at the end of the level term
    • Include all variables and interactions found to be significant
  • Add the predicted shock lapse as a new variable to the dataset
  • Use the data, including the predicted shock lapse, to build separate models (Step 2 Models) for experience during the PLT period for:
    • Lapse experience
    • Mortality experience


• Tableau Link: https://tableau.soa.org/t/soa-public/views/USPost-LevelTermPredictiveModelingInteractiveTool/1-ShockLapseOverview
Analysis of Historical U.S. Population Mortality Improvement Drivers Since 1950

Research Objective

• Authors: Andres Villegas, lead researcher

• Builds on earlier SOA-sponsored project “Components of Historical Mortality Improvements” (Li et al., 2017a,b).

• Identifying significant mortality drivers in the U.S. population that have a high likelihood of being linked to the improvement or deterioration of mortality by age, period and cohort (APC) components.

• Quantifying possible correlations using cause of death and other relevant data sources and quantifying the likely degree of causality between each APC mortality improvement component and the relevant extrinsic drivers.
Data Source

- HMD Cause of Death Data 1959-2016
- 6 broad causes of death - circulatory diseases, neoplasms, respiratory diseases, digestive system diseases, external causes and other causes.
- 26 subcategories
- 9 Risk factors associated with mortality – AIDS and tuberculosis, alcohol abuse, dementia and Alzheimers, diabetes and obesity, drug dependency, homicide, hypertensive disease, self harm, smoking
Age Standardized Death Rates - Subcause

Circulatory diseases

Female

Male

Year


CVD and stroke
Ischaemic heart disease
Other circulatory system diseases

Life Expectancy Decomposition

Decomposition of gains and losses in life expectancy by major causes


Female

Male

Circulatory diseases
Digestive system
External causes
Neoplasms
Respiratory diseases
Other
Heatmaps

Figure 4.13: Heatmaps for broad causes of death, ages 20–89, years 1959–2016, females

Link to Report

- https://www.soa.org/resources/research-reports/2021/analysis-historical-us-drivers/
## SOA Experience Studies

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Link/Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-2011 Evaluation into Mortality and lapse - Machine Learning Report</td>
<td>and a report regarding the TVL machine learning analysis that was done, this report will supplement the main report.</td>
<td><a href="https://www.soa.org/resources/research/2004-2011/evaluation-into-mortality-and-lapse-machine-learning-report">Link</a></td>
</tr>
<tr>
<td>2016 ILEC Study - Deferred Annuity Study</td>
<td>analysis upon and the utilization of guaranteed living withdrawal benefit options on hybrid annuity policies under a joint SOA/ILIF project and release Tableau visualizations with the assumptions from the study.</td>
<td><a href="https://www.soa.org/resources/experience/2016/covid-19-ilec-study-deferred-annuity-study">Link</a></td>
</tr>
<tr>
<td>2016 Variable Annuity Assured Minimum Benefit Utilization Study</td>
<td>United the valuation of guaranteed living benefit options on variable annuity policies under a joint SOA/ILIF project.</td>
<td>2016/10</td>
</tr>
<tr>
<td>2017 U.S. Population Mortality - Preview</td>
<td>Complete an analysis of 2017 U.S. population mortality using the CDC’s quarterly rapid release data.</td>
<td>2017/03</td>
</tr>
<tr>
<td>2017 Life Mortality Improvement</td>
<td>Develop Adult mortality improvement assumptions for FY 2021.</td>
<td>2017/03</td>
</tr>
<tr>
<td>COVID-19 Individual Life Mortality Study - Experience Study Report - 2020-21</td>
<td>Complete a mortality study assessing the impact of COVID-19 on individual life insurance.</td>
<td>2021/12</td>
</tr>
<tr>
<td>Economic Scenario Generator - 2020 update</td>
<td>Update the SOA Economics Scenario Generator.</td>
<td>2020/12</td>
</tr>
<tr>
<td>Q1 2017 for 2018</td>
<td>Update the database to December 31, 2017.</td>
<td>2018/02</td>
</tr>
<tr>
<td>COVID-19 Individual Life Mortality Study - Experience Study Report - 2020-21</td>
<td>Complete a mortality study assessing the impact of COVID-19 on individual life insurance.</td>
<td>2021/01</td>
</tr>
<tr>
<td>Mortality Improvement Survey</td>
<td>Complete a survey to learn how companies are reacting to the slowdown in the level of mortality improvement within the general population.</td>
<td>2020/01</td>
</tr>
<tr>
<td>Group Life COVID-19 Mortality Survey - Report</td>
<td>Complete an update on a mortality study assessing the impact of COVID-19 on group life insurance.</td>
<td>2020/01</td>
</tr>
<tr>
<td>U.S. Population Mortality Observations - Updated with 2020 Experience</td>
<td>Update demographics from the release date which the population mortality data.</td>
<td>2020/01</td>
</tr>
<tr>
<td>2011-2013 Deferred Annuity Mortality Study</td>
<td>Present the mortality experience from 2011-2013 in deferred annuity contracts and release a report with the findings and a database with the experience data.</td>
<td><a href="https://www.soa.org/resources/research/2011-2013/deferred-annuity-mortality-study">Link</a></td>
</tr>
</tbody>
</table>

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SOA Practice Research & Data Driven In-house Research

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Link/Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deep Learning for Liability-Driven Investments</td>
<td>Explores the possibility of using deep learning and reinforcement learning techniques to improve investment decision-making for pension funds and life insurance companies.</td>
<td><a href="http://www.soa.org/resources/research-reports/2021/deep-learning">http://www.soa.org/resources/research-reports/2021/deep-learning</a></td>
</tr>
<tr>
<td>Predictive Analytics for Early Detection of Insurer Resolvency</td>
<td>Develop a machine-learning prediction model to detect financially distressed insurers at an early stage.</td>
<td><a href="http://www.soa.org/resources/research-reports/2021/predictive-analytics-insurer-resolvency">http://www.soa.org/resources/research-reports/2021/predictive-analytics-insurer-resolvency</a></td>
</tr>
<tr>
<td>Obesity Trends and Morbidity and Longevity Impacts</td>
<td>Develop an estimate of the impact of obesity in mortality and morbidity costs in the US and Canada.</td>
<td>12/8/2021</td>
</tr>
<tr>
<td>Impact of Ins &amp; Re Products on Wealth Inequality</td>
<td>Quantify the impact of a variety of insurance, retirement and financial products and services on the wealth gap across various racial and ethnic groups in the US.</td>
<td>6/30/2022</td>
</tr>
<tr>
<td>Mortality Improvement Trends Analysis</td>
<td>Identify how mortality improvement varies by driver.</td>
<td>3/31/2022</td>
</tr>
<tr>
<td>U.S. Cause of Death Mortality By Socioeconomic Category</td>
<td>Develop US age-adjusted death rates by cause of death and socioeconomic category from 1982-2018.</td>
<td>3/31/2022</td>
</tr>
</tbody>
</table>

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Life Practice Council Update

Laura Hanson, MAAA, FSA
Outgoing Vice President

Agenda

☐ Webinars and Events
☐ Recent Activities and Deliverables
☐ Ongoing Efforts
Webinars and Events

- **Recent**
  - *PBR Boot Camp: The Regulatory Perspective* (Oct 13)
  - Academy Annual Meeting (Nov 4-5)
    - Life breakout sessions on reinsurance, long-term care, and registered index-linked annuities
- **Upcoming**
  - Winter 2022 Life Policy Update Webinar (January 2022)

Recent Activity

- Presented recommendations on updated C-2 mortality factors to the NAIC’s Life Risk-Based Capital Working Group
- Submitted comments to the Actuarial Standards Board on the exposure draft of ASOP No. 24
- Published an exposure draft on considerations regarding Market Risk Benefits
- Published an updated version of the Life Illustrations Practice Note
Recent Activity (continued)

- Submitted comments to LATF on Asset Adequacy Testing modeling
- Submitted comments to LATF on APF 2021-11
- Submitted comments to Accelerated Underwriting (A) Working Group on the charges and scope of the working group

Ongoing Activities

- Provide input on Economic Scenario Generator development
- Develop VM-22 and C-3 field study for non-variable annuities
- Publish the VM-21 Practice Note Addendum
- Publish FAQs on changes to tax reserve calculations and reporting under the federal Tax Cuts and Jobs Act of 2017
Ongoing Activities (continued)

- Provide public policy analysis on:
  - The use of annuities in retirement plans, including changes as a result of the federal SECURE* Act
  - The use of data and algorithms in risk classification and underwriting
  - Efforts to promote diversity and inclusion in the profession and in life insurance products

* Setting Every Community Up for Retirement Enhancement

Recent Academy Activities

- Released a major issue paper, *Big Data and Algorithms in Actuarial Modeling and Consumer Impacts*, from the Data Science and Analytics Committee
- Updated U.S. Qualifications Standards effective January 1, 2022
- Council on Professionalism and Education (CoPE)
Thank You

☐ Questions?

☐ For more information, please contact the Academy’s life policy analyst, Khloe Greenwood, at greenwood@actuary.org.
HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

| Health Insurance and Managed Care (B) Committee Dec. 15, 2021, Minutes ................................................................. 7-2 |
| Consumer Information (B) Subgroup Dec. 2, 2021, Minutes (Attachment One) .............................................................. 7-6 |
| Federal No Surprises Act (NSA) Consumer Document (Attachment One-A) ............................................................... 7-7 |
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| Health Care Reform Frequently Asked Questions (FAQ) Document (Two-A) ................................................................. 7-12 |
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The Health Insurance and Managed Care (B) Committee met in San Diego, CA, Dec. 15, 2021. The following Committee members participated: Jon Godfread, Chair (ND); Jessica K. Altman, Vice Chair (PA); Lori K. Wing-Heier (AK); Michael Conway (CO); John F. King (GA); Dean L. Cameron (ID); Kathleen A. Birrane (MD); Anita G. Fox (MI); Grace Arnold (MN); Russell Toal (NM); Glen Mulready (OK); Andrew R. Stolfi (OR); Jonathan T. Pike (UT); Mike Kreidler (WA); and Allan L. McVey represented by Tonya Gill espie (WV). Also participating were: Elizabeth Perri (AS); Ricardo Lara (CA); Frank Pyle (DE); Michelle B. Santos (GU); Doug Ommen and Andria Seip (IA); Vicki Schmidt (KS); Carter Lawrence (TN); and Jeff Rude (WY).

1. **Adopted its Summer National Meeting Minutes**

   Superintendent Toal made a motion, seconded by Commissioner Stolfi, to adopt the Committee’s Aug. 16 minutes (see NAIC Proceedings – Summer 2021, Health Insurance and Managed Care (B) Committee). The motion passed unanimously.

2. **Adopted its Subgroup, Working Group, and Task Force Reports**

   Commissioner Pike made a motion, seconded by Superintendent Toal, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its Dec. 2 (Attachment One), Oct. 20 (Attachment Two), Oct. 14 (Attachment Three), and Aug. 24 (Attachment Four) minutes; 2) the Health Innovations (B) Working Group, including its Dec. 11 (Attachment Five) and Nov. 2 (Attachment Six) minutes; 3) the Health Actuarial (B) Task Force; 4) the Regulatory Framework (B) Task Force; and 5) the Senior Issues (B) Task Force. The motion passed unanimously.

3. **Adopted its 2022 Proposed Charges**

   Commissioner Godfread said the Committee’s 2022 proposed charges were posted on the Committee’s web page and exposed for a public comment period ending Dec. 1. He said the Committee received no comments. Superintendent Toal made a motion, seconded by Commissioner Birrane, to adopt the Committee’s 2022 proposed charges (Attachment Seven). The motion passed unanimously.

4. **Adopted its Task Forces’ 2022 Proposed Charges**

   Commissioner Godfread said prior to the call, NAIC staff distributed the 2022 proposed charges for the Health Actuarial (B) Task Force, the Regulatory Framework (B) Task Force, and the Senior Issues (B) Task Force. The Health Actuarial (B) Task Force adopted its 2022 proposed charges during its Sept. 14 meeting. The Regulatory Framework (B) Task Force adopted its 2022 proposed charges during its Nov. 9 meeting. The Senior Issues (B) Task Force adopted its 2022 proposed charges during its Oct. 6 meeting.

   Commissioner Mulready made a motion, seconded by Director Fox, to adopt the 2022 proposed charges for the Health Actuarial (B) Task Force, the Regulatory Framework (B) Task Force, and the Senior Issues (B) Task Force (see NAIC Proceedings – Fall 2021, Executive (EX) Committee and Plenary, Attachment Three). The motion passed unanimously.

5. **Heard an Update from the CCIIO**

   Jeff Wu (Center for Consumer Information and Insurance Oversight—CCIIO) provided an update on the Biden administration’s current and future activities of interest to the Committee. He discussed the status of the 2022 open enrollment period noting a strong volume of enrollment both in the marketplace plans through HealthCare.gov and the state marketplaces. He highlighted the Biden administration’s $80 million in grants for outreach and enrollment assistance provided to assisters and navigators to assist consumers in their 2022 open enrollment plan selections. He also said approximately 2.8 million people enrolled in marketplace plans during the special enrollment period (SEP). He said approximately 2.1 million people have enrolled in federal marketplace plans, and approximately 700,000 enrolled in state-based exchange plans. He said these enrollments are in addition to the approximately 82 million people enrolled in Medicaid and the Children’s Health Insurance Program (CHIP). He discussed the Biden administration’s plans for unwinding the process and preparing for the end of the COVID-19 public health emergency to smoothly transition people from Medicaid and CHIP to other forms of coverage. He
said the CCIIO is working with its fellow centers, particularly the federal Center for Medicaid and CHIP Services (CMCS), and exploring all available options to limit coverage gaps and coverage losses for those consumers who will be going through the redetermination process. He noted that the NAIC and state insurance regulators will play a huge role in this process. He encouraged state insurance regulators to reach out to the CCIIO with any suggestions and concerns related to this unwinding process.

Mr. Wu discussed the CCIIO’s efforts related to the implementation and enforcement of the federal No Surprises Act (NSA), including the issuance of several sets of interim final and proposed rules. He highlighted the CCIIO’s creation of an NSA website with focus pages for specific stakeholders, such as providers and consumers. He said the CCIIO recognizes the need for extensive outreach and education to stakeholders about the NSA’s provisions and its consumer protections and responsibilities.

Mr. Wu said the CCIIO recognizes that the states are in different positions as far as enforcement when the NSA becomes effective Jan. 1, 2022. He discussed how the federal agencies charged with implementing the NSA can work together with the states to address any implementation and enforcement issues. He said the CCIIO has held meetings with the states to discuss NSA enforcement and has begun sending out letters to the states outlining whether the federal agencies or the states will be responsible for enforcing which provisions of the NSA.

Mr. Wu said despite the necessary focus on the NSA and its implementation, the CCIIO is continuing its work with the states on implementation and enforcement of the provisions of the federal Consolidated Appropriations Act of 2021 (CAA), which amended the federal Mental Health Parity and Addiction Equity Act (MHPAEA) to provide important new protections. He also noted the concerns state insurance regulators have had and have discussed with the CCIIO related to producer and plan marketing and enrollment practices.

Mr. Wu highlighted Kentucky, Maine, and New Mexico’s successful transition from federal marketplaces to full state-based marketplaces for 2022. He noted that these transitions create great opportunities for these states to have really focused specific programs for their residents. He also said the federal Affordable Care Act’s (ACA’s) section 1332 waiver program is still available and open for state applicants interested in pursuing new waivers that expand coverage and access; in particular, waivers that have a focus on underserved populations. He said the CCIIO plans to distribute approximately another $450 million to support the efforts of 14 states that have existing section 1332 waivers.

Mr. Wu said in addition to these initiatives, the federal Centers of Medicare & Medicaid Services (CMS) plans to focus on issues related to health equity as part of its work. He said such health disparities have particularly come to light with the COVID-19 public health emergency. However, he noted that the federal government cannot work on these issues alone, and it needs the help of all stakeholders to address these issues. He highlighted Colorado’s essential health benefit benchmark initiative, which the CMS approved earlier this year. He explained that this new benchmark plan is intended to promote access to coverage for gender affirming care by discouraging the use of a one-size-fits-all framework for transgender persons. He said this initiative is a great example of the important and innovative work the states can do. He said the CCIIO is open to engaging other states regarding these types of and other important and innovative initiatives that a state feels is appropriate for their residents.

Commissioner Altman noted that NSA implementation starts Jan. 1, 2022. She asked Mr. Wu about his thoughts on how the states and the CCIIO can work together to share information on any issues that arise as NSA implementation begins. Mr. Wu said he believes implementing the NSA will be a different and more challenging process than what has occurred before, such as the process for implementing the ACA. He said he believes it will be a gradual, ongoing process. He said particularly in the early months of implementation, communication with stakeholders will be key. He noted the current education and outreach efforts the CCIIO is conducting, particularly with providers.

Commissioner Conway said as one of the states that had a balance billing law prior to the NSA’s enactment, Colorado has been examining ways to align its law with the NSA to streamline provisions and make the implementation and enforcement process as efficient and effective for stakeholders—health care providers, consumers, and hospitals—as possible. He said one of the areas Colorado is finding it difficult to align relates to the arbitration process, particularly in a situation when a provider enters into the federal independent dispute resolution (IDR) process, but later it is determined that the plan involved is state regulated. Upon discovery of this, the provider is kicked out of the federal IDR process and referred to the state IDR process. He acknowledged that Mr. Wu most likely has no immediate answer to his concern. He urged the CCIIO to keep this issue in mind; and as NSA implementation moves forward, the CCIIO should consider and explore ways to address this issue, including allowing in such situations, a state-regulated plan to use the federal IDR process and having the arbitrators follow state law
requirements to conduct the IDR. Mr. Wu acknowledged the potential operational complexity of Commissioner Conway’s suggestion, but he agreed that it would be worthwhile to discuss this issue further in the future.

Commissioner Kreidler asked Mr. Wu when the proposed federal Notice of Benefit and Payment Parameters for 2022 rules would be released. Mr. Wu noted that the CCIIO’s timing for releasing the rules in the past has been challenging for stakeholders to incorporate all its requirements. He said the CCIIO hopes to release the proposed rules by the end of the year or shortly thereafter.

Commissioner Godfread reiterated the NAIC’s and state insurance regulators’ commitment to work with the CCIIO and other federal agencies regarding NSA implementation. He said he anticipates that this collaboration and Committee discussions on the NSA will continue in the coming year.

6. Discussed the Committee’s NSA Consumer and Provider Outreach Materials

Commissioner Godfread said at the Committee’s meeting during the Summer National Meeting, the Committee discussed developing consumer-facing and provider-facing outreach and education materials on the NSA to assist state insurance departments in educating and reaching out to consumers, providers, and insurers about the NSA, prior to its Jan. 1, 2022, starting date. He said based on that discussion, NAIC staff prepared a template that state departments of insurance (DOIs) can tailor to their needs to educate and inform providers in their state about their responsibilities under the NSA for plans starting in 2022. He also said based on those Committee discussions, the Consumer Information (B) Subgroup developed a consumer-facing document tailored to educate consumers on the NSA and the new protections it offers for balance bills. The Subgroup discussed and approved that document during a meeting on Dec. 2. Commissioner Godfread asked the Committee if it believes any additional materials would be needed at this time, such as specific materials for insurers. After discussion, the Committee decided that the current materials were sufficient and could also be used as part of a state DOI’s education and outreach to insurers.

7. Heard a Presentation from the KFF on Findings from the 2021 EHBS

Gary Claxton (Kaiser Family Foundation—KFF) and Matthew Rae (KFF) provided a summary overview of the findings from the KFF’s 2021 Employer Health Benefits Survey (EHBS). For the 2021 survey, the KFF revised it to ask about changes employers and health plans made to address potential issues and uncertainties related to the COVID-19 pandemic. Mr. Claxton said one expected finding related to this issue was an increase by some employers in the use of telemedicine to provide some health care services. He said many employers have also taken steps to assist employees and family members with the stress caused by the COVID-19 pandemic by offering enhanced mental and behavioral health benefits. Employers have also made changes to their health promotion and wellness programs. Mr. Claxton highlighted another survey finding: i.e., the increase in the number of small employers offering level-funded premium plans. He explained that these arrangements combine a relatively small self-funded component with stop-loss insurance, which limits the employer’s liability to low attachment points that transfer a substantial share of the risk to insurers.

Mr. Claxton noted that health insurance coverage remains expensive; but generally, over the past few years, premiums and annual deductibles have remained steady or flat. He said the survey also found that the level of employee cost-sharing has remained flat after previous years of increases. He suggested that this may be due to employers not wanting to make drastic plan changes because of the COVID-19 pandemic.

Commissioner Godfread explained that the reason the Committee invited the KFF to discuss its 2021 EHBS survey findings was because the Committee over the past few years has focused its discussion on the individual market and individual health plans. He said it is also important for the Committee to understand what is happening in the employer market, particularly the small employer market. He encouraged Committee members to view the full 2021 EBHS report on the KFF’s website.

Commissioner Altman noted that as Mr. Claxton stated, although the level of employee cost-sharing has leveled off over the past few years, prior to that level of employee cost-sharing, particularly with respect to deductibles, it has increased over the years. She asked Mr. Claxton if he could discuss empirically or anecdotally about how the current state of coverage in the small group market from a generosity and affordability perspective compares to the individual market taking into consideration the provisions of the federal American Rescue Plan Act of 2021 (ARPA) focusing on lowering the cost of premium for individuals obtaining coverage through the health insurance marketplaces. Mr. Claxton discussed options small employers might take to make coverage more affordable, including not offering coverage, particularly if the employees have lower incomes and can obtain coverage through the health insurance marketplaces and the use of level-funded plans. With respect to level-funded premium plans, Mr. Claxton explained that these plans might have less generous benefits than ACA-compliant plans because
they are not subject to the ACA’s essential health benefit requirements and mental health parity requirements. These plans would also probably be more affordable because they are medically underwritten as well. Mr. Claxton said it is important for state insurance regulators to be aware of these potential trends in the small group market and any possible impact of these types of plans being offered in the small group market versus the plans being offered in the ACA-compliant market.

8. Received an Update on the Special (EX) Committee on Race and Insurance Workstream Five’s Work

Commissioner Altman and Commissioner Lara, co-chairs of the Special (EX) Committee on Race and Insurance Workstream Five, provided an update to the Committee on Workstream Five’s work to date. Commissioner Altman said since the Workstream’s last update, it met Dec. 3, Nov. 18, Oct. 14, Sept. 9, and Aug. 26. She said most of these meetings focused on the Workstream’s work related to its “Principles for Data Collection” document. She said during its Dec. 3 meeting, the Workstream almost completed its work on the document. The Workstream plans to meet Dec. 20 to consider final revisions to the document and, if finalized, forward it document to the Special Committee for its consideration.

Commissioner Lara said in addition to the Workstream’s work on the “Principles for Data Collection” document, during some of the other meetings, the Workstream discussed a draft outline for its proposed white paper on provider networks, provider directories, and cultural competency, and it exposed it for a public comment period ending Nov. 8. He said the Workstream anticipates holding a meeting early next year to discuss the comments received and assign Workstream members to begin drafting sections of the proposed white paper.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

B Cmte Dec 15 minutes
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Dec. 2, 2021. The following Subgroup members participated: Mary Kwei, Chair, Patricia Dorn, and Paul Meyer (MD); Debra Judy, Vice Chair, Jill Mullen, and Tara Smith (CO); William Rodgers and Yada Horace, and Anthony L. Williams (AL); Michele MacKenzie, Shannon Hohl, Kathy McGill (ID); Ryan Gillespie (IL); Jenifer Groth, Alex Peck, and Kim van Rooy (IN); LeAnn Crow and Brenda Johnson (KS); Tricia Hearth, Gregory Maus, and Maybeth Moses (MN); Cynthia Amann, Carrie Couch, Amy Hoyt, Jo LeDuc, and Jessica Schrimpf (MO); Kathy Shortt (NC); Maggie Reinert (NE); Cuc Nguyen and Rebecca Ross (OK); Elizabeth Hart and Lars Thorne (PA); Gretchen Brodkorb (SD); Stephanie Cope, Scott McAnally, Jennifer Ramcharan, and Vickie Trice (TN); Heidi Clausen, Jaakob Sundberg, and Shelley Wiseman (UT); and Barbara Belling, Eric Cormany, Monica Hale, Christina Keeley, Rebecca Rebholz, Jennifer Stegall, Jody Ullman, and Julie Walsh (WI). Also participating was: Patrick Smock (RI).

1. **Adopted a Consumer Brief on Balance Billing**

Ms. Kwei brought up the consumer brief “New Protections Against Surprise Medical Bills.” She thanked the Subgroup members who had drafted the document and contributed edits. She said state insurance departments could use the document as a template and insert their own language regarding any state laws on balance billing or make other changes.

The Subgroup discussed the template. Kris Hathaway (America’s Health Insurance Plans—AHIP) suggested including something about the requirement that providers produce an estimate of costs when they ask a consumer to waive balance billing protections. Brenda J. Cude (University of Georgia) provided a statement on this requirement that the Subgroup decided to include. Ms. Cude asked about the use of the terms “hospitalist” and intensivist.” Some Subgroup members said the terms are not understandable for consumers, and others said they are important to include because federal regulations specifically prohibit waiver of balance bills from these professionals. The Subgroup decided to add brief parenthetical explanations of the terms.

Subgroup members further decided to update language about plans’ coverage of out-of-network providers and to clarify that surprise bills are unexpected balance bills.

Ms. Brodkorb made a motion, seconded by Ms. McGill, to adopt the template with the changes agreed to during the meeting (Attachment One-A). The motion passed unanimously.

Having no further business, the Consumer Information (B) Subgroup adjourned.
New Protections from Surprise Medical Bills

You may have heard stories from friends or in the news about balance bills or surprise bills from health care providers. Starting in 2022, a new law will protect you from many types of surprise bills. Here are the basics about the new protections and some examples of how they can protect consumers.

What is balance billing?

Balance billing happens when a health care provider (a doctor, for example) bills a patient after the patient’s health insurance company has paid its share of the bill. The balance bill is for the difference between the provider’s charge and the price the insurance company set, after the patient has paid any copays, coinsurance, or deductibles.

Balance billing can happen when a patient receives covered health care services from an out-of-network provider or an out-of-network facility (a hospital, for example).

In-network providers agree with an insurance company to accept the insurance payment in full, and don’t balance bill. Out-of-network providers don’t have this same agreement with insurers.

Some health plans, such as Preferred Provider Organization (PPO) or Point of Service (POS) plans, include some coverage for out-of-network care, but the provider may still balance bill the patient if state or federal protections don’t apply. Other plans don’t include coverage for out-of-network services and the patient is responsible for all of the costs of out-of-network care. Medicare and Medicaid have their own protections against balance billing.

What is surprise billing?

Surprise billing happens when a patient receives an unexpected balance bill after they receive care from an out-of-network provider or at an out-of-network facility, such as a hospital. It can happen for both emergency and non-emergency care. Typically, patients don’t know the provider or facility is out-of-network until they receive the bill.

Some states have laws or regulations that protect patients against surprise billing. However, state laws generally don’t apply to self-insured health plans, and most people who get coverage through an employer are in self-insured health plans. Now, a new federal law protects consumers in self-insured health plans as well as consumers in states that don’t have their own protections.

What protections are in place?

A new federal law, the No Surprises Act, protects you from:

- Surprise bills for covered emergency out-of-network services, including air ambulance services (but not ground ambulance services), and
- Surprise bills for covered non-emergency services at an in-network facility.

The law applies to health insurance plans starting in 2022. It applies to the self-insured health plans that employers offer as well as plans from health insurance companies.

- A facility (such as a hospital or freestanding emergency room (ER)) or a provider (such as a doctor) may not bill you more than your in-network coinsurance, copays, or deductibles for emergency services, even if the facility or provider is out-of-network.
- If your health plan requires you to pay copays, coinsurance, and/or deductibles for in-network care, you’re responsible for those.
- The new law also protects you when you receive non-emergency services from out-of-network providers (such as an anesthesiologist) at in-network facilities. An out-of-network provider may not bill you more than your in-network copays, coinsurance, or deductibles for covered services performed at an in-network facility.
You can never be asked to waive your protections and agree to pay more for out-of-network care at an in-network facility for care related to emergency medicine, anesthesiology, pathology, radiology, or neonatology—or for services provided by assistant surgeons, hospitalists (doctors who focus on care of hospitalized patients), and intensivists (doctors who care for patients needing intensive care), or for diagnostic services including radiology and lab services.

You still can agree in advance to be treated by an out-of-network provider in some situations, such as when you choose an out-of-network surgeon knowing the cost will be higher. The provider must give you information in advance about what your share of the costs will be. If you did that, you’d be expected to pay the balance bill as well as your out-of-network coinsurance, deductibles, and copays.

What else should I know?

- Your health plan and the facilities and providers that serve you must send you a notice of your rights under the new law.

- If you’ve received a surprise bill that you think isn’t allowed under the new law, you can file an appeal with your insurance company or ask for an external review of the company’s decision. You also can file a complaint with the [State Insurance Commissioner] or the federal Department of Health and Human Services.

- An independent dispute resolution (IDR) process, or another process your state sets up, is available to settle bills. Providers and insurance companies can use this process to settle disputes about your bill without putting you in the middle. A similar dispute resolution process is available for individuals who are uninsured, in certain circumstances, such as when the actual charges are much higher than the estimated charges.

- Other protections in the new law require insurance companies to keep their provider directories updated. They also must limit your copays, coinsurance, or deductibles to in-network amounts if you rely on inaccurate information in a provider directory.

- You can get more information and make complaints to federal agencies by calling 1-800-985-3059.

See the next page for examples of how the No Surprises Act protections apply.
Examples of Surprise Bill Protections

Q. Deion fell off a ladder, hitting his head and breaking his arm. He was taken to the nearest emergency room. He needed covered imaging and radiology services as well as surgery. Now bills are starting to come in. What is he responsible for paying? How can he get help if he's receiving bills that don't match the explanation of benefits (EOB) from his health insurance plan?

A. For emergency care he received, Deion is only responsible for paying his in-network deductibles, copays, and coinsurance, even if health care providers who were not in his plan network treated him or he was taken to a facility that was out-of-network. If the bills don't match his explanation of benefits (EOB), Deion can call his health insurer first. If he isn't satisfied with the insurer’s response, he can contact [insert state agency].

If Deion is admitted to the hospital after he receives care in the emergency room, he should know that any out-of-network health care providers at the facility may ask him to consent to continuing care and to agree to pay higher amounts. They can only ask for his consent to receive out-of-network care once he is stabilized, able to understand the information about his care and out-of-pocket costs, and it is safe to travel to an in-network facility using non-emergency transportation. If those conditions are met, Deion can decide if he wants to continue with the out-of-network provider, or travel to a provider who participates in his health plan's network. If he stays with the out-of-network provider and consents to out-of-network billing, he'll be responsible for any out-of-network deductibles, copays, or coinsurance. He'll also be responsible for the amount the provider charges that is more than what the insurance company pays (the balance bill).

Q. Bill had chest pains and went to his local hospital's emergency room. The doctors there said he had to be transported to a hospital in a major city for full treatment and he had to go by air ambulance to make it in time. Bill was flown to the larger hospital and is now doing well. Bill's wife, Nancy, has heard scary stories about air ambulance costs and is starting to worry. Are there any protections for someone who is transported by air ambulance in an emergency?

A. If the air ambulance company has an in-network contract with Bill’s health insurance plan, then Bill will only have to pay the in-network deductibles, coinsurance, or copays. The air ambulance company will accept their contracted amount as payment in full.

Starting in 2022, the new federal No Surprises Act protects patients even if the air ambulance company doesn’t have an in-network contract with their health insurance plan. Bill will only have to pay the deductibles, copays, or coinsurance that he would have to pay if the air ambulance were in-network. Federal law will help the air ambulance and the health insurance companies determine how to pay the rest of the bill.

Q. Elena is scheduled for a biopsy, a service that her health plan covers. Her hospital and surgeon are in-network with her health plan, but the hospital uses anesthesiologists and pathologists that are not in-network. Does this mean everything will be covered as in-network, or could Elena have some unexpected charges?

A. Surgery for a biopsy can involve health care providers that you don’t get to choose, such as an anesthesiologist and a pathologist. Starting in 2022, when Elena chooses an in-network facility and surgeon for her procedure, all of her out-of-pocket costs will be at the in-network rate. That includes the costs for any out-of-network providers she didn’t choose who participate in her care.

Q. Hannah changes jobs and her family is covered under a new employer health plan. Hannah and her husband's doctors are in-network with the new company, but their child’s pediatrician is not. How can they find an in-network pediatrician? Can they rely on the online provider directory for accurate information?

A. Hannah can review her new health plan’s online provider directory or call the insurance company to get information. An insurance company may have different networks for different health plans. It’s important to look at the directory for your specific health plan.

Most people rely on their health plan to give them accurate information about in-network health care providers. [States may insert protections in their laws.]

Starting in 2022, federal law requires health care providers to update their information with insurance companies when there is a change. In turn, insurance companies must verify that the information in their provider directories is complete.
If Hannah calls the insurance company to ask for a list of in-network pediatricians, the insurance company has one business day to give her a list. If Hannah relies on inaccurate information from the insurance company that a provider is in-network, then Hannah will be responsible only for the in-network deductibles, copays, or coinsurance.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Oct. 20, 2021. The following Subgroup members participated: Mary Kwei, Chair (MD); Debra Judy, Vice Chair (CO); Anthony L. Williams (AL); Michelle Baldock (IL); LeAnn Crow (KS); Judith Watters (ME); Carrie Couch (MO); Laura Arp (NE); Cue Nguyen (OK); Jill Kruger (SD); Vickie Trice (TN); and Jennifer Steagall (WI).

1. **Adopted Updates to “Frequently Asked Questions About Health Care Reform”**

The Subgroup conducted an e-vote to consider adoption of a revised and updated version of “Frequently Asked Questions about Health Care Reform” (Attachment Two-A). The motion passed unanimously.

Having no further business, the Consumer Information (B) Subgroup adjourned.

**Con Info 10.20.21 Min**
FREQUENTLY ASKED QUESTIONS ABOUT HEALTH CARE REFORM

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PURPOSE

This document is designed for state insurance departments to use as they give answers to frequently asked questions (FAQ) and guide consumers about their health care choices. This document reflects regulations and guidance received from the federal government as of October 2021 and is subject to change.

This document isn’t intended to be given directly to consumers. States will need to modify this document to include state-specific information and terminology. Content in [brackets] must be edited to provide state-specific information. Drafting notes indicate where states may choose to add additional clarity on state policies. While some sections may be useful for direct-to-consumer communications, the document’s primary purpose is to give insurance department staff accurate and understandable information to use when they respond to consumer questions about healthcare reform.

Note that the federal Affordable Care Act (ACA) and related regulations refer to “exchanges” that operate in the states, while federal guidance documents refer to these exchanges as “marketplaces.” This document uses the term “exchanges.” However, some states may decide to follow federal guidance and use the term “marketplaces.”

Note, also, that states will need to modify this FAQ if the state has combined the exchange for individuals and families with the Small Business Health Options Program (SHOP) exchange.

HEALTH CARE REFORM OVERVIEW

Health care has changed in many ways as a result of the passage and implementation of the Patient Protection and Affordable Care Act, Public Law 111-148 (PPACA), and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152. These two laws are collectively known as the ACA.

Q 1: When did the ACA take effect?

The ACA was enacted March 23, 2010.

Q 2: What changes have taken place?

Several changes took place before January 1, 2014:

- Lifetime and annual dollar limits on essential health benefits (EHB) are not allowed. Annual dollar limits on EHB were also phased out by January 1, 2014.
- Consumers are guaranteed certain appeal rights.
- Nearly all adult children up to age 26 are eligible to remain on a parent’s health insurance policy, regardless of the child’s marital status, financial dependency, enrollment in school, or place of residence.
- Insurers must cover certain preventive services without cost-sharing. (See Question 24.)
- Medical loss ratio (MLR) standards limit how much of premium dollars insurers can spend on administrative expenses.
- Many insurers must use a standardized Summary of Benefits and Coverage (SBC), which makes it easier to compare plans.
- Small businesses that provide health care for employees can apply for a tax credit.
- Persons with Medicare prescription drug coverage receive a rebate to help cover the cost of the “donut hole.” For 2022, consumers in a Medicare Part D standard plan no longer face a donut hole, but cost-sharing may vary for other plans.

Several major changes became effective for non-grandfathered individual and small group plans sold or renewed on or after January 1, 2014:
• Plans must include new consumer protections. Health insurers can’t deny or refuse to renew coverage because of a pre-existing medical condition. They also can’t charge a higher premium due to a person’s gender or health condition.
• Insurers must cover routine medical costs if a person participates in a clinical trial for cancer or other life-threatening diseases.
• Many, though not all, insurance plans must cover a minimum set of essential health benefits (EHB) and can’t put annual dollar limits on these benefits.
• Individuals and families may qualify for financial assistance when they shop in the health insurance exchanges. The American Rescue Plan Act increased the amount of financial assistance and removed the income limit of 400% of the federal poverty limit to qualify for assistance. This change will sunset at the end of 2022 if there is no additional legislation.
• In the small group market, from the period November 15 to December 15 each year, small employers can purchase coverage for their workers without having to meet minimum participation or minimum contribution requirements.

Note: Plans sold before March 23, 2010 that have had no significant changes are considered “grandfathered” and aren’t required to comply with many of these requirements. (See Question 31 on grandfathering.) Additionally, plans sold before January 1, 2014 may—if allowed by the state—continue to be renewed through policy years beginning on or before October 1, 2022 without coming into compliance with certain reforms. (See Question 31 on transitional policies.)

Q 3: Where can a person find more information about the ACA, including detailed timeline information?

For more general and detailed information about the ACA and its key provisions, visit the federal government’s website at www.healthcare.gov, or call 1-800-318-2596 (TTY: 1-855-889-4325).

For information about implementation of the ACA in [insert name of state], contact [insert name of state exchange] at [email address] or [xxx-xxx-xxxx].

There are also several other helpful sites and resources for more information about the ACA, including: Kaiser Family Foundation (www.kff.org/health-reform/); Commonwealth Fund (https://www.commonwealthfund.org/health-care-coverage-and-access); The Robert Wood Johnson Foundation (www.rwjf.org); the Georgetown Center on Health Insurance Reforms (https://chir.georgetown.edu/#); and the Center on Budget and Policy Priorities (www.healthreformbeyondthebasics.org).

Q 4: Do the consumer protections of the ACA apply to all health coverage?

No, the ACA consumer protections don’t apply to all health coverage. The ACA largely established new protections in the individual and small group markets, which includes policies sold through the exchanges in every state. Health coverage sold outside of the individual or small group markets, or that is not considered insurance, may not be required to comply with some or any of these protections.

Consumers may have questions about several types of coverage other than the qualified health plans sold through exchanges.

• Short-term, limited duration insurance. Several protections applicable in the individual market do not apply to short-term, limited duration insurance. However, state law or regulation may add some protections. Because the ACA does not apply, these plans may do any or all of the things in the list below, unless prohibited by state law or regulation:
  o deny coverage or increase premium due to health status,
  o exclude essential health benefits,
  o refuse renewal,
  o limit coverage of pre-existing conditions,
  o establish annual or lifetime benefit maximums,
  o set a yearly out-of-pocket maximum above $8,700, or
  o exceed medical loss ratio standards without rebating premium.
• Association health plans. Depending on the structure of the association and state law, consumer protections in the individual, small group, or large group market plans may apply to association health plans.
• Health care sharing ministry. These coverage arrangements are not considered to be insurance, so the requirements and protections described in this FAQ do not apply.
• Fixed indemnity insurance. The requirements and protections described in this FAQ generally do not apply. **Drafting Note:** States may want to add more details about state-level protections that apply to the coverage types mentioned in the bullets above.

**EXCHANGE BASICS**

Q 5: What is the [insert name of state health insurance exchange]? (For questions about the [insert name of state SHOP exchange], see Questions 42-46, 48-52, and 71-74).

The [insert name of state exchange] is the name of [insert name of state]’s health insurance exchange. The ACA created health insurance exchanges as places where individuals, families, and small employers can compare private health insurance plans and shop for coverage. Exchanges also provide access to a tax credit to help individuals pay for coverage. (See Questions 83-86.) Through exchanges, individuals may also qualify for help to lower their out-of-pocket costs (deductibles, coinsurance, or copayments) when they receive health care services. Insurers may sell plans through the exchange, as well as in the market outside the exchange. Premium tax credits and cost-sharing reductions aren’t available for plans sold outside the exchange.

**Drafting Note:** States that have no market outside the exchange should modify the previous paragraph accordingly. States should note, however, that some individuals such as incarcerated individuals and immigrants not legally present cannot be denied coverage on the basis of health status even though they will not be able to buy coverage through the exchange. (See Questions 121-122.)

To learn more, or to apply for coverage through the [insert name of state exchange], individuals and families should visit the website for the [insert name of state exchange] at [insert link to state exchange website]. For more general information about health insurance exchanges, visit the federal government’s website at [https://www.healthcare.gov/what-is-the-health-insurance-marketplace](https://www.healthcare.gov/what-is-the-health-insurance-marketplace).

Q 6: Are there different types of health insurance exchanges?

While the basic features of exchanges are the same in all of the states, the ACA allows for differences in who operates them. Some exchange operation options include the federal government operating the exchange, the state operating the exchange, and a partnership between the federal and state governments to operate the exchange. Please contact [insert state consumer affairs contact information] to learn how it is operated.

Q 7: What is a CO-OP plan?

CO-OP stands for Consumer Operated and Oriented Plan, which is a type of health insurer created under the ACA. The ACA gave low interest loans to private organizations to create a new type of nonprofit insurer designed to increase the plan choices available through the state exchanges. Any profits earned by CO-OPs must be applied to either lower premiums or expand benefits for customers. The federal Center for Consumer Information and Insurance Oversight (CCIIO) in the U.S. Department of Health and Human Services (HHS) maintains oversight of the CO-OPs. CO-OPs also must be governed by their members (or customers) and are required to offer plans through their respective states’ exchanges.

In [insert name of state], the [insert name of CO-OP] is the CO-OP available through the [insert name of state exchange]. If a CO-OP in the state is no longer available or enrollment has been capped, then consumers can explore other coverage options through the exchange during the open enrollment period (or may be eligible for a special enrollment period (SEP) if their CO-OP coverage ends outside of the open enrollment period).

To find out more about the CO-OP program, please visit [http://www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/Consumer-Operated-and-Oriented-Plan-Program.html](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/Consumer-Operated-and-Oriented-Plan-Program.html).
Drafting Note: States should modify or eliminate this question if there aren’t any CO-OPs in the state, if the CO-OP is no longer available, or enrollment has been capped.

Q 8: If consumers live in one state but work in another, to which state’s exchange should they apply?
Consumers who don’t have access to coverage through their employer (or their spouse’s employer) should apply for coverage in the state where they live.

Q 9: Who can buy a plan through the [insert name of state exchange]?
In [insert name of state], any individual or family who wants may buy coverage through the [insert name of state exchange]. The only people who can’t are those who are not lawfully present in the U.S. (see Questions 121-122), incarcerated individuals (other than pending disposition of charges) (see Question 123), and generally, people on Medicare (see Question 94). While most individuals and families can buy coverage through the exchange, eligibility for tax credits and subsidies is dependent on lacking access to other coverage, e.g., Medicaid/Medicare eligibility, offers of affordable employer-sponsored coverage (see Question 85). When individuals become eligible for Medicare while enrolled in an exchange plan, they will no longer be eligible for any premium tax credits or cost-sharing reductions.

Small employers (employers with fewer than [XX] employees) may buy health insurance for their employees through the [insert name of state SHOP exchange]. If a state SHOP exchange has not been established in a state, healthcare.gov generally directs small employers to contact brokers or insurance companies directly. (For more information about the [insert name of state SHOP exchange], see Questions 42-46, 48-52, and 71-74).

Drafting Note: States should insert the appropriate number in place of XX above, taking into account the specific state rules for SHOP participation.

Q 10: When are consumers able to enroll in plans through the [insert name of state exchange]?
Consumers may enroll during the annual open enrollment period or when they qualify for a special enrollment period. In [insert name of state], open enrollment through [insert name of state exchange] for 2022 coverage for individuals and families begins [November 1, 2021], and continues through [January 15, 2022].

Coverage effective dates depend on the date of enrollment and are contingent on consumers paying the first month’s premium directly to the insurance company. Enrollment during a special enrollment period will be effective on either the first day of the following month if a consumer enrolls by the 15th of the month, or on the first day of the second following month, if a consumer enrolls after the 15th of the month.

During open enrollment, consumers may change plans, change insurance companies, or stay with the plan they have, if it’s still available. Current enrollees will also receive a new eligibility determination to determine if they will receive more or less financial help in the form of premium tax credits or cost-sharing reductions. If a consumer does not actively select a new plan and is eligible for auto-renewal, they will be automatically re-enrolled into the closest comparable plan for [Plan Year]. So, consumers who want to make changes to their coverage effective on January 1 must choose a plan by [December 15].

Drafting Note: States should insert the appropriate dates for their Open Enrollment Periods.

Q 11: What if a consumer wants to enroll or change plans outside of the open enrollment period?
Consumers may be eligible to enroll in coverage at times other than during the open enrollment period. There are special enrollment periods (SEPs) for individuals or families if they experience certain events. Some examples of events that trigger an SEP include: 1) loss of minimum essential coverage for an individual or their dependent; 2) gaining or becoming a dependent (such as marriage or the birth/adoption of a baby); and 3) being enrolled in a plan without tax credits and then becoming newly eligible for tax credits. (See Question 85.) The federal website https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ lists possible options for consumers to obtain coverage outside an open enrollment period. Consumers generally have 60 days from the date of the event that triggered a SEP to enroll in coverage. Additional information about SEP rules is available at https://www.healthreformbeyondthebasics.org SEP reference chart/.
Consumers can apply for coverage through [insert name of state exchange] any time during the year, regardless of whether it’s an enrollment period. The [insert name of state exchange] will process applications and tell consumers whether or not they can enroll or must wait until an enrollment period. The exchange will also provide guidance on whether the applicant may be eligible for other types of coverage. Contact the [insert name of state exchange] at [insert website] or [insert phone number] for information about whether a consumer might be eligible to enroll in coverage through the [insert name of state exchange] during a SEP. People who are eligible for Medicaid and the Children’s Health Insurance Program (CHIP) can apply and enroll in [insert name of state Medicaid agency] at any time. People who become eligible for Medicare while enrolled in [insert name of exchange] should immediately notify the exchange and enroll in Medicare. (See Question 94.)

Q 12: How can a consumer prepare to enroll in a plan through the [insert name of state exchange]?

The federal website https://www.healthcare.gov/apply-and-enroll/get-ready-to-apply/ has suggestions for things consumers should think about to prepare to enroll in a plan through the exchange. The [insert name of state department of insurance] website at [insert website] has helpful information for consumers who are thinking about enrolling in a plan through the [insert name of state exchange]. Consumers can also make an appointment with a navigator, certified application counselor, insurance agent or broker, or other assister to help prepare for enrollment and compare plans. To find those who can assist consumers, go to Find Local Help at: https://localhelp.healthcare.gov/.

Consumers can start gathering basic information about household income, such as their most recent tax return if they filed one, or other income information. A full list of required documents is available at https://marketplace.cms.gov/outreach-and-education/marketplace-application-checklist.pdf. Many people will qualify for financial help to make insurance affordable, and consumers will need income information to find out how much help they are eligible for. Consumers can find more information about how to save money on coverage at https://www.healthcare.gov/lower-costs/.

SHOPPING FOR HEALTH INSURANCE: WHAT IS COVERED?

Q 13: What types of plans are available through the [insert name of state exchange]?

Health plans sold through the [insert name of state exchange] must meet comprehensive standards for items and services that must be covered. (See Question 16.) To help consumers compare costs, plans available through the [insert name of state exchange] are organized in four tiers/levels, that estimate the generosity of the plans’ coverage:

- **Bronze level** – The plan must cover about 60% of expected costs across a standard population. This is the lowest level of coverage.
- **Silver level** – The plan must cover about 70% of expected costs across a standard population.
- **Gold level** – The plan must cover about 80% of expected costs across a standard population.
- **Platinum level** – The plan must cover about 90% of expected costs across a standard population. This is the highest level of coverage.

In addition, catastrophic plans cover the same services, but their coverage is slightly less generous than the bronze level plans. A catastrophic plan may be a less expensive option for those who are eligible. Individuals are eligible to purchase a catastrophic plan if:

1. The individual is under the age 30.
2. The individual is over the age of 30 and qualifies for a “hardship exemption” (https://www.healthcare.gov/health-coverage-exemptions/hardship-exemptions/)
3. The individual is over the age of 30 and is unable to afford the lowest priced-coverage available to them. (https://www.healthcare.gov/exemptions-tool/#/results/2018/details/marketplace-affordability)

Premium tax credits and cost-sharing reductions are not available for catastrophic plans. Also, catastrophic plans cannot be used with health savings accounts (HSAs).

Stand-alone dental plans are available through the [insert name of state exchange]. (See Question 25.)
Q 14: What is actuarial value?

Actuarial value is how much of a standard population’s medical spending the health insurance plans in each metal level would cover. Percentages (60% for bronze, 70% for silver, 80% for gold, and 90% for platinum) represent the approximate actuarial value of plans at each level. A higher percentage means the plan covers more of a standard population’s costs (and the population pays less out of pocket). A lower percentage means the plan covers less (and the people who have the plan pay more out of pocket). The actuarial value calculation focuses on cost-sharing charges so that a bronze plan would have higher enrollee cost-sharing amounts compared to a gold plan. There also may be differences in how benefits are covered, such as differences in the prescription drugs that are covered or how many physical therapy visits the plan covers. The law requires all metal level plans and catastrophic plans to cover the essential health benefits (EHB). (See Q. 16)

Actuarial value is calculated for a standard population and does not mean that the plan will pay that percentage of any given person’s actual costs. For instance, a silver tier plan will pay more than 70% of covered medical expenses for some people and less than 70% for other people.

Actuarial value does not give other information about a plan that may be important to a particular person or affect their costs. It does not indicate how broad or narrow a plan’s provider network is, the quality of the provider network, information about the plan’s customer service and support, how broad or narrow the drug formulary is, or what the premium levels are. All of this information is important for consumers to consider when they choose a plan.

See https://www.healthcare.gov/choose-a-plan/ for more consumer information about choosing a plan.

Q 15: How do the tiers (bronze, silver, gold, and platinum) help consumers compare plans?

The tiers are a way to categorize plans based on “actuarial value.” Plans within each tier have a similar actuarial value, even if they cover different benefits or have different types of cost-sharing. While all plans in a tier must cover essential health benefits (EHB) (see Question 16), the details of their coverage (such as how many physical therapy visits are covered or which prescription drugs are covered) may be different. Not all plans in the same tier have the same benefits or cost-sharing requirements. Some plans may offer benefits in addition to the EHB.

The metal levels show the amount of cost-sharing required by the plan. Metal levels do not give consumers a signal about the plan’s provider network size, quality, or any other aspect of coverage.

Q 16: What services/benefits must plans cover? What are essential health benefits (EHB)?

Many plans sold in the individual and small group market, including all of those sold through the [insert name of state exchange] and [insert name of state SHOP exchange] must cover, at a minimum, a comprehensive set of benefits known as essential health benefits (EHB). These EHB include the following:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, including chronic disease management
- Pediatric services, including oral and vision care

“Grandfathered,” “transitional,” and “short-term” plans in the individual and small group markets aren’t required to include EHB. For more information about these plans, see Questions 30-31.

For more detailed information about essential health benefits in [insert name of state] and other states, visit https://www.cms.gov/cciio/resources/data-resources/ehb.html#ehb

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Q 17: What insurance companies will offer coverage through the [Insert name of state exchange]? How can consumers get a list of companies and plans available?

There are listings of the health plans available through the [insert name of state exchange] on its website: [Insert link to state exchange website]. People without access to the Internet can call the customer service line for the [insert name of state exchange] at [insert phone number] or get help from an agent, broker, or other type of assister. (See Question 61.)

Q 18: How can a consumer find out the details about what a particular plan covers?

All individual and small group plans offered after January 1, 2014, will cover essential health benefits (EHB) (see Question 16), except grandfathered, transitional, and short-term plans. (See Questions 30-31 and 91.)

To learn if a specific benefit is covered, and at what level, check a plan’s Summary of Benefits and Coverage (SBC). The SBC is a uniform document that includes details about what a plan does and does not cover. It also includes information about what kinds of costs a consumer can expect to pay out of pocket, such as copayments, coinsurance, and deductibles. An insurance company must provide an SBC for all health plans except for short-term and limited benefit plans. An SBC gives information in the same way for every plan to make it easier to compare plans. SBCs are available on the federal government’s website at www.healthcare.gov, the [insert name of state exchange] website at [insert link], the insurance company’s website, or from an agent or broker for plans offered in the market outside the exchange.

It should be noted that the SBC provides only a summary of the benefits. More detailed information is available through the insurer or an insurance agent or broker, and each SBC must include a link to a copy of the actual individual coverage policy or group certificate of coverage that will provide more detailed information.

The [insert name of state exchange] website at [insert link] includes information about what each plan covers and links to the insurer’s plan brochures.


Q 19: How can consumers compare benefits and understand what a plan covers?

In addition to getting a Summary of Benefits and Coverage (SBC) (see Question 18), consumers can get information about the health plan options available in their state online at the [insert name of state exchange] website at [insert link], through the [insert name of state exchange]’s toll-free telephone number, or from agents, brokers, navigators, or consumer assisters. To find those that can help consumers in their area, direct them to “Find Local Help” at https://localhelp.healthcare.gov/

Q 20: How can consumers see and compare premiums for plans?

The [insert name of state exchange] is set up to let consumers compare policies based on premiums, provider network, actuarial value, and other factors. In addition to premium costs, consumers should look at all the benefits and cost-sharing provisions when choosing a plan because plans with the lowest premium often have the highest out-of-pocket costs.

Consumers can get information to compare premiums from the [insert name of state exchange] website at [insert link] or call center at [insert phone number]. Also, navigators, certified application counselors, insurance agents or brokers, or other assisters should be able to help consumers compare plans.

Drafting Note: States that allow stand-alone vision plans to be sold through the exchange should change this answer to include stand-alone vision plans.

Q 21: Can a person or a health insurance issuer take benefits out of a plan? What if a consumer doesn’t need all of the benefits in a plan?
No. Neither consumers nor health insurance issuers can take benefits out of a plan. At a minimum, every health plan on the [insert name of state exchange] must provide coverage for all the essential health benefits (EHB) the ACA requires. (See Question 16.) Even though a person may not need every benefit in a plan, plans must cover all the essential benefits to share risk across a broad pool of consumers and be sure all benefits are available to everyone. This also helps to protect people from risks they cannot always predict across their lifetimes.

There may be short-term plans or limited benefit plans available that don’t cover all the essential health benefits (EHB).

Drafting Note: States with an individual mandate may want to add: Consumers who don’t have a plan that provides minimum essential coverage may have to pay a penalty when they file their state income taxes. The federal penalty was reduced to $0 starting with tax year 2019. (See Question 59.)

Q 22: Can consumers’ health conditions affect what coverage they are able to get?

No. Under the ACA, health insurance companies no longer can leave coverage out of a plan based on a person’s health condition, a practice that used to be known as a “pre-existing condition exclusion.” Nor can they charge a higher premium because of a person’s health condition. These protections apply whether a person buys an individual market plan through the exchange or outside the exchange. It is important to note that the prohibitions on pre-existing condition exclusions do not apply to short-term or limited benefit plans.

Q 23: Can an insurance company charge tobacco users more than non-tobacco users?

Under the ACA, health insurance companies in the individual and small group markets can charge consumers who use tobacco products a higher premium. People who use tobacco may be charged up to [insert state-specific tobacco surcharge – no higher than 50%] more than people who do not use tobacco. Consumers in group plans may not have to pay this extra charge if they complete a tobacco cessation program and cannot be charged more if they aren’t offered an opportunity to complete a tobacco cessation program. This does not apply to coverage that is not considered comprehensive individual coverage, including short-term plans.

Drafting Note: States that don’t allow the tobacco surcharge should replace the previous paragraph with the following one: In [insert name of state], health insurance companies cannot charge consumers a higher premium for being a tobacco user.

Q 24: What are preventive benefits and how are they covered?

Preventive benefits are designed to keep people healthy by providing screening for early detection of certain health conditions or to help prevent illnesses. The ACA requires that individual market and non-grandfathered group health plans cover many preventive services with no out-of-pocket costs (meaning no deductibles, copayments, and coinsurance) for all new plans sold after September 23, 2010. Some of these covered preventive services are:

- Colorectal cancer screenings, including polyp removal for individuals 45 or older.
- Immunizations and vaccines for adults and children
- Counseling to help adults stop smoking
- Well-woman check-ups, as well as mammograms and cervical cancer screenings
- Well-baby and well-child exams for children

As long as there is an in-network provider in a plan to do a particular preventive service, the plan can charge for that preventive service when an out-of-network provider does it. If there is no in-network provider available to provide a particular preventive service, then the plan can’t charge for the preventive service when an out-of-network provider delivers them.

For more detailed information about covered preventive services, visit the federal government’s website at https://www.healthcare.gov/what-are-my-preventive-care-benefits

Q 25: Are dental or vision benefits available through the [insert name of state exchange]?
The ACA requires plans sold through the [insert name of state exchange] to include vision coverage for children, so children’s vision benefits are included in plans through the [insert name of state exchange]. Dental benefits are treated differently. The ACA lets insurance companies offer health plans through the [insert name of state exchange] that don’t include children’s dental benefits as long as the [insert name of state exchange] offers a stand-alone dental plan that includes a children’s (pediatric) dental benefit.

Plans aren’t required to include dental or vision coverage for adults, but a plan can choose to include these benefits as part of its coverage. Check a plan’s Summary of Benefits and Coverage (SBC) to learn if the plan includes dental or vision coverage for adults.

Some insurance companies may offer stand-alone dental plans through the [insert name of state exchange]. Check the [insert name of state exchange] website at [insert link] for more information.

Check the federal website at www.healthcare.gov for more information about dental benefits.

**Drafting Note:** States where consumers may buy dental coverage without buying health coverage should add a sentence to explain, if appropriate.

**Drafting Note:** States that allow people with Medicare to buy dental plans through the exchange should include this information in this answer.

**Drafting Note:** States that allow stand-alone vision plans to be sold through the exchange should change the answer to this question as appropriate.

**Q 26: How does a consumer find out what drugs a plan covers?**

Health insurers keep lists of which drugs are covered and which are covered at the lowest cost for each of their plans. These lists are called formularies. Drug cost-sharing is often “tiered”—that is, consumers pay less for a generic drug, more for a brand name drug, and sometimes even more for a “nonpreferred” brand name drug. Consumers should review the formularies in any plan they are considering to be sure the plan meets their prescription drug needs and to know what cost-sharing is required for any given drug. For plans that use formularies, the Summary of Benefits and Coverage (SBC) includes an online link where consumers can find information about the plan’s drug coverage. Consumers also can call health insurers for information about formularies.

Formulary information is also available on [insert name of state exchange]’s website [insert link]. If a consumer enrolls in coverage and needs access to a drug not on the plan’s formulary, then the enrollee may be able to use the drug exceptions process to request and gain access to the needed drug.

**Drafting Note:** States should add language to describe their rules regarding whether the insurance company can change the formulary or tiering after the consumer has bought the plan.

**Q 27: What are out-of-network services, and do consumers have any coverage for them?**

Services are considered out-of-network if they are from a doctor, hospital, or other provider that does not have a contractual relationship with a particular health plan. Not all plans cover out-of-network services, but when they do, a consumer’s share of the cost is usually a lot higher than for an in-network service. (See Question 24 on preventive services and Question 29 on emergency services.) Whenever possible, consumers should find out whether a provider is in-network before they receive services. Consumers also should find out if their regular or desired health care providers are in-network before they buy a plan. Also, different plans offered by the same insurer may have different provider networks, so consumers should be careful to look at the network for their specific plan. When reviewing plans to buy, the specific plan name should be on the Summary of Benefits and Coverage (SBC). After a consumer buys a plan, he or she can find the specific plan name on the cover page of the policy document or on their health insurance identification card.

Though the ACA limits how much money a person must spend each year on his or her family’s health care, health insurers are allowed, although not required by federal law, to count the cost of out-of-network services toward these limits.
A plan’s Summary of Benefits and Coverage (SBC) includes information about coverage for out-of-network services and a link to the plan’s website and the provider network.

**Q 28: How do consumers determine if their doctor or dentist is in the network?**

The [insert name of state exchange] website (at [insert website]) lets consumers look up whether their doctor is in the plan network. For plans with a provider network, the Summary of Benefits and Coverage (SBC) includes an online link to a list of network providers. Because plan networks may change regularly, consumers also should check with the doctor or dentist before they schedule an appointment to learn if the provider is still in the plan’s network.

**Q 29: Do consumers have access to emergency care out-of-network?**

Yes. The ACA requires many health plans that provide benefits for emergency services to cover them regardless of whether the provider is in or out of the network. Under the ACA, health plans are not allowed to charge a higher copayment or coinsurance amount for out-of-network services received in an emergency. In addition, [insert name of state] prohibits balance billing for emergency care received out-of-network, meaning only in-network rates apply for all emergency care.

The No Surprises Act provides federal protections against balance bills for emergency services and care at in-network facilities. Most provisions of the No Surprises Act are effective for plan years beginning on or after January 1, 2022. The plans that are covered by this Federal law are: Fully insured plans, Self-funded plans, and Grandfathered plans. *The legislation does not protect those insured by short-term health plans and excepted benefit, dental and vision plans.*

See link: [https://www.cms.gov/nosurprises](https://www.cms.gov/nosurprises)

**Drafting Note:** States that allow health care providers to balance bill for emergency care received out-of-network should replace the previous paragraph with the following:

Yes. The ACA requires many health plans that provide benefits for emergency services to cover those services whether the provider is in or out of the network. While health plans are not allowed to charge a higher copayment or coinsurance for out-of-network services received in an emergency, [Insert state name] allows health care providers to bill consumers for the difference between the cost of emergency care received out-of-network and the amount the plan allows. For more information about [insert name of state]’s rules on balance billing, please contact [insert specific state contact information]. Under federal law, to limit amounts of balance billing for out-of-network emergency services, insurers must calculate amounts they pay for such services to yield the highest payment of the following three amounts:

(A) The amount negotiated with in-network providers for the emergency service provided, excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee.

(B) The amount for the emergency service calculated using the same method the plan uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee.

(C) The amount that would be paid under Medicare Parts A or B for the emergency service, excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee.

**Q 30: What is a “grandfathered” health plan?**

A grandfathered health plan is a plan that has existed continuously prior to March 23, 2010, and that has not made certain significant changes in the plan. Grandfathered plans are not subject to many of the ACA requirements, such as the requirement that plans cover essential health benefits (EHB) (see Question 16), but they are considered to provide minimum essential coverage under the ACA. (See Question 59.)

Grandfathered plans may lose their “grandfather” status if a plan makes certain changes, such as a major increase in their cost-sharing (coinsurance, deductibles, copayments) or dropping benefits to diagnose or treat a particular condition.
Employer-sponsored plans that significantly increase the employee share of the premium also could lose “grandfathered” status. If a plan’s “grandfathered” status is forfeited, that plan would have to follow the applicable ACA requirements.

In the individual market, a consumer cannot enroll in a grandfathered plan with a new enrollment. However, consumers who are already enrolled in an individual market plan prior to March 23, 2010 can renew their coverage in that grandfathered plan.

A plan must show in the plan materials if it is a grandfathered plan. Also, consumers can check with their insurance company or employer to figure out if their plan is grandfathered.

Q 31: Can consumers keep an existing plan that isn’t grandfathered, but doesn’t comply with the ACA reforms (known as transitional plans or “grandmothered” plans)?

It depends. In November 2013, CMS announced a transitional policy that would let insurers, if the state allows, to extend policyholders’ 2013 coverage for up to several more years even if the plan didn’t follow certain ACA reforms. These transitional plans can no longer be sold to new customers (after January 1, 2014), and individuals who bought them aren’t eligible for subsidies. An individual or small business that has one of these plans would be notified by the insurer. If a consumer has a transitional plan, they should check with their insurance carrier to learn if it will renew their plan and what changes, if any, it will be making to the plan.

**Drafting Note:** States that did not adopt this policy, applied it only in certain markets (i.e., in the small group market but not the individual market), or that have already phased out transitional plans would need to edit this answer accordingly or delete it entirely.

**EMPLOYER-SPONSORED COVERAGE**

Q 32: Is employer-based coverage required to cover dependents (spouses and children)?

Under the ACA, if an employer with 50 or more employees doesn’t offer coverage that meets minimum standards to employees and their dependents and employees access premium tax credits through the exchange, then the employer may have to pay a tax penalty. (See Questions 55-56.) However, for purposes of this penalty, the IRS has interpreted the phrase “and their dependents” to mean children under age 26 but not spouses. For more information, see [https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions](https://www.irs.gov). Small employers with fewer than 50 employees that don’t offer coverage to employees or their dependents are not subject to any tax penalties, but may qualify for a tax credit if they choose to offer coverage. (See Question 54.)

Also, if employer-based coverage includes children, then the ACA requires employers to let children up to age 26 stay on their parents’ policy. Adult children up to age 26 can stay on their parents’ policy whether or not they live in their parents’ home, are married, or the parents no longer claim them as a dependent on their tax return. The employee can be required to pay for this coverage, however.

An employer who offers health benefits to employees must also offer the same health benefits to similarly-situated employees who are eligible for Medicare. This rule applies when an employee is 65 or older and the employer has 20 or more employees. This rule applies to dependents when an employer offers health benefits that include dependents.

Q 33: What can a consumer do when employer-based health coverage ends?

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal health law since 1986, when employees and their dependents lose employer-based coverage, they are still eligible to stay on their employer’s group health plan, even though that coverage would otherwise end. COBRA doesn’t apply to employers with fewer than 20 employees [insert state mini-COBA law information if applicable]. Employees or their dependents who are eligible for Medicare when employer group health coverage ends are eligible to enroll in COBRA. However, COBRA coverage is expensive and will only pay benefits secondary to Medicare benefits, even if the Medicare-eligible individual has not enrolled in Medicare. The most recent Department of Labor model COBRA notice includes more specific information about coordination of benefits between

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these two programs. This model notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra. If an individual is enrolled in COBRA coverage and subsequently becomes eligible for Medicare, then primary COBRA benefits will end.

Drafting Note: COBRA is secondary to Medicare benefits because Medicare secondary payer rules that apply to employer group health benefits don’t apply to COBRA benefits. Most employer group health plans have strong coordination of benefit rules. Medicare-eligible individuals are subject to recovery actions if COBRA mistakenly pays primary benefits even if the Medicare-eligible individual has not actually enrolled for those benefits.

COBRA coverage can be expensive because the former employer isn’t required to pay any part of the premium. Those who have lost employer-based health coverage may be eligible to access advance premium tax credits to buy a more affordable individual or family policy through the [insert name of state exchange] (see Questions 85-86), even if the loss of coverage occurs outside of the open enrollment period. Consumers enrolled in COBRA don’t qualify for advance premium tax credits. Dropping COBRA coverage outside of an open enrollment period doesn’t qualify as a special enrollment opportunity.

Q 34: Must a consumer use all available COBRA coverage before buying coverage through the exchange with subsidies?

No. COBRA allows group health plan participants and beneficiaries to continue coverage under their group health plan for a limited period of time after certain events cause a loss of coverage, such as voluntary or involuntary job loss, reduction in the number of hours worked, transition between jobs, death, and divorce. Individuals who lose eligibility for minimum essential coverage, including employer-based coverage, will be eligible for a special enrollment period (SEP) during when they can buy coverage on the [insert name of state exchange] or in the individual market outside of the exchange. At this time, they also may apply for advance premium tax credits and cost-sharing reductions through [insert name of state exchange] to learn if they are eligible to receive them. However, individuals who have already enrolled in COBRA coverage must wait until the next open enrollment period or until that COBRA coverage has been exhausted before enrolling in an individual market plan.

Medicare-eligible former employees have an 8-month SEP to enroll in Medicare Part B that starts on the date of their last month of employment. If they enroll during this SEP, there is no late enrollment premium penalty or other coverage restrictions. They have 63 days to enroll in Medicare Part D from the last date without prescription drug benefits that are at least equivalent to Medicare’s.

Q 35: If a consumer has access to employer-based coverage, can an employer make the consumer wait before becoming eligible for benefits?

Yes. Employers may require a waiting period before individuals become eligible for benefits. Under the ACA, this waiting period can’t be longer than 90 days. Employers also may impose an additional one-month orientation period before the waiting period begins. For more information, consumers should contact their employer’s human resources department.

Q 36: Can a consumer with access to employer-based coverage get a tax credit to buy a plan through the [insert name of state exchange]?

A consumer who has access to employer-based coverage is free to buy a plan through the [insert name of state exchange], but tax credits to buy the coverage are available only if the employer’s plan isn’t affordable or doesn’t provide minimum value. (See Question 85.) Consumers who have access to employer-based coverage that is affordable and provides minimum value will not be able to get tax credits and cost-sharing reductions.

Coverage isn’t affordable if the cost of employee-only coverage under the lowest-cost employer plan is more than 9.61% of the employee’s annual household income in 2022. The plan doesn’t provide minimum value if it pays for less than 60% of medical costs that the plan covers, or if it doesn’t provide substantial coverage of inpatient hospital or physician services. The HHS and IRS have developed a minimum value calculator available at www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm.

Consumers can learn if an employer plan meets minimum value by looking at the Summary of Benefits and Coverage (SBC) or by asking the employer to fill out an Employer Coverage Tool. This form provides information that will help the consumer
answer application questions correctly at the [insert name of state exchange]. The Employer Coverage Tool can be found at https://marketplace.cms.gov/applications-and-forms/employer-coverage-tool.pdf

There’s more information on [insert name of state exchange]’s website at [insert link] and on the IRS websites listed below:

www.irs.gov/Affordable-Care-Act/Individuals-and-Families/The-Premium-Tax-Credit


Q 37: If a consumer is offered employer-based coverage that would cover a spouse or dependents, can that consumer’s spouse or children get a tax credit to buy coverage through the exchange?

It depends on whether the employer-based coverage is affordable and meets minimum value. If the premiums for employee-only coverage in the lowest-cost plan are less than 9.61% of household income and the coverage provides minimum value, then no one in the family who is eligible for the plan is eligible for premium tax credits. This may be the case even when it would be unaffordable for a spouse or children to enroll in the plan, based on the cost of family coverage. Depending on state eligibility rules, the children may be eligible for Medicaid or CHIP coverage. (See Question 102.) Contact the [insert name of state exchange] to learn more.

Q 38: What is a health reimbursement arrangement?

In a health reimbursement arrangement (HRA), an employer may offer employees tax-free funds they can use to buy health coverage. There are different types of HRAs. In an individual coverage HRA, an employer may offer funds instead of a group health plan to some or all employees. The employees use the funds to buy individual market health plans for themselves and their families. In an excepted benefits HRA, an employer may offer funds and a group health plan. The employees and their families may use the HRA funds to buy health coverage other than comprehensive health coverage, such as dental and vision coverage or short-term, limited duration health insurance.

A Medicare-eligible employee can have an HRA if the employee is enrolled in a health care flexible spending account (HCFSA). The employer can pay Medicare Part B and Part D premiums for active employees only if the employer payment plan is integrated with the group health plan. (See Department of Labor rules.)

Q 39: If a consumer is offered a health reimbursement arrangement, can that consumer get a tax credit to buy coverage through the exchange?

The answer depends on the amount of the HRA the employer offers. If the employer offers enough money through an HRA to make an exchange plan affordable for an employee, then neither the employee nor their dependents are eligible for a premium tax credit. If the amount of the HRA isn’t enough to make an exchange plan affordable, then the employee and their dependents may still receive a premium tax credit. If the HRA is a qualified small employer HRA (QSEHRA), then the amount of the tax credit is reduced by the amount of the QSEHRA. More information about HRAs and small businesses can be found at: https://www.healthcare.gov/small-businesses/learn-more/qsehra/

The [state exchange name] might not take a consumer’s HRA into account when calculating how much premium tax credit the consumer is eligible for. In that case, the consumer may want to apply less than the full amount of the credit they are awarded when they pay their premiums each month. This can help to prevent the need to pay back some of the credit when the consumer files his or her federal income tax return.

Q 40: What are Health Savings Accounts?

Individuals may contribute to tax-advantaged Health Savings Accounts (HSAs) when they are enrolled in a health plan that meets certain IRS requirements to be an "HSA-qualified" health insurance plan. The plan must have a minimum deductible (presently $1400 for self-only coverage and $2800 for family coverage). The deductible must apply to all covered benefits received from in-network providers. Importantly, only certain "preventive care" benefits may be provided before the
deductible is met. The health plan must not be limited to vision, dental, disability, workers' compensation and other so-called "excepted benefits" or other types of limited coverage.

An individual is not eligible to contribute to an HSA for any month that they: (1) have coverage under any health insurance plan or other arrangement (including employer-sponsored health flexible spending arrangements or health reimbursement arrangements) that does not apply a deductible equal to or exceeding the minimums described above; (2) are enrolled in Medicare; or (3) can be claimed as a dependent on another individual's tax return.

A Medicare beneficiary cannot contribute to an HSA once they are enrolled in Medicare. For individuals that enroll in Medicare after they turn 65, their Medicare effective date could be retroactive up to six months which could impact their eligibility to make HSA contributions. HSA account owners can still use their HSA funds to pay Medicare premiums (all Parts but not Medicare Supplement insurance), deductibles, co-pays, coinsurance, as well as other eligible expenses for services not covered by Medicare (e.g., dental, vision, hearing).

Q 41: When an employee is enrolled in employer-based coverage and in Medicare, is Medicare a primary or secondary payer?

When an employee or a dependent is eligible for Medicare, the size of the employer group determines if the group plan is primary or secondary to Medicare. When an employee or a dependent is 65 or older and there are 20 or more employees, the employer group health plan is primary. When an employee or their dependent is disabled and there are 100 or more employees, the group health plan is primary. The number of employees includes both full-time and part-time employees. If the employer has fewer than 20 or 100 employees, then Medicare will be primary and the group health plan will be secondary coverage.

Q 42: What is the [insert name of state SHOP exchange]?

Under the ACA, states or the federal government may create Small Business Health Options Program (SHOP) exchanges, where small employers who want to offer coverage to their employees can shop for plans. In [insert name of state], the SHOP exchange is called the [insert name of state SHOP exchange]. The SHOP can allow a small employer to offer a range of small group plans to their workers. Eligible employers can apply for the Small Business Health Care Tax Credit if they offer coverage through the SHOP and meet certain other criteria. The SHOP has no minimum contribution requirements for employers, but some states may impose a contribution requirement in addition to a minimum participation rate. Employers who are interested in applying for the Small Business Health Care Tax Credit, however, must contribute at least 50% of the cost of their employees’ premiums to be eligible for the credit. Just as with the regular small group market, employers who sign up for coverage during the small group open enrollment period that runs from November 15 to December 15 will face no minimum participation requirements. Coverage would then be effective for workers beginning January 1.

The ACA calls for “employee choice” in the SHOP exchanges. Under this provision, small employers may choose to give their employees a choice of health plans from multiple insurers across all metal levels (See Question 15) on the SHOP exchange. In some states, employers may also choose to offer coverage from one insurance company. Whether or not they offer employees choice, in most states, employers will work with their SHOP-registered agent or broker or insurance company (or companies) to obtain application, enrollment, and billing information.

There’s more information about the [insert name of state SHOP exchange] at [insert link to state SHOP exchange website]. There are resources with information about small employer issues and the ACA on the following websites:

http://healthcare.gov/small-businesses

U.S. Department of Labor Patient Protection and Affordable Care Act information

Affordable Care Act Tax Provisions

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Q 43: Is there a cost to participate in [insert name of state SHOP exchange]?

There’s no fee for small employers or their employees to enroll in SHOP coverage. Some employers may be eligible for the Small Business Health Care Tax Credit, which can be worth up to 50% of the employer’s premium contribution.

Q 44: Can insurers charge more (or less) for policies sold through [insert name of state SHOP exchange]?

No. Insurers must charge the same for similar plans whether they’re sold through the [insert name of state SHOP exchange] or in the market outside of the [insert name of state SHOP exchange].

Q 45: What happens if an employer’s staff increases to more than [50] employees in the year after the employer bought coverage through the SHOP?

Once enrolled in SHOP exchange, businesses can renew their coverage even if the number of their employees increases to more than [50].

Drafting Note: States should modify the number of employees in accordance with the state definition of small employer.

Q 46: How are small employers defined?

In [state], small employers who are eligible for coverage in the small group market or in the SHOP exchange are those with [50] or fewer employees. The definition may be different in other states.

Drafting Note: States should modify the number of employees in accordance with the state definition of small employer.

Q 47: How do employers with full-time and part-time employees know whether they’re required to pay a penalty if they don’t offer health insurance to their workers?

Small employers are not required to pay a penalty if they do not offer health coverage. To avoid the penalty, large employers must be considered to have at least 50 full-time equivalent employees. Penalties are assessed against employers with at least 50 full-time equivalent employees who 1) do not offer health coverage that meets minimum standards or 2) have an employee who gets coverage through the exchange and gets the premium tax credit. (See Questions 55-56).


Q 48: Are health insurers required to sell their plans through the federal SHOP exchange?

Beginning January 1, 2018, SHOP plans are no longer offered through the federal SHOP Exchange. Instead, there are two options to enroll in a SHOP plan, which are:

1. Work with a SHOP-registered agent or broker.
2. Sign up with an insurance company.

For more SHOP information, including SHOP plans and prices, click on the Healthcare.gov link below.

Drafting Note: Consumers should not create an account, log into an existing account, or start an application on HealthCare.gov for SHOP coverage, even if that is how they enrolled in SHOP coverage in the past.

Q 49: Are small employers required to buy a health plan for their employees through [insert name of state SHOP exchange]?
No. Small employers may buy health insurance for employees through the [insert name of state SHOP exchange] or in the market outside the exchange. However, to be eligible for the Small Business Health Care Tax Credit (see Question 57), in most cases a small employer must have bought the coverage through the SHOP exchange. It is important for small employers to understand and compare all options available to them. State-licensed health insurance agents and brokers, including SHOP registered agents and brokers, are available to help small employers compare options and determine which plan best meets their needs.

More information about the Small Business Health Care Tax Credit is available at


**Drafting Note:** States that require small employers to buy health insurance for their employees through the exchange should modify this answer as appropriate.

**Q 50:** Will consumers be better off with individual coverage through the [insert name of state exchange] rather than through the small employer coverage?

Maybe. It depends on many variables, such as the employees’ out-of-pocket expenses under the small group plan offered, the consumers’ personal circumstances, and the premiums of plans available through the exchange. Employees, their spouses, and dependents offered coverage through an employer are usually not eligible for premium tax credits, so small employer-sponsored coverage could cost less than individual coverage through the federal exchange.

Employers and employees should compare rates for plans offered through the [insert name of state exchange] and for plans in the market outside the [insert name of state exchange].

**Q 51:** Are there participation rates that insurers can require employers to meet to be eligible to buy small group coverage through the [insert name of state SHOP exchange] or in the market outside the [insert name of state SHOP exchange]?

As a result of the ACA, insurers offering coverage in the small group market can’t deny coverage to a small employer who doesn’t meet minimum participation requirements, if the employer seeks coverage during the small group open enrollment period that runs from November 15 to December 15 each year. Outside of that time period, insurers in the small group market can require small employers to meet participation requirements through the [insert name of state exchange] or outside the [insert name of state exchange] consistent with [insert name of state] law.

[Insert name of state] law doesn’t allow a small employer insurer to impose more stringent requirements than the following:

- [insert participation limits consistent with state law]

**Drafting Note:** States with state-based exchanges may impose minimum participation rates as a condition of participation in a state SHOP exchange. In states with a federally-facilitated exchange, the SHOP has a default minimum participation rate of 70% for qualified health plans (QHPs). The minimum participation rate also will be adjusted higher or lower depending on state law or general insurer practice. For more information, see this link: https://marketplace.cms.gov/outreach-and-education/shop-minimum-participation-rates.pdf

**Q 52:** Can small employers who are the sole employees of their business buy small group coverage either through the [insert name of state SHOP exchange] or the outside market?

Neither federal nor state law lets insurers sell small group health insurance plans to self-employed individuals with no common law employees through the SHOP.

Contact the [insert name of state exchange] at [insert link] or [phone number] or a licensed agent or broker for help.
Q 53: How does rating work in the small group market?

Under the ACA, there is adjusted community rating in the small group market. This means that the rates each employer pays for health insurance depends on the claims experience of the insurer’s entire small group market in [insert name of state], rather than the claims experience of that employer’s small group.

The ACA offers states the option to combine the individual and small group markets. By combining the markets, risk is pooled among a larger number of policyholders. A larger risk pool increases rate stability; however, initially premiums for individuals are likely to be lower on average, while premiums for small employers are likely to be higher.

Q 54: Do small employers who don’t offer health care insurance coverage to their employees have to pay a tax penalty?

No. Small employers who want to provide coverage may be eligible for the Small Business Health Care Tax Credit to help make insurance more affordable.

If the employer does offer coverage, then the coverage must meet the ACA’s minimum standards for small group insurance plans, as well as specific requirements that apply to the small group market, such as coverage of essential health benefits (EHB) and the prohibition on discrimination based on health status.

In [insert name of state], the [insert name of state SHOP exchange] is a place where small employers who want to offer coverage to their employees can shop. There’s more information about the [insert name of state SHOP exchange] at [insert link to state SHOP exchange website].

Q 55: Do large employers have to offer health care insurance coverage to their employees? What about seasonal employees?

Under the ACA, if an applicable large employer doesn’t offer affordable coverage that provides minimum value to full-time employees (and their dependents1), and an employee gets a premium tax credit, then the employer has to pay a penalty. For employer-based coverage to be considered affordable in 2022, the premiums for the plan’s employee-only option must be less than 9.61% of his or her 2022 annual household income.

To offer minimum value, the plan must pay at least 60% of the medical costs for services the plan covers and include substantial coverage of inpatient hospital and physician services. The HHS and IRS have developed a minimum value calculator at www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm.

Applicable large employers are employers with 50 or more full-time employees, including full-time equivalent (FTE) employees. Full-time employees are employees with 30 hours or more of service in a week. The number of FTE employees is determined by adding the number of hours of service in a month for all part-time workers and dividing by 120 hours per month. The term “applicable large employer” is used for the employer shared responsibility and information reporting provisions of the ACA.

Penalties were assessed starting January 1, 2016 against employers with 50 or more FTE employees who do not offer health coverage if an employee gets the premium tax credit.

Employers with a large seasonal workforce (such as agricultural workers hired for the harvest season or retail clerks hired for the holiday season) are given leeway under the ACA not to count seasonal employees to decide if they meet the definition of

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1 The rules implementing employer shared responsibility provisions have interpreted the phrase “and their dependents” to mean children under age 26, but not spouses. There’s more information at https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions.
a large employer. If the employer has more than 50 full-time or FTE employees during 120 or fewer days per year, then the employer doesn’t have to count those employees for those months.

For more information, go to the IRS website at https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions. IRS Publication 5208 also has information to determine if an employer is an applicable large employer.

This question does not take into account all possible situations. Employers should consult a tax professional for help with their particular situation.


Q 56: What are the penalties if large employers don’t provide coverage?

Large employers may have to pay a tax penalty if they don’t offer affordable coverage that provides minimum value (see Question 55) for at least 95% of their full-time employees and their dependents, or all but five full-time employees, whichever is greater, and at least one of their employees gets premium tax credits through the [insert name of state exchange].

In general, an applicable large employer that does not offer minimum essential coverage to at least 95 percent of its full-time employees (and their dependents) will be liable for the first of two types of employer shared responsibility payments if at least one full-time employee receives the premium tax credit for purchasing coverage through the exchange. On an annual basis, this payment is equal to $2,320 (indexed for future years) for each full-time employee, with the first 30 employees excluded from the calculation. This calculation is based on all full-time employees (minus 30), including full-time employees who have minimum essential coverage under the employer’s plan or from another source.

In general, an applicable large employer that does offer minimum essential coverage to at least 95 percent of its full-time employees (and their dependents) will be liable for the second type of employer shared responsibility payment if at least one full-time employee receives the premium tax credit because the minimum essential coverage offered was not affordable, did not provide minimum value, or because the employee was not one of the at least 95 percent of full-time employees offered minimum essential coverage. On an annual basis, this payment is equal to $3,480 (indexed for future years) but only for each full-time employee who receives the premium tax credit. The total payment in this instance cannot exceed the amount the employer would have owed had the employer not offered minimum essential coverage to at least 95 percent of its full-time employees (and their dependents).


Medicaid-eligible employees can’t get premium tax credits, so employers will not face penalties for employees who receive Medicaid coverage or for employees’ children who receive CHIP coverage.

Q 57: How do small employers find out if they’re eligible for the Small Business Health Care Tax Credit?

Employers who buy coverage for their employees through the [insert name of state SHOP exchange] may be eligible for the Small Business Health Care Tax Credit. To qualify, the employer must: 1) have fewer than 25 full-time equivalent employees; 2) pay employees an average annual wage that’s less than $50,000; and 3) pay at least half of the insurance premiums.

The tax credit operates on a sliding scale, with a maximum credit of 50% of the employer’s share of the premium costs. It is only available to small employers buying health insurance through [insert name of state SHOP exchange]. The tax credit may be worth up to 50% of an employer’s contribution toward employees’ premium costs (up to 35% for tax-exempt employers).
Q 58: What ACA requirements apply to large employers?

Several ACA requirements apply to non-grandfathered health plans that large employers offer on either an insured or self-insured basis. The requirements include limits on out-of-pocket expenditures and waiting periods, no annual or lifetime dollar limits on coverage of essential health benefits or cost-sharing for preventive services, the requirement that coverage be offered to adult children up to age 26, and the requirement of access to internal and external appeals. Also, as noted in Question 56, large employers are required to offer affordable and adequate coverage, or face a tax penalty.

ACA REQUIREMENT TO HAVE BASIC HEALTH CARE COVERAGE (INDIVIDUAL MANDATE)

Q 59: What is the individual responsibility requirement, and does it mean consumers must maintain coverage?

Under the ACA, consumers and their dependent children are required to have “minimum essential coverage,” unless they qualify for an exemption. This requirement is known as “individual shared responsibility” or the “individual mandate.” However, beginning in 2019, the federal tax penalty for going without coverage was reduced to $0. Therefore, those without coverage will have to pay out of pocket for any health care expenses they incur, but they will not pay an additional tax penalty.

This link to the IRS website has more information: www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage

Coverage purchased through an exchange counts as minimum essential coverage, and so do other types of coverage. Employer-sponsored coverage, grandfathered plans, Medicare, Medicaid, and CHIP are all minimum essential coverage. Short-term health plans, fixed indemnity insurance, and coverage through a health care sharing ministry are not minimum essential coverage.

Check the website at www.healthcare.gov/fees/fee-for-not-being-covered/ for more information.

Q 60: Without a tax penalty, is having minimum essential coverage important?

After 2018, the tax penalty for not having minimum essential coverage (MEC) was reduced to $0. There’s more information about the penalty at http://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/

Individuals who are not enrolled in minimum essential coverage (MEC) are not eligible for one type of Special Enrollment Period (SEP). Those who are enrolled in MEC that ends are eligible for an SEP that allows them to enroll in individual market coverage, including exchange coverage. Those who are enrolled in coverage that is not MEC do not qualify for this SEP. Therefore, if their coverage ends, they need to wait until the next Open Enrollment Period or until they qualify for another SEP to enroll. Individuals cannot be eligible for premium tax credits until they are enrolled in an exchange plan.

And, of course, having coverage offers consumers some protection against high health costs, even if there is no tax penalty for going without coverage.

Drafting Note: States with their own penalties for not having MEC should include that information.
ENROLLING IN HEALTH CARE COVERAGE: WHERE CAN CONSUMERS GET HELP?

Q 61: Where do consumers go for help to choose and enroll in a plan?

Consumers should make a list of questions before they shop for a health plan. Consumers should gather information about their household income and set a budget for health insurance. Consumers should find out if they can stay with their current doctors and pharmacy, whether their medications are covered, and understand how insurance works—including understanding deductibles, out-of-pocket maximums, and copayments.

There are several resources from the Kaiser Family Foundation, Consumer Reports, the NAIC, HHS, and the U.S. Department of Labor (DOL) to help consumers understand how insurance works, the different insurance options, and what to consider when buying coverage. For questions about Medicare and other health coverage, consumers can contact the state SHIP.

A standard form called the Summary of Benefits and Coverage, or SBC, and the companion set of uniform definitions, also is available for many health insurance plans. This information can help consumers compare different insurance options. (See Question 18.) Consumers can get the form and definitions through the [insert name of state exchange] at [insert link to state exchange website], or ask the plan for it. The [insert name of state exchange] also can direct consumers to more information and resources about the options that are available.

Consumers who are eligible to buy coverage through the [insert name of state exchange] can enroll through the [insert name of state exchange] website at [insert link], by phone at [insert phone number], or in person through [insert links and contact information].

Also, a few types of individuals are trained to help consumers make decisions about health coverage:

A. Insurance agents or brokers

Health insurance agents and brokers sell insurance coverage from one or more insurance companies. Health insurance agents and brokers are licensed by [insert name of state] and receive continuing education related to their job. They can help educate consumers about health insurance policies, help consumers apply for coverage, and advise consumers about the type of health insurance coverage that best suits them and their family. Agents and brokers can sell consumers insurance plans in the market outside the exchange, as they always have.

Agents and brokers who want to sell policies through the [insert name of state exchange] have extra training from the HHS or the state-based exchange. They have passed a test at the end of their training to sell insurance policies through the [insert name of state exchange]. [Insert name of state] requires agents and brokers to have extra state-specific training before they sell through the [insert name of state exchange]. A list of agents and brokers authorized to sell through the [insert name of state exchange] is available on the [insert name of state exchange] website at [insert link]. Consumers may want to talk with more than one agent or broker before they decide which plan to buy. (See Question 68.)

Drafting Note: If a state doesn’t have a list of agents and brokers on the exchange, then modify the answer accordingly.

B. Navigators

Navigators are individuals trained to help consumers understand the insurance policies available through the [insert name of state exchange] and answer consumer questions about the [insert name of state exchange]. They also can answer questions about insurance affordability programs, including Medicaid and CHIP. Navigators also can help educate consumers about their health insurance policy options and help them apply for coverage. Navigators get grants from the [insert name of state exchange] to receive training to help consumers. After training, they must pass a test and be certified by [insert name of state exchange]. In [insert name of state], navigators also must have extra state-specific training before they can help consumers. Consumers can contact navigators at [insert state contact information]. (See Question 69.)

Drafting Note: States where the HHS will be doing training and certification should modify the preceding paragraph accordingly. The HHS will certify navigators in the federally-facilitated exchanges.
C. In-person assistance personnel

In-person assistance personnel generally do the same things as navigators. In-person assistance personnel have received and successfully completed comprehensive training. They also can help educate consumers about health insurance policies and help them apply for coverage. [Insert name of state] has set up an in-person assistance program. Consumers can contact in-person assistance personnel at [insert contact information].

Drafting Note: States should delete this section if they do not have in-person assistance personnel.

D. Certified application counselors

Certified application counselors provide enrollment assistance to consumers. Certified application counselors receive and successfully complete comprehensive training. They, too, can help educate consumers about health insurance plans and help them complete an application for coverage. In [insert name of state], examples of application counselors include staff at [insert name of local community health centers or hospitals or consumer nonprofit organizations].

Drafting Note: States will need to customize this section depending on the type of exchange they have and what kinds of individuals will be assisting consumers. More customization may be necessary if the state has any licensure or certification requirements.

Q 62: May consumers directly enroll for coverage through insurers?

Yes. Consumers may buy coverage directly from an insurance company. However, consumers should make sure that the coverage they buy is offered through the [insert state name of state exchange] and that the insurer has an agreement to do direct enrollment through the [insert name of state exchange] so they can get any tax credits or cost-sharing reductions to which they are entitled.

Consumers enrolling directly through the insurance company portal may not see all plans available through the [insert name of state exchange]. An insurance company portal may also offer plans that are not offered through the exchange. An enrollee who buys one of those plans is not eligible for premium tax credits.

Drafting Note: States that do not allow insurers to enroll consumers directly into plans through the exchange should change this answer accordingly.

Q 63: How are people who help consumers enroll in health coverage paid?

Insurance agents and brokers may have an agreement that the insurance company will pay them if they enroll consumers in a health insurance policy consistent with state law. The state-based exchange may set rules about paying health insurance agents and brokers from the exchange or directly from insurance companies. In [insert name of state], the agent or broker will be paid an amount agreed to by the health insurance agent or broker and the company.

In [insert name of state], navigators will get funding from [insert funding source]. They don’t get enrollment-based reimbursement from insurance companies and aren’t allowed to charge a fee.

In-person assistance personnel will be paid by [insert funding source]. They don’t get enrollment-based reimbursement from insurance companies and aren’t allowed to charge a fee.

Certified application counselors will not be paid through the [insert name of state exchange]. They don’t get enrollment-based reimbursement from insurance companies and aren’t allowed to charge a fee. They may, however, receive federal funding through other grant programs, or Medicaid, or from another source.

Q 64: How can consumers find an insurance agent or broker to help them enroll in a plan?

In [insert state name], the [insert name of state health insurance exchange] website at [insert link] lists insurance agents and brokers authorized to enroll individuals, families, and small businesses in coverage through the [insert name of state exchange].
exchange]. Consumers can contact the [insert state Insurance Department] for a list of licensed health insurance agents and brokers in their area. Some agents and brokers don’t contract with all health plans, so consumers must make sure they know the full list of plans that are available to them before they ask an agent or broker for help. Also, health insurance agents and brokers may or may not be able to help individuals complete the enrollment process for Medicaid or CHIP after they get an eligibility decision.

There’s also helpful information at healthcare.gov https://localhelp.healthcare.gov/

**Drafting Note:** States should modify this answer consistent with the information available in the state.

Q 65: What are the qualifications required for health insurance agents and brokers to participate in the [insert name of state exchange]?

In [insert name of state], health insurance agents and brokers are regulated by the [insert name of state department of insurance]. Agents and brokers receive training from the [insert name of state exchange or the HHS]. The insurance companies must appoint the insurance agents and brokers who sell their plans through the [insert name of state exchange]. An agent or broker selling plans through the [insert name of state exchange] must provide information about all plans that are offered on the [insert name of state exchange], even if the agent or broker isn’t authorized to sell some of those plans.

**Drafting Note:** States that don’t require agents and brokers to be appointed to all the insurance companies selling through the exchange or that don’t require agents to provide information about all plans available through the exchange should modify the previous paragraph accordingly.

Q 66: Where should consumers go if they have a problem enrolling in a plan through the [insert name of state exchange]?

The [insert name of state exchange] should be able to help consumers with any problems. In particular, [insert name of state exchange] operates a call center to help answer consumer questions. The number for the call center is [insert number]. The phone number is available on the [insert name of state exchange] website at [insert link]. Insurance agents and brokers, navigators, in-person assistance personnel, and certified application counselors also should be able to help. (See Question 61.) Consumers can also contact the [insert name of state insurance department] at [insert phone number] to file a complaint or report a concern about a negative experience with an insurance company, agent and broker, navigator, in-person assister, or certified application counselor during and after the enrollment process.

Q 67: Do consumers have to re-enroll annually?

Eligibility for premium assistance and enrollment in a health plan will be decided annually using updated income, family size, and tax information (when authorized). Each year, before the open enrollment period, the [insert name of state exchange] will check income data and send a notice to consumers who are determined eligible for enrollment in a plan through the [insert name of state exchange]. This notice explains the consumer’s eligibility for the upcoming year and tells the consumer to let the [insert name of state exchange] know of any changes. After this, there will be an annual open enrollment period for consumers to change plans or insurance companies if they want to.

All consumers are encouraged to go to the exchange to review all of their options and to update income and other information to ensure the correct subsidy is received. Those enrolled in a plan through the exchange in 2021 who are eligible for auto-renewal and choose not to re-enroll or enroll in a different plan by December 15, 2021 will be automatically re-enrolled in their current or similar plan. For the 2022 coverage year, the key dates are as follows:

- **November 1, 2021:** Open enrollment starts—the first day a consumer can apply for 2022 coverage.
- **December 15, 2021:** The last date to enroll for coverage that starts January 1, 2022.
- **December 31, 2021:** The date when all 2021 exchange coverage ends, no matter when the consumer enrolled.
- **January 1, 2022:** The date 2022 coverage can start if consumers applied by December 15, 2021, or consumers were automatically re-enrolled in their 2021 plan or a similar plan.
• **January 15, 2022**: The last date to enroll in 2022 plan year coverage, with an effective date of February 1, 2022. Consumers who miss this deadline can’t sign up for a comprehensive individual market health plan inside or outside the exchange or change plans unless they qualify for a special enrollment period (SEP). (See Question 11.)

During the year, consumers with coverage through the [insert name of state exchange] must report certain life changes to the [insert name of state exchange]. Consumers should report changes as soon as possible, especially changes that qualify a consumer for a SEP. Consumers eligible for a SEP typically have 60 days to enroll in new coverage. (See Question 11.) Life changes include changes in income from a new job and getting married or divorced. See [www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/](http://www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/) [or cite to SBM if appropriate] for information about reporting life changes.

Consumers who have not requested financial assistance don’t need to report changes related to financial assistance eligibility.

**Drafting Note**: Some state-based marketplaces may have different deadlines for automatic re-enrollment and end dates for open enrollment and the timeframes above should be revised accordingly.

**Q 68: How do insurance agents and brokers help consumers with enrollment through the [insert name of state exchange]?”**

In [insert name of state], health insurance companies appoint agents and brokers. Insurance companies make sure the agent’s license is valid and registered with the [insert name of state exchange]. The agent can help consumers log on to the [insert name of state exchange]. Consumers should log into their own [insert name of state exchange] account. The agent or broker can help consumers as needed. The agent or broker then works with consumers to complete the application. Consumers are prompted to enter the insurance professional’s [insert name of state exchange] user identification number and national producer number on the application to show that the professional helped them.

**Drafting Note**: States should change this answer as appropriate to reflect the process in the state.

**Q 69: How does a navigator help consumers with enrollment through the [insert name of state exchange]?”**

In [insert name of state], navigators can help consumers create an account and log on to the [insert name of state exchange]. Consumers should log into their own [insert name of state exchange] account. The navigator can help consumers as needed to complete the application. Consumers may be prompted to enter the navigator’s [insert name of state exchange] user identification number on the application to show that the navigator helped them.

The navigator can help consumers to compare health plans and answer questions about health insurance policies in general. The navigator can answer questions from consumers about the differences in health plans and what they might mean for them, but the navigator **CANNOT** recommend or suggest which health plan would be best for consumers and their families. Navigators aren’t permitted to collect premium payments on behalf of an insurer or the [insert name of state exchange]. Consumers are asked to enter the navigator’s [insert name of state exchange] user identification number on the enrollment page to show that the navigator helped them.

Navigators **CANNOT** sell, solicit, or negotiate a health plan through the [insert name of state exchange]. They **CANNOT** suggest that one plan would be better for the individual than another.

**Drafting Note**: States should change this answer as appropriate to reflect the process in the state.

**Q 70: How do in-person assisters or certified application counselors help consumers with enrollment through the [insert name of state exchange]?”**

In [insert name of state], the in-person assister or certified application counselor can help consumers create an account and log on to the [insert name of state exchange]. Consumers should log in to their own [insert name of state exchange] account. The in-person assister or certified application counselor can help consumers as needed to complete the eligibility application. Consumers may be prompted to enter the in-person assister’s or the certified application counselor’s [insert name of state exchange] user identification number on the application to show that the assister or counselor helped them.
The in-person assister or certified application counselor can help consumers compare health plans and answer questions about health insurance policies in general. The assister or counselor can answer questions from the consumer about the differences in health plans and what they might mean to them (such as explaining deductibles or out-of-pocket limits), but the assister or counselor CANNOT recommend or suggest which health plan would be best for consumers and their families. Consumers are asked to enter the in-person assister’s or certified application counselor’s [insert name of state exchange] user identification number on the enrollment page to show that they helped them.

The in-person assister or certified application counselor CANNOT sell, solicit, or negotiate a health plan through the [insert name of state exchange]. They CANNOT suggest that one plan would be better for the individual than another.

**Drafting Note:** States should change this answer as appropriate to reflect the process in the state.

**Q 71: Can small employers use licensed insurance agents or brokers to buy health insurance through [insert name of state SHOP exchange]?**

Yes. Licensed insurance agents and brokers are available to help small employers compare and determine which health plan best meets their needs, like they do today. This is true whether they’re interested in buying coverage in the market outside the [insert name of state SHOP exchange] or through the [insert name of state SHOP exchange].

Licensed insurance agents and brokers are able to compare plans in the market outside the [insert name of state SHOP exchange] with those offered through the [insert name of state SHOP exchange] to decide where they can buy the plan best for them. Employers may wish to talk with more than one agent or broker before making a decision about which plan to buy.

**Q 72: May small employers use navigators to buy health insurance?**

Navigators, by law, aren’t allowed to sell health insurance unless they have an agent/broker license. Navigators are available to help small employers view plan options displayed on the [insert name of state SHOP exchange] website and can help small employers to enroll through the [insert name of SHOP exchange]. Navigators can explain the parts of the plans offered through the [insert name of state SHOP exchange] but CANNOT legally offer advice as to which plan is a better fit for the small employer. Only a licensed insurance agent or broker is qualified and allowed to offer this advice.

**Q 73: How can an insurance agent or broker help a small employer participate the [insert name of state SHOP exchange]?**

An insurance agent or broker can help any small employer, as has been true in the past. The agent or broker can help the employer decide which health insurance policy would be best for them, enroll employees in the plan, file health insurance claims, and understand the process of enrollment.

In the [insert name of state SHOP exchange], the HHS expects that insurance agents and brokers will be in contact with employers both before and after enrollment, as they will be a primary contact for customer service issues.

**Q 74: What is the benefit of using an insurance agent to enroll in the [insert name of state exchange] or the [insert name of state SHOP exchange]?**

Whether consumers are individuals or small group businesses, the insurance agent or broker can work with their needs and requirements. Agents and brokers have a working knowledge of the qualified health plans and their benefits. An agent or broker may help individual consumers or small employers create an account with the [insert name of state exchange] or [insert name of state SHOP exchange] if needed, but consumers, or a legally authorized representative, must create their own [insert name of state exchange] username and password. Consumers should not share this information with third parties, including insurance agents or brokers.

**Q 75: Will an insurance agent or broker show consumers all of the plan choices available through the [insert name of state exchange]?
In [insert name of state], agents and brokers aren’t required to show consumers all available health plans. If the consumer is using the [insert name of state exchange] website with the help of an agent or broker, then all QHP choices will be displayed. If the agent or broker goes through an insurance company portal, all plans available through the [insert name of state exchange] may not be shown, but other plans available in the market outside the exchange—that aren’t eligible for the advance premium tax credit—may be shown. Consumers should ask the insurance agent or broker if they’re being shown all of the plans available through the [insert name of state exchange] and whether tax credits or cost-sharing reductions apply to the plans they are looking at.

All agents and brokers must follow applicable [insert name of state] laws, regulations, and [insert name of state exchange] requirements, including standards related to relationships or appointments with insurance companies.

[Insert name of state] expects that the insurance agent or broker will tell consumers if the information given is about health plans with which the agent or broker has a business relationship and that consumers can always directly access the [insert name of state exchange] website. They’ll find information about other available qualified health plans there. The [insert name of state] expects that insurance agents and brokers will advise consumers to check with the [insert name of state exchange] about available tax credits or cost-sharing reductions.

**Drafting Note:** States should modify this answer if agents and brokers are required to show consumers all options available through the exchange.

**Q 76: Will consumers have to share their personal information, including their tax returns, with an agent or broker, navigator, in-person assistance personnel, or certified application counselor?**

No. A consumer shouldn’t share personal information, including tax returns, with an agent or broker, navigator, in-person assistance personnel, or certified application counselor. When consumers complete the application on the [insert name of state exchange] website with the help of an agent or broker, navigator, or assister, they should be able to fill out and submit their eligibility application without the agent, navigator, or assister in direct view of the application. While consumers applying for financial assistance are asked to enter their income, income figures from the IRS won’t be shown during the application process, whether the consumer gets help filling out the application or does it independently. In [insert name of state], after completing the registration and training, agents or brokers, navigators, in-person assistance personnel, and certified application counselors must complete and comply with a privacy and security agreement and get a user ID to use with the [insert name of state exchange].

**Q 77: Will consumers have to share their account username and password with an insurance agent or broker, navigator, in-person assister, or certified application counselor?**

No. An agent or broker, navigator, in-person assistance personnel, or certified application counselor should never ask for a consumer’s account username and password. If a consumer is asked to share a username or password, then he or she should immediately contact the [insert name of state insurance department] at [insert phone number] and discuss this with the consumer assistance representatives.

**Q 78: What help should an insurance agent or broker, navigator, in-person assister, or certified application counselor give consumers if they or their dependents are eligible for Medicaid or CHIP?**

Agents or brokers, navigators, in-person assisters, and certified application counselors will work with all consumers who ask for help with [insert name of state exchange] enrollment, including those eligible for Medicaid or CHIP. The [insert name of state exchange] will send a notice to consumers who are eligible for Medicaid or CHIP. An agent or broker, navigator, in-person assister, or certified application counselor working with these consumers is expected to refer consumers to the [insert name of state Medicaid and CHIP agency]. Agent and broker, navigator, in-person assister, and certified application counselor training will include information about where to direct Medicaid- or CHIP-eligible consumers.

Agents and brokers should be able to give consumers a referral to a navigator, in-person assister, certified application counselor, or the [insert name of state Medicaid agency]. Navigators, in-person assisters, and certified application counselors should help all consumers seeking assistance with completing an application through the [insert name of state exchange]. If the [insert name of state exchange] assesses the consumer as Medicaid- or CHIP-eligible, then the navigator, in-person...
assister, or certified application counselor may refer the consumer to the state Medicaid agency for more information. Navigators, in-person assisters, and certified application counselors often are not required to help consumers fill out a state Medicaid application if it is different from the application used by the [insert name of state exchange], but they can refer consumers to appropriate resources in those cases.

Q 79: May an insurance agent or broker continue to work with consumers once they’re enrolled in a plan through the [insert name of state exchange]?

Insurance agents and brokers may continue to communicate with consumers after they’ve enrolled in a plan through the [insert name of state exchange], as long as the communications follow any laws and regulations that apply.

The communications also must follow the privacy and security standards the [insert name of state exchange] has adopted (pursuant to 45 C.F.R. §155.260). These standards limit how an agent or broker may use any information gained to provide help and services to qualified consumers.

COSTS AND ASSISTANCE WITH COSTS

Q 80: Is there cost-sharing for contraceptives?

With the exception of health plans sponsored by certain employers that have religious or moral objections to contraception, all plans, including those offered through the [insert state name of state exchange], must cover in-network doctor-prescribed FDA-approved methods of contraception without cost-sharing.

For specific information about a plan’s contraceptive coverage, consumers should check the plan’s SBC (see Question 18) or ask their employer or benefits administrator. There’s more information about contraceptive coverage on the federal website at www.healthcare.gov/coverage/birth-control-benefits/ and www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf

Q 81: How much do plans offered through the [insert name of state exchange] cost?

There are a variety of plans intended to fit different budgets, both through the [insert name of state exchange] and in the market outside the exchange. Also, many consumers purchasing coverage through [insert name of state exchange] qualify for the premium tax credits (see Questions 84-85), which pay for part of their premium and help lower the cost of coverage.

Consumers whose incomes are below a certain amount may be eligible for a premium tax credit and a Silver plan that features lower cost-sharing and lower out-of-pocket costs (copayments, coinsurance and deductibles) without paying a higher premium. Check with the [insert name of state exchange] at [insert link] or direct the consumer to an online calculator to estimate whether they may qualify for subsidies: [https://www.kff.org/interactive/subsidy-calculator/](https://www.kff.org/interactive/subsidy-calculator/)

To see specific costs of plans offered through the [insert name of state exchange], go to [insert state exchange website], call [insert state exchange telephone number], or talk to a navigator, certified application counselor, in-person assister, insurance agent or broker, or other assister. (See Question 61.)

Q 82: Do plans offered through the [insert name of state exchange] have large out-of-pocket costs?

The health insurance plans available through the [insert name of state exchange] feature a variety of out-of-pocket costs for consumers. But, the ACA requires that all non-grandfathered plans (including most plans that people get from an employer) limit consumers’ annual out-of-pocket costs for in-network essential health benefits (EHB) services to no more than $8,700 for individuals and $17,400 for families in 2022. These maximum out-of-pocket amounts will go up in future years. However, out-of-network services do not count toward these limits on annual out-of-pocket costs. (See Question 27.) There are separate out-of-pocket maximums for stand-alone dental plans.

Plans are required to cover certain preventive services without cost-sharing. (See Question 24.) Also, consumers whose incomes are below a certain amount may be eligible for a premium tax credit and a Silver plan, which features lower cost-sharing and lower out-of-pocket costs (copayments, coinsurance and deductibles) without paying a higher premium. Check
with the [insert name of state exchange] at [insert link] or direct the consumer to an online calculator to estimate whether they may qualify for subsidies: https://www.kff.org/interactive/subsidy-calculator/

Navigators, certified application counselors, in-person assisters, agents or brokers, or other assisters should be able to help consumers learn if they qualify. Also, the exchange application tells consumers whether they might be eligible for Medicaid or CHIP programs, which have very limited out-of-pocket costs.

Q 83: Where can consumers inquire to learn if they’re eligible for help paying premiums or for Medicaid?

Consumers may apply with the [insert name of state exchange] or the [insert name of state Medicaid agency]. The [insert name of state exchange] determines eligibility for advance payments of premium tax credits and cost-sharing reductions. The [insert name of state exchange] also assesses Medicaid and CHIP eligibility and makes a referral, if appropriate, to the [insert name of state Medicaid agency] for a final determination.

Consumers also may apply directly with the [insert name of state Medicaid agency]. The [insert name of state Medicaid agency] will enroll eligible consumers in Medicaid or CHIP, or send their information to the [insert name of state exchange] to determine their eligibility for advance payments of the premium tax credit and cost-sharing reductions if they aren’t eligible for Medicaid or CHIP.

Drafting Note: States with a different process will need to modify this answer accordingly.

Q 84: Is there help for consumers who can’t afford coverage?

Yes, consumers with low or moderate incomes can qualify for reduced costs, through Medicaid, CHIP, or exchange coverage, but eligibility rules apply. Most states use federal government funds to expand Medicaid so that it covers adults with an income at or lower than 138% of the federal poverty level. In 2022, that is roughly $17,800 for a family of one and $36,400 for a family of four. Consumers should contact the [insert name of state exchange] or the [insert name of state Medicaid agency] directly if they think they might be eligible for Medicaid.

In [insert name of state], children may be able to get coverage through Medicaid or CHIP programs for which their parents aren’t eligible. Some families may find it more affordable to enroll their children in Medicaid or CHIP and buy coverage for the parents through the exchange.

Drafting Note: States may need to modify the answer to this question depending on the state’s decisions regarding Medicaid expansion.

Q 85: Who’s eligible for premium tax credits and cost-sharing reductions?

The ACA created premium tax credits and cost-sharing reductions to help cut costs for eligible consumers who buy a plan through the [insert name of state exchange]. (See Question 84.) The amount of the tax credit or cost-sharing reduction depends on family size and income and varies on a sliding scale: Larger families and families with lower incomes get the most help. Tax credits and cost-sharing reductions aren’t available for individuals who are eligible for Medicaid, CHIP, Medicare, or qualifying employer-sponsored coverage. Consumers who forget to update the [insert name of state exchange] about changes in their eligibility for other coverage might owe money at tax time. More information about tax credits and cost-sharing reductions is available at www.healthcare.gov

This link allows consumers to estimate how much financial help is available for them: www.healthcare.gov/lower-costs/qualifying-for-lower-costs/

Q 86: How do premium tax credits to buy coverage through the [insert name of state exchange] work?

Consumers who qualify for premium tax credits can either receive them in advance, or they can wait until they file their taxes. The advance payment is sent to the insurance company that offers the plan the consumer has chosen and is used to
reduce the monthly insurance premium. Consumers also have the choice to wait to receive their tax credits until they file their federal income tax return. They also can use just part of their estimated tax credit in advance.

Consumers who want to use their tax credit in advance need to be as accurate as possible to estimate how much income they expect to have in the year they get coverage. If they underestimate their income and the tax credit is overestimated, then they may have to repay part of their tax credit at tax time.

Consumers need to update the [insert name of state exchange] during the year about any changes in income, family size (like having a baby), employment (like getting a job where health coverage is offered), or becoming eligible for Medicare. The [insert name of state exchange] will change the tax credit amount to reflect the new information. Consumers who forget to update the [insert name of state exchange] about such changes might owe money at tax time or realize they could have been using a larger tax credit amount in advance.

Consumers who don’t use the tax credit in advance don’t have to tell the [insert name of state exchange] about any changes to their income or employment during the year. They can get the tax credit on their tax returns.

Consumers may go to the [insert name of state exchange] website at [insert link] or call the [insert name of the state exchange] at [insert telephone number] for more information about tax credits. Navigators, certified application counselors, in-person assisters, agents or brokers, or other assisters also are able to give consumers information about the tax credit. There’s more information about premium tax credits on the federal website www.healthcare.gov.

Q 87: Is an individual who is a victim of domestic abuse and separated (but not divorced) from his or her spouse eligible for subsidies on the exchange?

Yes. In general, married couples must file a joint tax return in order to be eligible for a premium tax credit and cost-sharing reductions. For victims of domestic abuse, however, contacting their spouse to file a joint return may present a risk and may be legally prohibited if a restraining order is in place. As a result, married individuals who are victims of domestic abuse may still be eligible for subsidies if they are living separately from their spouse. Consumers in this situation should list “unmarried” on their exchange application and can do that without fear of penalty for misstating their marital status. For more information, see www.healthcare.gov/income-and-household-information/household-size or www.irs.gov.

Q 88: If a consumer is eligible for premium tax credits, is there a grace period before a company can terminate the consumer for non-payment of premiums?

Yes. The ACA requires insurance companies to give enrollees who receive premium tax credits a 90-day grace period for non-payment of premiums before the policy can be terminated, provided the enrollee has paid at least one month’s premium. Claims must be paid during the first 30 days of the grace period, but the insurer may suspend payments to providers during the remainder of the grace period. In order to keep coverage at the end of the grace period, a consumer’s account must be fully paid within 90 days of missing a premium payment. For example, a consumer who misses a payment in July but makes payments in August and September will be terminated in October if he or she has not also paid the missing payment from July. And, a company may deny coverage in the next year if the consumer is in the grace period. For example, a consumer who misses a payment in November and December may be denied coverage in January if they haven’t paid premiums due the year before.

Drafting Note: States should review their laws for other grace periods that might apply.

Q 89: What should consumers do if they find themselves enrolled in both exchange coverage with premium tax credits and Medicaid, CHIP, or Medicare?

The [insert name of exchange] conducts periodic data matching to identify individuals enrolled in both private insurance with premium tax credits and Medicare or private insurance with premium tax credits and Medicaid/CHIP and sends notices to those consumers. Upon receiving the notice, consumers may end their exchange coverage with premium tax credits by contacting the exchange.
When individuals become eligible for Medicaid, CHIP, or Medicare while enrolled in an exchange plan, they will no longer be eligible for any premium tax credits or cost-sharing reductions. If a consumer wants to maintain exchange coverage while enrolled in Medicaid or CHIP, they will have to pay the full premium. Private plans generally may not cover an individual for the same benefits covered by Medicare, so people who become eligible for Medicare while enrolled in [insert name of exchange] should immediately notify the exchange to end their coverage and enroll in Medicare.

A consumer who wants to maintain exchange coverage while enrolled in Medicaid/CHIP may apply for coverage without financial assistance during the annual open enrollment period or a special enrollment period (SEP). Consumers who are no longer enrolled in Medicaid/CHIP or the exchange with premium tax credits after the data match don’t need to do anything else. However, they might opt to contact their state Medicaid or CHIP agency to confirm that they aren’t enrolled. Consumers who are enrolled in both Medicaid/CHIP and private insurance with premium tax credits should end exchange coverage with premium tax credits, because consumers determined eligible for Medicaid/CHIP aren’t eligible for exchange coverage with premium tax credits or cost-sharing reductions.

When a consumer is enrolled in exchange coverage with premium tax credits or cost-sharing reductions and simultaneously covered by Medicaid, CHIP, or Medicare, the consumer likely will have to pay back all or some of the tax credits received for the months after they were determined to be eligible for Medicare or Medicaid/CHIP. Consumers who receive the notice but have more recently been denied eligibility for Medicaid or CHIP do not need to take any further action with [insert name of state exchange], but they may want to contact their state Medicaid or CHIP agency to confirm that they’re not enrolled.

QUESTIONS ABOUT OTHER TYPES OF COVERAGE

Q 90: What is available in the market outside the [insert name of state exchange]?

In [insert state name], health insurance coverage is also available in the market outside the [insert name of state exchange]. However, if consumers want to take advantage of premium tax credits to help pay for part of their premiums or for cost-sharing assistance, then they must buy coverage through the [insert name of state exchange]. (See Question 84 and Question 85.)

Consumers may buy plans in the market outside the exchange that aren’t required to cover the essential health benefits (EHB), such as fixed indemnity plans, short-term policies, or insurance coverage and discount plans that include only specialty or ancillary services (for example, hearing, chiropractic, etc.) Note, though, that these policies don’t have to comply with ACA reforms such as the requirement that plans cover pre-existing conditions. (See Question 4.) The NAIC has some resources discussing these types of plans:

https://www.naic.org/documents/consumer_alert_health_sharing_ministries.htm

Contact [insert state Department of Insurance contact] or an insurance agent or broker for help.

Q 91: What are short-term plans?

Under federal law, short-term plans are those with an initial term of no more than 364 days that include a statement describing potential coverage limitations. Short-term plans may be renewed at the option of the insurer, but the same policy may only be in effect for up to three years in total. Short-term plans are not required to comply with many of the consumer protections of the ACA. For instance, they may charge different premiums based on an applicant’s health conditions, exclude essential health benefits, and exclude coverage for pre-existing conditions.

Drafting note: States with their own regulations on short-term plans should add a statement that describes allowable short-term plans, including duration restrictions, rating requirements, or benefit mandates.

Q 92: If consumers already have coverage, may they buy separate policies for their children?

Consumers who already have coverage for themselves are eligible to buy a policy for a child through the [insert name of state exchange]. The ACA requires that any health plan offered through the exchange also must be offered as a child-only plan at the same tier of coverage. Consumers also may be eligible for tax credits for child-only plans they buy through the [insert
name of state exchange]. Visit the [insert name of state exchange] website at [insert website for the state exchange] for more information about child-only plans available through the [insert name of state exchange].

However, children who aren’t legal residents of the United States aren’t eligible for child-only plans through the [insert name of state exchange]. Consumers may be able to buy a child-only policy in the market outside the [insert name of state exchange], either directly from an insurer or through an agent or broker. For a list of licensed insurers in [insert name of state], visit the [name of state department of insurance] website at [insert link]. A child also may be eligible for Medicaid (contact [insert name of state Medicaid agency] at [insert contact information]) or coverage through [insert state Children’s Health Insurance Program (CHIP)]. To learn more about CHIP plans, visit www.insurekidsnow.gov.

**ACA MEDICARE-RELATED QUESTIONS**

**Q 93: Who should consumers contact with questions about Medicare, Medicare Supplement insurance, or Medicare Advantage Plans?**

Medicare coverage, Medicare Supplement insurance (Medigap), and Medicare Advantage plans aren’t available through the [insert name of state exchange]. Consumers who are currently enrolled in Medicare may not buy coverage through the exchange. Enrollees who are enrolled in Medicare because of end stage renal disease (ESRD) can enroll in a Medicare Advantage plan beginning in 2021. Questions involving the ACA and Medicare, Medicare Supplement insurance, or Medicare Advantage Plans can be referred to [insert name of State Health Insurance Program (SHIP)] at [insert contact information]. The federal government’s Medicare website, www.medicare.gov, also has more information about health reform and Medicare changes.

**Q 94: Are people who pay premiums for Medicare Part A able to enroll through the [insert name of exchange]?**

Individuals who aren’t entitled to premium-free Medicare Part A may buy coverage through [insert name of exchange] instead of paying the Part A premium and being enrolled in Part A, and they may also be eligible for a tax credit. This includes those beneficiaries who only enrolled in Medicare Part B because they couldn’t afford the Part A premium. In both cases, these beneficiaries must disenroll from Medicare Part A, if they have it, and from Medicare Part B, if they have it. There are consequences to substituting a qualified health plan (QHP) for Medicare. Consumers may pay higher premiums for Medicare if they decide to enroll in Medicare in the future and may have a gap in benefits. The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about their choices.

**Q 95: Can a person with ESRD (End Stage Renal Disease) enroll in or stay in an Exchange plan instead of enrolling in Medicare?**

If a consumer with ESRD has not applied for Medicare, then she or he can stay in or apply for coverage through the [insert name of exchange]. However, there are consequences of delaying Medicare benefits. Individuals with ESRD may not be eligible for certain Medicare benefits if they enroll in Medicare in the future, may pay a higher premium for late enrollment, or may have a delay in benefits when they begin. The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about these complex choices.

**Drafting Note:** Medicare beneficiaries with ESRD can enroll in Medicare Advantage Plans.

**Q 96: If individuals become eligible for Medicare and are already in a QHP, can they stay in their plan?**

A person who stays in a QHP* and is eligible for or enrolled in Medicare is no longer eligible to receive any tax credits. If the consumer has been receiving an advance premium tax credit, then the consumer must report eligibility for Medicare to the [insert name of state exchange] to end the tax credit. A consumer who does not do this will be liable to repay the tax credits for which they were not eligible.

Without the enrollee’s authorization, a QHP may not terminate coverage from a policy in which the individual was enrolled upon becoming eligible for Medicare. However, a QHP is not designed to coordinate its benefits with Medicare. Both the premium and the benefits of a QHP are designed to provide primary coverage, not supplemental coverage. Depending on state law, a QHP may reduce its benefits to pay covered expenses that remain after Medicare pays, but the premium will stay...
the same. This may happen even if the individual does not sign up for Part B of Medicare. Consumers are encouraged to enroll in Medicare when they are eligible to avoid premium penalties and delayed benefits later. The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about how and when to enroll in Medicare and any penalties that can apply.

*Note that this information (except for the tax credit) applies to individual coverage inside and outside an exchange.

Q 97: Is there anything consumers and their dependents who are already on Medicare and have employer-based coverage need to do because of the ACA?

Generally, there’s nothing consumers need to do because of the ACA if they’re already on Medicare and have employer-based coverage. If consumers have coverage through a large employer and that employer’s current benefits pay first and Medicare pays second, then the ACA didn’t change that.

If the employer changes the benefits that cover consumers or their dependents, then they will send consumers a notice about those changes. Consumers can ask their employer’s human resources department how those changes work with Medicare.

The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about how their existing coverage works with Medicare.

Q 98: Is there anything consumers and their dependents who are already on Medicare and have retiree coverage from an employer need to do because of the ACA?

The ACA didn’t change retiree benefits. Consumers should contact their employer’s human resources department for help. Consumers who need more information about how Medicare and retiree benefits work together can contact the SHIP at [insert contact information].

Q 99: Will consumers with Medicare Supplement insurance be affected by the ACA?

No. The ACA doesn’t change the cost-sharing for Medicare supplement policies.

Q 100: How will consumers’ Medicare prescription drug “donut hole” be affected?

The ACA began closing the “donut hole” in 2011, and it was closed entirely effective for 2019. The donut hole was closed by combining a discount on the cost of brand-name drugs and a gradual increase in the share of prescription drug costs for both generics and brand name drugs that the Medicare Part D plan pays, until a beneficiary only owes 25% of the total cost. In the standard plan, Medicare beneficiaries whose prescription drug costs are greater than the Part D deductible will need to pay only a 25% coinsurance rate (after meeting the plan’s deductible, if any) until their expenditures reach the catastrophic level. In other plans, cost-sharing may vary.

For more information, contact Medicare at www.medicare.gov or 1-800-MEDICARE or the [insert name of SHIP] at [insert contact information].

Q 101: What about long term care (LTC) insurance policies?

The [insert name of state exchange] doesn’t include long term care (LTC) insurance policies, and policies sold on the [insert name of state exchange] don’t typically cover LTC services. Insurance agents and brokers still sell LTC insurance outside the exchange. The HHS website https://acl.gov/ltchas information about LTC insurance and the NAIC has produced a Shopper’s Guide available at https://www.naic.org/documents/prod_serv_consumer_ltc_lp.pdf
ACA MEDICAID-RELATED QUESTIONS

Q 102: Where can consumers find more information about Medicaid?

Contact the [insert name of state Medicaid agency] at [insert contact information] with any questions or concerns about Medicaid and the ACA. Also, the HHS website has basic information about Medicaid posted at www.healthcare.gov.

Q 103: Did consumers’ eligibility for Medicaid change under the ACA?

The ACA provides funds for states to expand their eligibility for Medicaid. Childless adults with income below 138% of the federal poverty level generally were not eligible for Medicaid prior to the ACA. Most states have used ACA funds to open eligibility to this group. The pre-ACA Medicaid eligibility categories continue to be eligible for Medicaid, although the financial method to decide eligibility has changed. Medicaid-eligible consumers include children, pregnant women, parents (or other caretaker relatives), blind, disabled, or elderly, and they still need to meet the financial eligibility test set by [insert name of state]. Contact the [insert state Medicaid agency] at [insert contact information] for more information.

Drafting Note: States that have not expanded Medicaid should modify this answer as appropriate.

There is more information about who is eligible for Medicaid and the Children’s Health Insurance Program at this link: https://www.healthcare.gov/medicaid-chip/.

Q 104: What is the expanded Medicaid eligibility category under the ACA?

Adults who weren’t eligible for Medicaid in the past may be eligible under the ACA. [Insert name of state] has decided to expand Medicaid coverage to new groups, now covering childless adults with household income under 138% of the federal poverty level. Contact the [insert name of state Medicaid agency] at [insert contact information] for more information.

Drafting Note: States that have not expanded Medicaid will need to revise this answer accordingly.

There is more information about who is eligible for Medicaid and the Children’s Health Insurance Program at this link: https://www.healthcare.gov/medicaid-chip/.

Q 105: What is the federal poverty level (FPL), and why is it important in the context of health care coverage?

The FPL is how the federal government defines poverty, and it’s used to decide who’s eligible for federal subsidies and entitlement programs. In states that expanded Medicaid, childless adults under 65 with incomes up to 138% of the FPL (or about $36,000 for a family of four) generally can get Medicaid coverage. Children, parents, pregnant women, seniors, and people with disabilities have different income limits. People with incomes above these levels may be eligible for premium tax credits to help them buy a plan through the [insert name of state exchange]. Cost-sharing reductions are available until a family’s income reaches 250% of the FPL. Individuals who are eligible for both Medicare and Medicaid, or whose incomes don’t exceed certain amounts, may be eligible for one of several low-income programs to supplement their Medicare benefits. The [insert name of SHIP] at [insert contact information] should be able to give consumers more information about their eligibility for these low-income programs.

Drafting Note: States that didn’t expand Medicaid will need to revise the previous paragraph accordingly.

This link has general information about income levels at which financial help or coverage is available, as well as what counts as income: www.healthcare.gov/lower-costs/qualifying-for-lower-costs/.

Q 106: What benefits are available for childless adults eligible for Medicaid?

Each state that expanded Medicaid has defined the benefit package for this newly-eligible group. The benchmark benefit package needs to at least include the essential health benefits (EHB) available through the [insert name of state exchange]. (See Question 16.) Contact the [insert name of state Medicaid agency] at [insert contact information] for more information.
Q 107: Are undocumented immigrants eligible for Medicaid?

Undocumented immigrants are not eligible for most categories of Medicaid coverage, but may receive services in emergency circumstances.

Q 108: How do consumers apply for Medicaid?

Consumers can apply online through the [insert name of state exchange]. They also can apply by mail, fax, or in person. If a consumer applies through the [insert name of state exchange], then his or her eligibility for Medicaid also will be assessed, and the consumer’s application will be transferred to the [insert name of state Medicaid agency] for final determination. Under the law, there’s “no wrong door” to apply for health coverage, whether it’s through [insert name of state Medicaid agency], CHIP, or the [insert name of state exchange]. If a consumer isn’t eligible for Medicaid, then the consumer’s eligibility for coverage through the [insert name of state exchange] and for premium tax credits or cost-sharing reductions will be evaluated.

Q 109: Will consumers still need to submit documents to prove their income?

As much as possible, the [insert name of state exchange] uses existing data sources or gets information from various federal and state agencies, such as the IRS, to verify income. The rules are designed to ensure a high degree of program integrity and reduce the amount of paperwork that consumers need to provide.

Some consumers will be asked to provide documents to prove their income. There are separate processes to verify income to qualify for Medicaid and CHIP and for premium tax credits and cost-sharing reductions. To verify income for Medicaid, CHIP, premium tax credits, and cost-sharing reductions, [insert name of state exchange] will use data from the IRS, the Social Security Administration (SSA), and other income data sources.

For Medicaid and CHIP, issues that come up about verifying income will be resolved through a process of explanations and documentation. For premium tax credits and cost-sharing reductions, most verification issues will be resolved through a process of explanations and documentation. But, to limit the administrative burden, the [insert name of state exchange] may use a sample-based review in some cases.

COMMON CONCERNS ABOUT HOW THE ACA AFFECTS CONSUMERS

Q 110: Does the ACA eliminate private health insurance?

No. There is still private health insurance under the ACA. The ACA created health insurance exchanges (see Questions 5-6) where consumers can compare and shop for private insurance plans. The ACA also sets many new federal rules and protections that apply to people who buy private health insurance in each state. (See Questions 2 and 4.)

Q 111: Does the ACA include rules about insurance premiums?

For individual and small group health insurance market plans covered by the ACA’s rating rules, premiums may only vary based on an individual’s age, the area of the state in which the policy is sold, tobacco use, and family composition. For covered plans, these are the only factors that an insurance company can use when it sets premiums. Covered plans can’t refuse to insure or charge higher premiums to consumers with medical problems. The ACA also reduces the difference in premiums covered plans charge for younger and older people and eliminates differences between premiums charged for men and women. These rating rules cover individual and small group health plans offered through the exchanges or outside of them, but do not apply to short-term, limited duration plans.

To help make coverage affordable, many consumers who buy qualified health plans through the individual market exchanges are eligible for premium tax credits. Also, consumers under age 30 or who obtain a hardship exemption may be eligible to buy catastrophic plans, which cost less.
Drafting Note: States may want to link to rate submissions and final approvals. States that don’t allow the tobacco surcharge or use a different ratio than 1.5:1 should note that health insurance companies are prevented from charging consumers a higher premium for being a tobacco user or are limited in the amount of tobacco surcharge they can apply.

Q 112: Does the ACA address discrimination?

ACA explicitly prohibits insurance companies from discriminating on the basis of race, color, national origin, sex, age, or disability.

Section 1557 of the ACA prohibits discrimination by any health program or activity receiving funds from HHS. The scope of this prohibition was first outlined via final rule in 2016, which broadly defined the areas of prohibited discrimination. Gender identity was a controversial inclusion in the rule. On June 12, 2020, a final rule was published that changed the 2016 regulations to limit the applicability. One of the changes in the 2020 rule was to remove the prohibition on discrimination based on gender identity. On June 15, 2020, the U.S. Supreme Court held that discrimination on the basis of sex included discrimination based on gender identity. HHS announced that effective May 10, 2021, it would interpret and enforce § 1557’s prohibition on discrimination to include discrimination based on sexual orientation and gender identity.

Health insurers, however, must follow any state laws and regulations that apply to marketing and can’t use marketing practices or benefit designs that will discourage individuals with significant health needs from enrolling. Health insurers must also provide meaningful access for individuals with limited English proficiency and post taglines in the languages spoken by persons with limited English proficiency.

Insurance companies won’t pay for services not covered by a plan, such as care that isn’t medically necessary. Consumers have the right to ask their insurance company to reconsider a decision to deny coverage and, after that, consumers have the right to an independent external review of the decision. (See Question 117.)

Q 113: What are the income tax implications of the ACA?

The [insert name of department of insurance] does not interpret or enforce obligations under the tax code. Consumers can contact the IRS or their tax advisor for information.

Q 114: Where else can consumers find answers to health insurance questions?

[Insert links to State DOI, Exchange, Medicaid, navigator organizations, etc.]

Q 115: What does the health plan “accreditation status” information on the exchange website mean?

Accreditation is a comprehensive process by private, nonprofit organizations that review how well health plans deliver care and how they work to improve the delivery of care over time. Health plans offered through the [insert name of state exchange] must be certified by a recognized accrediting body, such as URAQ and/or the National Committee for Quality Assurance (NCQA).

Part of the certification requires that the plan is accredited by a recognized accrediting entity within a time frame set by the [insert name of state exchange]. Accreditation ensures that the plans sold on the [insert name of state exchange] meet minimum quality, access, nondiscrimination, and marketing standards in the ACA.

Q 116: What does the health plan “consumer experience” information on the [insert name of state exchange] website mean?

Consumer experience ratings come from surveys that ask individuals who have coverage through a health insurance plan how they like the plan. These individuals also rate the quality of the medical care they receive and the accessibility of the medical care that they need.
Q 117: What appeal rights do consumers have?

Consumers have a right to appeal an unfavorable coverage decision by their health insurance company. Insurance companies must give consumers owning an individual policy a first-level internal appeal, administered by the company, and if the company upholds its initial unfavorable coverage decision, then it must provide an external review administered by an independent third party. Consumers in individual policies may also be able to request a voluntary second-level internal appeal. However, those two levels of internal appeals must also be done within the time limit imposed by the law for all internal appeal process, whether one or two levels. Expedited review for emergency situations is available. For group policies, the insurance company may require two levels of internal appeals before the external review option. For more information about how to appeal a health insurance company’s unfavorable coverage decision (often referred to an Explanation of Benefits, or EOB), plan or policy documents, or contact [insert state insurance department] at [insert telephone number].

Consumers also can file complaints with [insert name of state insurance department] when claims are denied, or when they believe that their health insurance company isn’t properly following the legal appeals process. Consumers can contact the state insurance department at [insert contact information].

Note that there is a separate appeals process if a consumer is dissatisfied with an eligibility decision made by [insert name of state exchange]. The consumer can contact [insert name of state exchange] for more information.

Q 118: Where do consumers file a complaint for a product sold through the [insert name of state exchange]? What about plans sold in the market outside the [insert name of state exchange]?

Consumers should first contact the insurance company with any complaint about benefits or services they’re not receiving. If consumers aren’t satisfied, they should contact the [insert name of state exchange] for help with questions or complaints.

The [insert state department of insurance] investigates complaints about insurance companies and can either look up consumers’ complaints or direct consumers to the right place to file a [insert name of state exchange] related complaint. The [insert state insurance department] is ready to help consumers with any question or complaint they may have about their coverage. To find out more about filing appeals, consumers can contact the [insert state department of insurance] at [insert contact information].

Q 119: If consumers apply for coverage in the market outside the [insert name of state exchange], what are the rules regarding open and special enrollment?

In [insert name of state], insurance companies sell policies in the market outside the exchange. Enrollment periods for coverage outside the [insert name of state exchange] generally are the same as enrollment periods through the exchange. (See Question 11.) Contact the [insert name of state department of insurance] at [insert contact information], or an insurance agent or broker for more information about enrollment.

If someone is not eligible to enroll in health coverage through the [insert name of state exchange] or does not want to enroll in coverage through the [insert name of state exchange], insurers must make policies available in the [insert name of state exchange] available outside the [insert name of state exchange], although the policies aren’t required to be marketed as available outside the [insert name of state exchange].

For more information about special enrollment periods (SEPs), see this link: https://www.healthreformbeyondthebasics.org/sep-reference-chart/

QUESTIONS INVOLVING SPECIAL CIRCUMSTANCES AND POPULATIONS

Q 120: What is available for consumers with chronic conditions? Does the ACA help them get better coverage?

Yes. All plans subject to the ACA must insure consumers with a chronic or pre-existing medical condition, must cover pre-existing conditions, and can’t charge higher premiums because of a health or medical condition. They are also required to offer comprehensive coverage. Discrimination on the basis of age, disability, or expected length of life is prohibited.
Coverage for these benefits is available from the beginning of the policy coverage period, without a waiting period, even if there was no prior coverage. Many plans include wellness programs to help consumers manage chronic conditions.

Q 121: What options are there for consumers with children who aren’t citizens or legal residents?

Consumers won’t be able to buy a policy through the [insert name of state exchange] for those children who aren’t lawfully present, but they may be able to buy a policy directly from an insurance company or through an agent. Insurers that sell policies through the exchange must make those policies available upon request to individuals, including children, who are not eligible to participate in the [insert name of state exchange]. For a list of licensed insurance companies in [insert name of state], visit [insert link]. Lawfully-present children also may be eligible for [insert name of state Medicaid and CHIP]. To learn more about these plans, go to www.insurekidsnow.gov

Q 122: Are immigrants not legally present eligible for coverage through the [insert name of state exchange] or for premium tax credits?

No. Immigrants not legally present aren’t eligible for coverage through the [insert name of state exchange]. They also aren’t eligible for advance payment of premium tax credits. Insurers that sell policies through the exchange, however, must make those policies available upon request to individuals, including children, who aren’t eligible to participate in the [insert name of state exchange].

Q 123: Are incarcerated people eligible for coverage through the [insert name of state exchange] or for premium tax credits?

No. Incarcerated people generally aren’t eligible for coverage through the [insert name of state exchange]. They also aren’t eligible for advance payments of the premium tax credits. Consumers who are incarcerated pending the disposition of charges are eligible. Insurers that sell policies through the exchange must make those policies available upon request to individuals, including children, who are not eligible to participate in the [insert name of state exchange].

Q 124: Are tribal members eligible for coverage through the [insert name of state exchange] or for premium tax credits?

Yes. Tribal members may buy coverage through the [insert name of state exchange]. Tribal members have access to enrollment continuously. They’re also eligible for premium tax credits. And, because of the federal government’s special trust responsibility, members of federally-recognized Indian tribes are eligible to receive benefits not available to others, such as plans with no cost-sharing, under certain circumstances. For more information, go to www.healthcare.gov or the website for the Indian Health Service (IHS) agency within the HHS at www.ihs.gov/

QUESTIONS ABOUT MLR

Q 125: What is the Medical Loss Ratio (MLR) requirement?

The ACA’s MLR requirement is that health insurers must spend at least a certain percentage of consumers’ premium dollars on direct medical care and health care quality improvement. The MLR limits the amount of premium dollars spent on administrative expenses, such as overhead, marketing, salaries, and profit.

The ACA requires that health insurance companies providing coverage in the large employer market (usually 50 or more employees) must spend at least 85% of premiums on direct medical care and quality improvement activities. Health insurers who provide coverage in the small employer market (usually fewer than 50 employees) and individual market must spend at least 80% of premiums on direct medical care and quality improvement activities, or they must rebate (refund) the extra premium.

Q 126: What is an MLR Rebate?
Under federal law, if a health insurer doesn’t meet the MLR target (described in Question 125), then that health insurer must give consumers or employers a rebate for the amount of premiums it collected that was greater than the target.

**Q 127: How can consumers learn if their insurer paid rebates?**

Companies that pay rebates send notices to enrollees. The list of the rebates paid can be found at www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html

**QUESTIONS ABOUT WHETHER A PLAN ISLEGITIMATE**

**Q 128: Why is this a time to be especially on guard against health insurance fraud?**

Health insurance rules and regulations are constantly changing. Con artists posing as representatives of the federal government or posing as legitimate insurance agents, brokers, or navigators might try to steal consumers’ money, identity, or health information through various health insurance schemes. For instance, criminals might try to convince consumers to reveal personal information to receive a “national health insurance card” or a new Medicare card under the ACA. Or they may also try to sell consumers health insurance policies that are fake, worthless, or not what they claim to be. These scams are often attempted through automated telephone calls or websites that mimic legitimate sites.

**Q 129: Can consumers get help from their current insurance agent or insurance company to buy health insurance coverage through the [insert name of state exchange]?**

Yes. Working with individuals known personally or known to be working for a licensed agency or company is a dependable way to avoid fraud.

**Q 130: If consumers don’t have a relationship with an insurance agent or company, where should they go for help?**

When consumers contact the [insert name of state exchange], they’ll have the option to contact a navigator specifically trained to help them choose the best health insurance product for their needs.

**Drafting Note:** States without navigators should update this response to provide alternate sources for consumer assistance.

**Q 131: If someone comes to consumers’ homes, calls consumers out of the blue, or sends emails to offer consumers health insurance coverage for a terrific premium, how will consumers know whether the person and the health insurance coverage are legitimate?**

Remember this simple formula: **STOP – CALL – CONFIRM.**

**STOP –** Consumers should ask the person for identification and a phone number where they may be reached later. If the person refuses to give this information for any reason, or tries to pressure them into signing any document, then consumers should immediately hang up, close their door, or walk away.

Consumers should NOT volunteer their Social Security number (SSN) or a credit/debit card number to anyone unless they personally know the individual. Likewise, they should NOT sign any paperwork or write a check.

**CALL –** Consumers then should contact the [insert name of state department of insurance] or the [insert name of state exchange]. The insurance company or agent or broker, as well as the navigator, must be registered or licensed with the [insert state department of insurance] before they can sell coverage or counsel consumers through the [insert name of state exchange].

**Drafting Note:** States should modify the previous paragraph as necessary to reference the entity charged with registering or licensing navigators.
CONFIRM – Consumers should always confirm that the company, agent, or broker offering insurance coverage, or the navigator trying to providing assistance, is authorized to provide information or coverage before they sign any documents or give any personal information.

Remember that if something seems too good to be true, it usually is.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Oct. 14, 2021. The following Subgroup members participated: Mary Kwei, Chair, and Paul Meyer (MD); Debra Judy, Vice Chair (CO); William Rodgers (AL); Kristen Finau, Kathy McGill, Randy Pipal, Weston Trexler, and Fernanda Vallejo (ID); Michelle Baldock (IL); Alex Peck (IN); LeAnn Crow, Chris Hollenbeck, Tate Flott, and Brenda Johnson (KS); Judith Watters (ME); Candace Gergen, Gregory Maus, and Sherri Mortensen-Brown (MN); Carrie Couch, Amy Hoyt, and Jo LeDuc, (MO); Cuc Nguyen, Mike Rhoads, and Rebecca Ross (OK); Gretchen Brodkorb and Jill Kruger (SD); Brian Hoffmeister, Bill Huddleston, Scott McAnally, Jennifer Ramcharan, and Vickie Trice (TN); and Eric Cormany, Darcy Paskey, Jennifer Stegall, and Julie Walsh (WI). Also participating was: Patrick Smock (RI).

1. **Discussed “Frequently Asked Questions About Health Care Reform”**

Ms. Kwei said the NAIC’s Communications Department created branded versions of the claims guides the Subgroup previously approved, and they are available on the NAIC website. She thanked the Subgroup members who contributed edits to “Frequently Asked Questions About Health Care Reform,” as well as Brenda J. Cude (University of Georgia) for reviewing the document. She said Ms. Cude had two outstanding questions about the document. The Subgroup discussed whether the use of the term “excepted benefits” was clear, and it decided it is an appropriate term because the document is intended for state insurance regulators. The second question was regarding the term “applicable large employer.” The Subgroup discussed whether all large employers are applicable large employers and how often department of insurance (DOI) staff are called to respond to questions about them. It considered adding a link to Internal Revenue Service (IRS) information or adding an additional question to the document that defines “applicable large employer.”

Ms. Kwei asked whether Subgroup members or interested parties had other comments or edits on “Frequently Asked Questions About Health Care Reform,” and no one offered any. The Subgroup decided to conduct a vote to approve “Frequently Asked Questions About Health Care Reform” by email.

2. **Discussed a Consumer Brief on Balance Billing**

Ms. Kwei brought up balance billing and the federal No Surprises Act (NSA). She said previous Subgroup discussions have concluded that there is not yet enough information available to develop a useful document for consumers. She said the Health Insurance and Managed Care (B) Committee discussed overall education on the NSA, including materials targeted at consumers, insurers, and providers.

Ms. Kwei asked if any states have been working on consumer information on either state or federal balance billing protections and whether the Subgroup could offer any helpful assistance. No members or interested parties made suggestions.

Ms. Kwei said the Committee is working on a template that state DOIs could use to educate providers on the coming effective date of the NSA. She suggested that the Subgroup could develop a similar template that states could use for consumers. Ms. Cude said consumers are expected to have many questions about the NSA protections, so materials would be helpful.

Ms. Kwei suggested that the Subgroup develop a very simple document on balance billing, including scenarios of what could happen and what consumers can do to respond to certain situations. Ms. Cude said documents should help consumers apply knowledge, not just provide definitions. Subgroup members agreed that a scenario-based approach would be helpful. Kris Hathaway (America’s Health Insurance Plans—AHIP) said AHIP has developed a one-pager on balance billing protections, and she said she would share it.

The Subgroup decided that it should develop draft materials by late November, circulate them, and aim to finalize materials by mid-December. The materials would be for consumer use, not targeted to insurance department staff.

Having no further business, the Consumer Information (B) Subgroup adjourned.
Consumer Information (B) Subgroup
Virtual Meeting
August 24, 2021

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Aug. 24, 2021. The following Subgroup members participated: Mary Kwei, Chair, and Paul Meyer (MD); Debra Judy, Vice Chair (CO); Yada Horace, William Rodgers, and Anthony L. Williams (AL); Kathy McGill, Randy Pipal, and Weston Trexler (ID); Ryan Gillespie (IL); Jenifer Groth (IN); LeAnn Crow, Tate Flott, and Tom Treacy (KS); Judith Watters (ME); Carrie Couch, Amy Hoyt, Jo LeDuc, Jessica Schrimpf, and Michelle Vickers (MO); Tracy Biehn and Kathy Shortt (NC); Martin Swanson (NE); Landon Hubbart and Rebecca Ross (OK); David Buono and Elizabeth Hart (PA); Candy Holbrook and Bill Huddleston and Scott McAnally (TN); Heidi Clausen and Jaakob Sundberg (UT); and Diane Dambach, Christina Keely, Darcy Paskey, and Jennifer Stegall (WI). Also participating was: Jana Jarret (OH).

1. **Adopted Consumer Guides on the Claims Process**

Ms. Kwei said the consumer guides are intended to stand on their own, but they also cover the entire claims process from filing a claim to external appeals. She said edits had been incorporated from Brenda J. Cude (University of Georgia) and Subgroup members.

Ms. Watters made a motion, seconded by Ms. Kruger, to adopt the consumer guides (Attachment Four-A). The motion passed unanimously.

Ms. Kwei said that the guides would be emailed and posted to the Subgroup’s website and that states are free to add their own content.

2. **Heard a Presentation on Consumer Group Perspectives on Barriers to Insurance**

Ms. Kwei said consumer representatives had requested time to share the results of a survey.

Ms. Cude said the survey was conducted due to the NAIC’s attention to diversity and to inform the work of state insurance regulators. She said it was funded by the Robert Wood Johnson Foundation (RWJF), and its purpose was to gather information on challenges to access and identify any systemic discrimination. She said it was an online survey of state, local, and regional grassroots, nonprofit, and community organizations with information across different lines of insurance, including health.

Harry Ting (Health Care Consumer Advocate) explained survey results that show the most pressing health insurance issues for constituents of the surveyed organizations, including unaffordability and difficulty of understanding coverage and costs. He also shared results on where consumers get information about insurance, which included family and friends, as well as community organizations at the top, followed by internet searches, agents and brokers, and TV and radio. He said consumer groups reported little interaction with state insurance departments. He said it would be more impactful for state insurance departments to distribute information through community organizations in addition to the departments’ websites and social media. He said the Subgroup should consider adding to its 2022 charges completion of a survey on best practices by state insurance departments in communicating with consumers. Ms. Cude added that information could also be distributed via programs like income tax assistance. She said insurance department public information officers (PIOs) and other stakeholders may not be aware of materials on the Subgroup’s website.

Ms. Judy asked about what difficulties consumers have in understanding coverage. Ms. Cude said further conversations with community organizations would be helpful since they perceive that information is not understandable. Mr. Ting said few organizations felt their constituents check insurance department websites and that presentations to the groups would be beneficial. Ms. Kwei said Maryland had made or planned presentations to groups representing communities like LGBTQ individuals or rural residents.

Bonnie Burns (California Health Advocates) said consumer understanding of insurance terms is low. Mr. Ting said community organizations can be helpful in walking through concepts and definitions, and Ms. Cude said prepared content can help in improving understanding. Ms. Burns and Mr. Ting discussed the value of using employers, State Health Insurance Assistance Program (SHIP) counselors, and unemployment assistance staff in reaching consumers who need health insurance information.
Mr. Ting asked for reactions to the suggestion of new charges for a survey of best practices in consumer information. Ms. Watters suggested looking at entities external to state insurance departments as well. Ms. Cude said part of surveying state insurance departments could be asking about other agencies in their states or outside groups that do consumer communication well.

Ms. Ross said the Oklahoma Insurance Department has a section on its website with health options for the unemployed, including videos and updated information.

3. Discussed Future Work Products for the Subgroup

Ms. Kwei said the Subgroup has been waiting for further federal guidance on the federal No Surprises Act (NSA) before producing a guide on balance billing and asked for input on whether to move forward or continue to wait. Ms. Kruger said she is concerned that too little information is available. Ms. Judy said any document would have to be high-level because of differing state laws. Ms. Cude said a basic document with definitions and examples would be helpful. Ms. Judy said states with balance billing laws may already have that information available, so the Subgroup should build on what exists.

Ms. Kwei said the Subgroup traditionally updates its *Frequently Asked Questions About Health Care Reform* document by the beginning of Open Enrollment, coming on Nov. 1. She asked how the Subgroup should proceed this year, given the frequently asked questions (FAQ) addendum produced earlier in the year. Ms. Watters said the Beyond the Basics website has some updated information. The Subgroup discussed the extent of updates that are needed. Ms. Judy said the FAQ updates should take precedence over a guide on balance billing. Ms. Kwei suggested that Subgroup members could take sections of the FAQ, review them, and make suggested updates.

Ms. Cude said some links on the Subgroup website do not work and asked whether content on the NAIC’s consumer website is compatible with the Subgroup’s work.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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Health Care Bills: Codes and Claims

To get paid for medical care you receive, providers usually bill your health insurer directly using what’s known as a “claim” form. However, sometimes you may have to submit a claim yourself. To process a claim correctly, your insurer needs to know the billing codes for the medical care you received. You’ll need a detailed bill with billing codes from your provider to send with your claim.

Usually insurers pay claims. But, if your insurer denies a claim, it could be because you or your provider used the wrong billing code on the claim form. Knowing how codes are used can help you get your bill paid.

How are billing codes used on a claim?

Providers use billing codes to describe the service(s) you received. The codes let providers send insurers very detailed information in a condensed way.

There are different types of billing codes. Two types are:

- **Diagnosis codes**, which also may be called the ICD-10 codes. These codes describe the condition for which you received treatment. For example, E10.9 is the diagnostic code for Type 1 diabetes mellitus without complications.
- **Procedure codes**, which include but aren’t limited to Current Procedural Terminology ® (CPT) codes. These codes describe the treatment you receive. For example, CPT code 95251 is the procedure code for “ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation, and report.” You might refer to this simply as glucose monitoring.

Hospitals and other facilities also use billing codes to bundle a group of codes and charge one fee for the various items and services provided. An example is Diagnosis-Related Group (DRG) 638 for Diabetes without complications or comorbidities.

Why would an insurer deny a claim based on a billing code?

An insurer may deny a claim for many reasons. A billing code could be one reason. An insurer could deny a claim if the billing code doesn’t exist, your policy doesn’t cover it, or if the code doesn’t match the other information in the claim.

For example, your provider’s billing office could use one of five different levels of codes to code a general visit to your family doctor. Which code it uses depends on the complexity or length of your visit. The insurer could deny the claim if the doctor’s office bills for a higher-level code than the medical record describes. Or, it could ask the doctor’s office to re-submit the claim with a lower-level code.

If your insurer denies your claim, you should call your insurer to ask questions. If the billing codes were the reason for the denial, ask your provider’s billing office to check the code(s) submitted and re-submit the claim.

You also can file an appeal of a denied claim. See the companion guide Health Care Bills: How To Appeal A Denied Claim.
Health Care Bills: Explanation of Benefits

After you receive medical care, your health insurer will send you information about your claim in an Explanation of Benefits or EOB. The EOB is not a bill. It’s the insurer’s explanation of how the costs of services are shared between you and the insurer.

What does an EOB tell me?

An EOB tells how much each provider charged, how much the health insurer paid, and how much you owe each provider. Be sure to compare the “owed” amounts on the EOB with amounts on bills from your providers and what you’ve already paid.

What does an EOB look like?

Not all EOBs look alike, but here are a few things to look for on your EOB.

- *Information about the person who received the services.* This includes the health insurance ID number and the member name, sometimes identified as “patient.” If it’s your insurance, the EOB often refers to the patient as “self.” If the insurance is through your spouse or your parent, then their name will be on the EOB.
• A list of services received, including the dates you received them. There also may be billing codes. (See companion guide Health Care Bills: Codes and Claims.) If those aren’t on the EOB, there should be notes about how to get the codes if you need or want them.

• Information about the provider or facility. This will name the person (doctor, nurse practitioner, psychologist, physical therapist) or facility (laboratory, hospital) that provided the service.

• The amount the provider or facility billed the insurer.

• The “allowed” amount. This is the amount the insurer will pay the provider for the health care you received. The allowed amount is negotiated between the provider and the insurer.

• The amount the insurer paid for each service.

• The amount you owe the provider. This may include money you paid during your visit.

• Information about denials and other details or notes. The insurer may use codes to explain denial reasons and notes. You should see an explanation of the codes on the EOB.

How else is an EOB helpful?

An EOB is an important tool to help you track how much you’ve spent out-of-pocket for covered health care costs. That helps you know how far along you are in meeting your deductible and out-of-pocket limit for the year. If you’ve reached your out-of-pocket limit and you’re asked to pay for services, you should contact your insurer right away.

You’ll also find instructions on your EOB to file a grievance or appeal if the insurer denies coverage for services or only pays part of the claim.

Who receives an EOB?

Usually, the insurer sends the EOB to the primary person on the health plan. If an employer provides the insurance, the employee usually receives the EOB, including EOBs for a spouse and dependents on the plan.

You may ask the insurer to send your EOBs to a different address for confidential services or if the information on an EOB would put you in danger.
Health Care Bills: Filing Health Insurance Claims

When you receive medical care, you usually pay the provider (doctor, hospital, therapist, etc.) your share of the bill. You expect your health insurer to pay the rest of the bill. To get that payment, the provider files a claim with your insurer.

But sometimes you may have to file a claim with the insurer yourself. This could happen if you see an out-of-network provider or if the provider doesn’t accept your insurance.

If you need to file your own health insurance claim, here’s what you need to know:

**How do I file a claim with my insurer?**

You’ll find a claim form on most health insurers’ websites, along with information on how to submit the claim. Look at your health insurance card for your insurer’s website or a phone number to call for information about filing a claim.

**What will I need?**

You will need the following to file a claim:

- **An itemized bill from your health care provider.** Ask the provider for this. The bill should include the date you received care and a list of services you received with the provider’s charge and a description and/or billing code for each service.
- **Your personal information,** including your social security number, your health insurance ID number, and, if you received medical care due to an accident or illness at work, your employment status.
- **Whether to send payment directly to the provider or to you.** If the insurer sends the payment to you, you’re responsible for paying the provider.

**When do I file the claim?**

File the claim as soon as possible after you receive the medical care. Many insurers have a deadline to file a claim, such as no more than 90 days after you receive care.

**Where do I submit the claim?**

Look for an address on the claim form. If it's not there, check the insurer’s website and the back of your health insurance card or call your insurer.

**What happens after I file the claim?**

After you file the claim, the insurer has a limited time to tell you if it will pay the claim. How long the insurer has varies by state.
After the insurer reviews the claim, it will send you an Explanation of Benefits or EOB (See companion guide Health Care Bills: Explanation of Benefits). If the insurer is paying the claim, it will send the payment as you directed, either to the provider or to you.

Your health care provider may send you a bill before the insurer has reviewed the claim. If so, call the provider’s billing office. Ask to delay payment until after the claim is processed. Check the EOB to know the correct amount you owe the provider.
Health Care Bills: How to Appeal a Denied Claim

When you receive medical care, either you or your provider (doctor, hospital, therapist, etc.) must file a claim with your health insurer. Often, the provider files the claim. Most of the time, the insurer pays the claim. But, sometimes the insurer refuses to pay part or all of the claim for services you believe should have been covered. You have a right to appeal that decision.

There are two types of appeals—an internal appeal and an external review.

Here are the steps you can take if your insurer denies a claim

File an Internal Appeal

You file an internal appeal to ask your insurer to review a decision to deny a claim. You have up to six months (180 days) after you learn a claim was denied to file an internal appeal.

- To learn how to file an internal appeal, look at the claim denial or call the customer service number on your insurance card/materials.
- An internal appeal usually requires you to write a letter. Be sure to include in the letter your name, claim number, and health insurance ID number, and any other information you have to support your claim. (See reverse side for sample letter.)
- If the insurer denied a claim for a medical reason, you’ll need your health care provider’s help to file an appeal. Ask your provider to write a letter explaining why the care was medically necessary. Send that letter with your appeal.

After it receives your appeal, the insurer has a set amount of time to review it and make a decision. How much time the insurer has varies by state. If a delay in receiving medical care could harm your life, health, or ability to function, you can ask that the appeal be reviewed quickly (“on an expedited basis”).

And if your insurer still says “No”....

File an External Review

If your insurer still denies the claim after the internal appeal, you can ask for an external review. An independent review organization will do the external review. You may have a limited time to ask for an external review after you receive the decision from your internal appeal.

- You should find the information about how to ask for an external review on your internal appeal notice.
- Your state’s insurance regulatory agency is usually in charge of the external review process.
- You can submit information you didn’t include in your internal appeal to support your position.
- The external reviewer has a limited time to reach a decision.
- The external reviewer will give you and your insurer a written notice of its decision.
- The insurer must pay the claim if the external reviewer decides the insurer should.

Things to Keep in Mind

Medicare and Medicaid

If you’re enrolled in Medicare or Medicaid, there are different rules for appeals.

- For Medicare, call 1-800-MEDICARE to ask for information about free help to appeal a decision.
- For Medicaid, contact your state’s Medicaid agency for help.

Keep Records

Keep detailed records, including bills from your provider, notices from your insurer, copies of denial letters, appeal requests, and medical information related to your case.

Take Detailed Notes and Set Response Deadlines

Keep notes about the dates/times of all calls and other communication, names of people with whom you had
conversations, and details of all conversations. Ask about and make notes of any set deadlines for expected responses or information from your insurer.

Sample letter to request an internal appeal
Add your own information when you see italics below.

Your Name
Your Address

Date

Address of the Health Plan’s Appeal Department
Re: Name of Insured
Plan ID#:
Claim #:

To Whom It May Concern:

I am writing to request a review of your denial of the claim for treatment or services provided by name of provider on date provided.

The reason for the denial was listed as (reason listed for denial), but I have reviewed my policy and believe the service should be covered. Here is where you may provide more detailed information about the situation. Write short, factual statements. Do not include emotional wording. If you’re including documents, include a list of what you’re sending here.

If you need additional information, I can be reached at telephone number and/or e-mail address. I look forward to receiving your response as soon as possible.

Sincerely,

Signature

Typed Name
Telephone Number
Email address

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Health Care Bills: Understanding Medical Necessity

What is medical necessity?

Typically, health insurance plans only provide benefits for treatments or services that are “medically necessary.” So, what does that mean?

Your policy will define medically necessary. But usually “Medically necessary” or “medical necessity” means health care a prudent physician, using professional standards and judgment, would give a patient. These are services that:

- Evaluate, diagnose, or treat an illness, injury, disease, or its symptoms;
- Follow generally accepted standards of medical practice;
- Are “clinically appropriate,” meaning the level of care would be effective to treat the patient’s illness, injury, or disease;
- Aren’t primarily for the convenience of the patient, health care provider, or insured’s family;
- Don’t cost more than another service or series of services that would be at least as effective; and
- Are not for experimental, investigational, or cosmetic purposes.

How does medical necessity affect coverage of my health care services?

Medical necessity limits health insurance payments for cosmetic procedures, treatments that haven’t been proven to be effective, or treatments that are more expensive than others that also are effective.

How is “medical necessity” determined?

A doctor’s prescription or order for a service is the first evidence of medical necessity. If the insurer asks for more proof that the claim meets the standard for medical necessity, it may ask your doctor or other provider for a “Letter of Medical Necessity.” The request for a letter typically is part of a “certification” or “utilization review” process. This process lets the insurer review medical services to decide if they cover the service. This can be done before, during, or after the treatment.

In a “precertification review,” the insurer decides if the requested treatment satisfies the plan’s requirements for medical necessity before the treatment is provided. The insurer typically reviews the Letter of Medical Necessity, medical records, and the plan’s medical policy.

In a “concurrent review,” the insurer decides if the treatment is medically necessary while it’s ongoing.

In a “retrospective review,” the insurer decides if services already provided were medically necessary or, in the case of emergency services, whether they truly required emergency care. The decision is made after you receive the treatment.

What are medical guidelines?

All insurers follow guidelines that determine if a treatment is within accepted standards in the medical community. An insurer must make its medical guidelines available to you if it used them to make a decision to deny you coverage.

Are experimental, investigational, or cosmetic services medically necessary?
Some definitions of medical necessity specifically exclude services for “experimental, investigational, or cosmetic purposes.” An insurer’s medical guidelines determine if a treatment is considered experimental for your condition. An insurer also follows its medical guidelines to decide if treatments that could be considered cosmetic also have a medical purpose. Insurers may use medical records to decide if services are medically necessary, but they also may base decisions on the available scientific literature.

**Does medical necessity affect coverage for emergency services?**

After you receive emergency services, insurers may review your care to decide if emergency care was appropriate for your diagnosis and medically necessary. To decide, insurers use a “prudent layperson” standard. Getting approval before you receive medical services (precertification) isn’t necessary if a prudent layperson would believe there was an emergency condition and delaying treatment would make that condition worse.
The Health Innovations (B) Working Group met in San Diego, CA, Dec. 11, 2021. The following Working Group members participated: Andrew R. Stolfi, Chair, and TK Keen (OR); Laura Arp, Co-Vice Chair, and Martin Swanson (NE); Nathan Houdek and Jennifer Stegall, Co-Vice Chairs (WI); Andria Seip (IA); Julie Holmes (KS); Robert Wake (ME); Cynthia Anman (MO); Jon Godfread (ND); Maureen Belanger (NH); Paige Duhamel (NM); David Buono and Shannen Logue (PA); Chris Herrick (TX); Tanji J. Northrup (UT); Molly Nollette (WA); and Joylynn Fix (WV). Also participating were: Lori K. Wing-Heier (AK); David Altmaier and Chris Struk (FL); Weston Trexler (ID); Stephanie McGee (NV); and Glen Mulready (OK).

1. Heard a Presentation on Health Plan Efforts to Address Health Disparities

Commissioner Stolfi reviewed the changes the Working Group received from the Special (EX) Committee on Race and Insurance. He said the Working Group plans to evaluate existing research on the health disparities impacts of telehealth and alternative payment models and hear from stakeholders on these topics.

Dr. John Lumpkin (Blue Cross and Blue Shield of North Carolina—BCBS NC) described his organization’s work to develop a health equity index score. He shared a statement from BCBS NC that says, “[n]o community can truly be healthy until racism no longer exists.” He said North Carolina counties can be divided into tiers based on their economic distress. He said a health equity index can provide accountability to measure what works. He said BCBS NC’s index measures both racial and economic disparities and currently shows a summary score for overall equity of 87%. He said the index score would be used to support BCBS NC’s priorities of improved data on race, ethnicity, and language; improve maternal care; increase behavioral health access; and increase immunizations and wellness visits. He described an example of work to improve maternal health, particularly for Black Americans.

Commissioner Stolfi asked how other states can develop similar health equity index scores. Dr. Lumpkin said health insurance plans cannot do it alone, and states should work with a range of stakeholders to develop coordinated measures. Commissioner Stolfi asked what strategies BCBS NC has used to collect data. Dr. Lumpkin said the biggest challenge in developing the index was that race and ethnicity data are not readily available. He said some data is self-reported by enrollees, and other data is calculated, but the best data is reported by consumers. Commissioner Stolfi asked what state insurance regulators can do to support industry efforts to reduce health disparities. Dr. Lumpkin said there must be an open partnership between state insurance regulators and regulated plans.

Dr. Darrell Gray (Anthem) presented on the company’s efforts to improve health equity. He said Anthem has an integrated approach to whole health that includes physical, behavioral, social, and pharmacy health and incorporates consumers, communities, and associates. He described the difference between equality and equity, and he said Anthem’s approach to equity is data-driven, inclusive, and nimble. He stressed the importance of addressing a variety of needs, including upstream (poverty, racism, and discrimination), midstream (housing, transportation, and violence), and downstream (chronic disease, poor nutrition, and poor mental health). He said Anthem is working to develop a Whole Health Index that includes measures of global health, social drivers, and clinical quality. He described three steps for identifying social needs, coordinating social care, and creating social interventions. He said health-related social needs contribute to 70–80% of clinical outcomes, while clinical care contributes only 20%.

Ms. Seip asked in what markets Anthem is applying its social interventions. Dr. Gray said the company’s goal is to deploy them across all public and private markets in which it operates. Mr. Houdek asked what length of time the company expects to move from the first step of identifying social needs to the third step of creating social interventions. Dr. Gray said it varies greatly by the type of need, the population, and the insurance market being served. Commissioner Stolfi asked how state insurance regulators can support industry efforts to reduce health disparities. Dr. Gray said assisting with data definition and collection efforts would be helpful since the company does not have complete self-reported data on race and ethnicity or sexual orientation and gender identity. He said New York has been able to get better data on race and ethnicity in its individual market through updates to collection practices in its state-based exchange.
2. **Heard a Presentation on the Health Disparities Impacts of Telehealth and Alternative Payment Models**

Kelly Edmiston (NAIC) presented the findings of research he conducted with the Center for Insurance Policy and Research (CIPR) colleagues on the health disparities impacts of the rise in telehealth services and the move to alternative payment models. He said the key take-away is that both telehealth and alternative payment models have the potential to improve health and reduce disparities, but they must evolve to do so because they are not there yet. He said prior to the pandemic, the share of claims delivered through telehealth was minimal, grew enormously early in the pandemic, and has since declined but not to pre-pandemic levels. He said telehealth can provide greater access to culturally competent care based on language, race, or gender. He said telehealth is especially effective for chronic conditions, which disproportionately affect vulnerable populations. He said the potential of telehealth is limited by restricted access to broadband connections. He said telehealth requires significant upfront costs, and uncertainty in payment policies can limit needed investments.

Mr. Edmiston said alternative payment models seek to reduce the incentive to overtreat and the disincentive to treat underserved populations, which occurs because underserved or vulnerable populations may need more low-margin care. He said value-based payment models are intended to reduce the cost of care without reducing quality or improve quality without increasing cost. He said research has not shown value-based payments to be effective in reducing disparities, despite the potential to do so. He said models can include social risk factors, but they are not currently sophisticated enough due to data limitations.

Mr. Keen asked whether any single telehealth technology platform has emerged and whether it allows medical records to be easily exchanged between patients and providers. Mr. Edmiston said the fast adoption of electronic health records is a good sign for telehealth. He said there are multiple models that exist for telehealth, and some have higher sales than others. He said basic digital literacy is more important than the technology used. Ms. Seip asked whether alternative payment models that incorporate social determinants of health have better outcomes than those that do not. Mr. Edmiston said research on Medicare Advantage showed small effects of accountable care organizations overall, and the measurement of social determinants is not adequate yet to reach a conclusion. Mr. Trexler asked whether payment parity rules are related to the needed investments in telehealth. Mr. Edmiston said some states have added parity requirements since the pandemic, and they may be temporary. He said this may limit providers’ willingness to make investments. Mr. Trexler asked whether telehealth could result in lower health care costs overall. Mr. Edmiston said telehealth use has leveled off in the last year and is likely here to stay. Mr. Wake said telehealth is different from in-person health care. He said Maine imposed temporary payment parity during the pandemic because telehealth needed to substitute for in-person care, but it does not always need to be a substitute. He said in cases where different services are provided through telehealth, payment parity is not appropriate because it is one-size-fits-all. He said telehealth providers need equity in payments, not equality. Ms. Arp asked about the age distribution of patients who use telehealth. Mr. Edmiston said consumers who use telehealth tend to be older than those who do not, and non-white populations are less likely to use it. He said urban consumers are more likely to use it, potentially due to a lack of broadband access in rural areas. Ms. Arp said state insurance regulators could look at telehealth as a bonus, requiring in-person networks to be adequate while offering access to more culturally competent or specialized providers through telehealth.

3. **Discussed Other Matters**

Commissioner Stolfi said NAIC staff would ask the Working Group what questions the presentations raised and how else members would like to dig into the issues highlighted. In addition, NAIC staff would ask members how they want to move toward developing recommendations related to race and insurance work.

Having no further business, the Health Innovations (B) Working Group adjourned.
The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met Nov. 2, 2021. The following Working Group members participated: Andrew R. Stolfi, Chair, TK Keen, and Cassie Soucy (OR); Laura Arp, Co-Vice Chair (NE); Nathan Houdek and Jennifer Stegall, Co-Vice Chairs, Barbara Belling, Diane Dambach, Mark Prodoehl, Rebecca Rebholz, Julie Walsh, and Richard Wicka (WI); Howard Liebers (DC); Andria Seip and Cynthia Banks Radke (IA); Meghann Leaird and Scott Shover (IN); Craig Van Aalst, LeAnn Crow, Julie Holmes, Brenda Johnson, and Tate Flott (KS); Renee Campbell, Karen Dennis, and Stephanie Francis (MI); Cam Jenkins, Andrew Kleinendorst, and Gregory Maus (MN); Chris Murrah, Amy Hoyt, and Jessica Schrmpf (MO); Chrystal Bartuska and Angie Voegele (ND); Michelle Heaton (NH); Philip Gennace (NJ); Colin Baillio, Sahar Hassanin, Bogdanka Kurahovic, and Viara Ianakieva (NM); Mark Garratt (NV); Jessica K. Altman, Katie Dzurec, Katie Merritt, and Sandra L. Ykema (PA); Rachel Bowden, Valerie Brown, Essi Eargle, Ryan Jaffe, R. Michael Markham, and Michael Nored (TX); Heidi Clausen, Tanji J. Northrup, and Jaakob Sundberg (UT); and Jane Beyer, Rory Paine-Donovan, and Molly Nollette (WA).

1. **Heard a Presentation on Using State Rate Review Authority to Limit Premium Growth**

Commissioner Stolfi said states have a number of tools to address health insurance prices and premium affordability. He introduced Professor Erin Fuse Brown of Georgia State University, who wrote a toolkit on using rate review to address premium affordability. Professor Fuse Brown said the toolkit is intended to help other states follow a model that Rhode Island employed to limit growth in health insurance premiums.

Professor Fuse Brown said the main determinant of health care prices is consolidation and the market power of providers, not utilization or health status. She said hospital costs can be limited by using insurance rate review authority, even if it is a circuitous route for doing so. She explained that Rhode Island’s affordability standard capped increases in hospital rates, which reduced growth in inpatient spending and total spending. She said steps could employ a number of steps to follow Rhode Island’s approach: assess existing authority, pass revised rate review authority, and adopt regulations to implement new standards. She said statutory language should give the insurance commissioner authority to protect the consumers and the public interest. She suggested that regulations could be used to establish an affordability standard which could be tied to overall inflation and potentially split between inpatient and outpatient services.

Professor Fuse Brown acknowledged that enhanced affordability review requires greater resources from insurance departments. She said that hospital prices are a reasonable place to start that helps to avoid taking on the entire market for health care services. She said that using one affordability standard does not address redistributing resources to provide greater revenue to critical access hospitals, rural hospitals, or others the state wants to support.

Commissioner Stolfi asked how states can enforce limits to hospital rates when insurance regulators have authority over insurers, but not hospitals directly. Professor Fuse Brown said that an affordability standard in law gives insurers a stronger position in negotiations with hospitals. Eric Ellsworth (Consumer Checkbook) asked how the standard could be adjusted for critical access or rural hospitals. Professor Fuse Brown said that a waiver process or other flexibility could be used to address these types of hospitals, but doing so can create political difficulty. Commissioner Altman asked about the impact of implementing an affordability standard only in the individual and small group markets. Professor Fuse Brown said it may be worth starting in these markets and there may be positive spill-overs to the large group market if the same contracts are used across markets.

2. **Heard a Presentation on State Policy Considerations with Enhanced Premium Tax Credits**

Commissioner Stolfi introduced Jason Levitis and Daniel Meuse (State Health and Value Strategies) to discuss how the larger premium tax credits affect premium affordability and choices states have in responding.

Mr. Meuse said the temporary tax credit changes change the calculus for state efforts to reduce the base level of premiums. He said the Build Back Better Act would extent those credits through 2025. He emphasized the importance of building flexibility into state policies so they can work if the enhanced credits stay in place or if they go away. He said some states provided their
own subsidies prior to the availability of enhanced federal subsidies. He explained how federal subsidies have been enhanced, increasing the value of the subsidies and making them available to many people who were previous ineligible.

Mr. Levitis described how the Build Back Better Act would extend the enhanced subsidies for three additional years and make other changes. He said continued uncertainty is likely, particularly because the enhanced subsidies would not be made permanent. He said states do not need to refrain from action due to the uncertainty. He reviewed several policy options. He said additional state subsidies are no longer as helpful. He said cost sharing assistance is more valuable for enrollees. He said the family glitch could be addressed through federal administrative action. He said states could target subsidies for younger consumers or undocumented residents. He said to deal with uncertainty and changing circumstances, states can provide administrative authority for state regulators or a state-based marketplace to set affordability parameters year by year.

Mr. Meuse said states may want to shift away from premium reduction and toward plan generosity, stronger networks, and higher actuarial value within allowable limits. He said enhanced tax credits reduce concerns with Section 1332 waiver deficit neutrality requirements and increase the funds available. He said states with existing reinsurance programs are getting greater funding, but may not be impacting consumers as much as they did previously.

Mr. Levitis said states can make use of facilitated enrollment and greater outreach with or without enhanced premium subsidies.

3. **Discussed Work on Race and Insurance**

Commissioner Stolfi asked members and interested parties for input on presentations for the Working Group’s session at the Fall National Meeting. He said the session would focus on the Working Group’s charges from the Special Committee on Race and Insurance, particularly around telehealth, alternative payment models, and their impacts on health disparities.

Having no further business, the Health Innovations (B) Working Group adjourned.
2022 Proposed Charges

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Health Insurance and Managed Care (B) Committee will:
   A. Respond to inquiries from the U.S. Congress (Congress), the White House, and federal agencies; analyze policy implications and their effect on the states of proposed and enacted federal legislation and regulations; and communicate the NAIC’s position through letters and testimony, when requested.
   B. Monitor the activities of the Health Actuarial (B) Task Force.
   C. Monitor the activities of the Regulatory Framework (B) Task Force.
   D. Monitor the activities of the Senior Issues (B) Task Force.
   E. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC).
   F. Examine factors that contribute to rising health care costs and insurance premiums. Review state initiatives to address cost drivers.
   G. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
   H. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the federal Affordable Care Act (ACA), including short-term, limited-duration (STLD) insurance, association health plans (AHPs), and packaged indemnity health products.

2. The Consumer Information (B) Subgroup will:
   A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
   B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.

3. The Health Innovations (B) Working Group will:
   A. Gather and share information, best practices, experience, and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.
   B. Discuss state innovations related to health care—i.e., access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision-making, and health care delivery and financing models—to achieve better patient outcomes and lower spending trends.
   C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.
   D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to utilize the information gathered by the Working Group.
   E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

NAIC Support Staff: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook
HEALTH ACTUARIAL (B) TASK FORCE

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The Health Actuarial (B) Task Force met Nov. 29, 2021. The following Task Force members participated: Eric A. Cioppa, Chair, represented by Marti Hooper (ME); Andrew N. Mais, Co-Vice Chair, represented by Paul Lombardo (CT); Jonathan T. Pike, Co-Vice Chair, represented by Jaakob Sundberg (UT); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Lan Brown (CA); Michael Conway represented by Eric Unger (CO); Colin M. Hayashida represented by Kathleen Nakasone (HI); Dean L. Cameron represented by Weston Trexler (ID); Vicki Schmidt represented by Nicole Boyd (KS); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal (NM); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Shannen Logue (PA); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by R. Michael Markham (TX); Scott A. White represented by David Shea (VA); Mike Kreidler represented by Lichiou Lee (WA); Mark Afable represented by Rebecca Rebholz (WV); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted its Sept. 14 Minutes

The Task Force met Sept. 14 and took the following action: 1) adopted its April 23 and April 6 minutes and the May 17 and March 29 minutes of the Long-Term Care Actuarial (B) Working Group; 2) disbanded the Health Care Reform Actuarial (B) Working Group and the State Rate Review (B) Subgroup; 3) adopted its 2022 proposed charges; and 4) discussed its proposal to revise instructions for the Health Annual Statement of Actuarial Opinion (SAO).

Mr. Lombardo made a motion, seconded by Mr. Leung, to adopt the Task Force’s Sept. 14 minutes (Attachment One). The motion passed unanimously.

2. Heard an Update from the Federal CCIIO

Megan Mason (federal Center for Consumer Information and Insurance Oversight—CCIIO) presented an update (Attachment Two) on a system connection between the System for Electronic Rates & Forms Filing (SERFF) and the Health Insurance Oversight System (HIOS) Unified Rate Review (URR) module.

3. Heard an Update on SOA Health Care Trend Research

Dale Hall (Society of Actuaries—SOA) gave an update (Attachment Three) on SOA health care trend research.

4. Heard an Update from the Academy Health Practice Council

Barb Klever (American Academy of Actuaries—Academy) gave an update (Attachment Four) on Academy Health Practice Council activities.

5. Heard an Update from the Academy and the SOA Research Institute on an LTCI Mortality and Lapse Study

Warren Jones (Academy—Retired) and Bruce Stahl (Reinsurance Group of America—RGA) gave an update (Attachment Five) on a long-term care insurance (LTCI) mortality and lapse study.

6. Discussed a Proposal to Revise Instructions for the Health Annual Statement SAO

Ms. Hooper said the Task Force submitted a proposal for changes to instructions for the Health Annual SAO related to the definition of “actuarial assets” to the Blanks (E) Working Group in May. She said the Actuarial Standards Board (ASB) received comments while exposing Actuarial Standard of Practice (ASOP) No. 28 that indicated some actuaries believe the NAIC Health Annual Statement instructions regarding SAOs are not in concert with the proposed ASOP. She said the Annual Statement instructions specifically address the treatment of actuarial liabilities but not actuarial assets. She said to avoid future confusion on the matter, the Task Force intends to update the wording for the 2022 instructions to clarify that both actuarial liabilities and assets should be considered in the opinion. She said the proposal was submitted past the deadline for inclusion in the 2021 Annual Statement instructions, but the Task Force views this as a clarification and not a change in practice; actuaries...
should be considering actuarial assets when making SAOs. She said the Task Force sent a letter to the Working Group in June requesting that this clarification be included as guidance for completion of 2021 Health Annual Statement SAOs. She said the Task Force will schedule a meeting to discuss the proposal as it stands and any additional items that should be included in the 2022 Health Annual Statement instructions.


Ms. Hooper said the Task Force was asked by the Senior Issues (B) Task Force for input on the impact on Medicare supplement insurance plans by the addition of dental, hearing, and vision benefits to Medicare Part B. Brian R. Webb (NAIC) said at this time, only hearing benefits are being considered for coverage under Medicare Part B by federal legislators. Ms. Hooper said Maine recently added hearing aid coverage for adults as a mandated benefit in its federal Affordable Care Act (ACA) major medical insurance plans. She said this benefit was not added to Medicare supplement plans, as was erroneously reported by various sources. She said the possibility of the availability of non-prescription hearing aids could reduce the pricing impact of the addition of hearing benefits to Medicare Part B. She said the Task Force will be available to provide input in the event that hearing coverage is added.

Mr. Sundberg said the financial impact on Medicare supplement plans of the addition of hearing benefits does not concern him, but the addition of vision and dental benefits is of financial significance, and the Task Force should examine the potential impacts of these additions.

8. Heard an Update on STLD Insurance Plans in Idaho

Mr. Trexler gave a presentation (Attachment Six) on short-term, limited-duration (STLD) insurance plan experience in the Idaho market.

Having no further business, the Health Actuarial (B) Task Force adjourned.

https://naiconline.sharepoint.com/w:/r/sites/NAICSupportStaffHub/Member%20Meetings/Fall%202021/TF/HealthActuarial/Conference%20Calls/11-29%20HATF/11-29-21%20HATF.docx?d=w873e3a43feb64a3691b6a759848004b7&csf=1&web=1&src=0b62Fv
Health Actuarial (B) Task Force
Virtual Meeting
September 14, 2021

The Health Actuarial (B) Task Force met Sept. 14, 2021. The following Task Force members participated: Eric A. Cioppa, Chair, represented by Marti Hooper (ME); Andrew N. Mais, Co-Vice Chair, represented by Paul Lombardo (CT); Jonathan T. Pike, Co-Vice Chair, represented by Jaak Sundberg (UT); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Lan Brown (CA); Michael Conway represented by Eric Unger (CO); Colin M. Hayashida represented by Kathleen Nakasone (HI); Dean L. Cameron represented by Weston Trexler (ID); Dana Popish Severinghaus represented by Eric Anderson (IL); Amy L. Beard represented by Stephen Chamblee (IN); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal (NM); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Tracie Gray (PA); Carter Lawrence (TN); Doug Slape represented by Barbara Snyder (TX); Scott A. White represented by David Shea (VA); and Mike Kreidler represented by Lichiou Lee (WA).

1. **Adopted its April 23 and April 6 Minutes, and the May 17 and March 29 Minutes of the Long-Term Care Actuarial (B) Working Group**

Mr. Toal made a motion, seconded by Mr. Leung, to adopt the Task Force’s April 23 (Attachment One-A) and April 6 (Attachment One-B) minutes, and the May 17 (Attachment One-C) and March 29 (Attachment One-D) minutes of the Long-Term Care Actuarial (B) Working Group. The motion passed unanimously.

2. **Adopted a Motion to Disband the Health Care Reform Actuarial (B) Working Group and the State Rate Review (B) Subgroup**

Mr. Shea said the functions of the Health Care Reform Actuarial (B) Working Group and the State Rate Review (B) Subgroup can be performed at the Task Force level. He made a motion, seconded by Mr. Dyke, to disband both the Working Group and the Subgroup. The motion passed unanimously.

3. **Adopted its Proposed 2022 Charges**

Ms. Eom made a motion, seconded by Mr. Shea, to adopt its 2022 proposed charges (Attachment One-E). The motion passed unanimously.

4. **Discussed its Proposal to Revise Instructions for the Health Annual Statement SAO**

Mr. Sundberg said the Task Force needs to revisit its proposal to revise the language in Section 4, Section 5, Section 7 and Section 9 of the instructions for the health Statement of Actuarial Opinion (SAO) to ensure that all items—actuarial assets and liabilities—within the scope of the SAO are treated consistently, and provide a final recommendation to the Blanks (E) Working Group. Ms. Hooper said the Task Force will begin work on this.

Having no further business, the Health Actuarial (B) Task Force adjourned.
The Health Actuarial (B) Task Force met April 23, 2021. The following Task Force members participated: Eric A. Cioppa, Chair, represented by Marti Hooper (ME); Andrew N. Mais, Co-Vice Chair, represented by Paul Lombardo (CT); Jonathan T. Pike, Co-Vice Chair, represented by Jaak Sundberg (UT); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Colin M. Hayashida represented by Kathleen Nakasone (HI); Dean L. Cameron represented by Weston Trexler (ID); Dana Popish Severinghaus represented by Eric Anderson (IL); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Julia Lyng (MN); Chlora Lindley-Myers represented by William Leung (MO); Eric Dunning represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Russell Toal (NM); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Tracie Gray (PA); Doug Slape represented by Barbara Snyder (TX); Scott A. White represented by David Shea (VA); Mike Kreidler represented by Lichiou Lee (WA); Mark Afable represented by Brian Brown (WI); and James A. Dodrill represented by Joylynn Fix (WV).

1. Exposed a Proposal to Revise the Instructions for the Health SAO

Ms. Hooper said the Task Force received several comment letters in response to an exposure of a proposal to revise the language in Section 4, Section 5, Section 7 and Section 9 of the instructions for the health Statement of Actuarial Opinion (SAO) to ensure that all items—actuarial assets and liabilities—within the scope of the SAO are treated consistently.

Mr. Leung gave a summary of comments from Missouri (Attachment One-A1).

Ms. Lee gave a summary of comments from Washington (Attachment One-A2). Annette James (NovaRest Actuarial Consulting) suggested that “actuarial asset” and “actuarial liability” be defined as:

“Actuarial asset” means an actuarial item presented as an asset in the annual statement and included in the scope of the Statement of Actuarial Opinion.

“Actuarial liability” means an actuarial item presented as a liability in the annual statement and included in the scope of the Statement of Actuarial Opinion.

The Task Force agreed to include these definitions in the revisions to the proposal.

Barbara Klever (Blue Cross Blue Shield Association—BCBSA) gave a summary of comments from the BCBSA (Attachment One-A3). The Task Force agreed to the suggested change to Section 7.C.

Marc Lambright (Oliver Wyman) gave a summary of comments from the American Academy of Actuaries (Academy) (Attachment One-A4).

James Braue (UnitedHealth Group—UHG) gave a summary of comments from the UHG (Attachment One-A5).

The Task Force agreed to expose the proposal with the revisions discussed during the meeting (Attachment One-A6) for a public comment period ending May 7.

Having no further business, the Health Actuarial (B) Task Force adjourned.
Mr King,

Missouri has the following comments regarding the Health Statement of Actuarial Opinion Instructions Change Proposal, together with suggested changes in the attached redlined proposal:

1. The original requirement in Section 7C that the amounts carried in the balance sheet on account of the items identified above ... are at least as great as the minimum aggregate amounts required by any state, refers to the reserve and liabilities identified. The inclusion of actuarial assets in Sections 4 and 5 makes the opinion expressed on minimum aggregated amounts confusing. If not clarifying, one may think that a minimum amount of actuarial asset is required. A simple way to address the issue is to continue the prescribed language in the opinion with the understanding that actuarial assets are simply actuarial liabilities of negative value and the opinion is about the reasonableness and adequacy of actuarial liabilities or reserves reported. This change will make the original proposed revisions to Section 7D and Section 9 unnecessary.

2. Another simplification in Section 9 is simply refer to “the reserves or assets included in the of the opinion for a certain item or items in question” as “the amounts for a certain item or items in question.”

https://naiconline.sharepoint.com/:b:/r/sites/NAICSupportStaffHub/Member%20Meetings/Summer%202021/TF/HealthActuarial/Conference%20Calls/4-23%20HATF/Exposure%20Comments/MO%20Comments.pdf?csf=1&web=1&e=Ytza3e
Section 1C.

The Actuarial Memorandum and underlying actuarial work papers supporting the Actuarial Opinion will be available for regulatory examination for seven years.

The Actuarial Memorandum contains significant proprietary information. It is expected that the Memorandum will be held confidential and is not intended for public inspection. The Memorandum must be available by May 1 of the year following the year-end for which the opinion was rendered or within two weeks after a request from an individual state commissioner.

The Actuarial Memorandum should conform to the documentation and disclosure requirements of the Standards of Practice as promulgated from time to time by the Actuarial Standards Board. The Actuarial Memorandum should contain both narrative and technical components. The narrative component should provide sufficient detail to clearly explain to company management, the regulator, or other authority the findings, recommendations and conclusions, as well as their significance. The technical component should provide sufficient documentation and disclosure for another actuary practicing in the same field to evaluate the work. This technical component must show the analysis from the basic data, (e.g., claim lags) to the conclusions.

The Memorandum must also include:

- An exhibit which ties to the Annual Statement and compares the actuary’s conclusions to the carried amounts;
- Documentation of the required reconciliation from the data used for analysis to the Underwriting and Investment Exhibit, Part 2B;
- Any other follow-up studies documenting the prior year’s claim liability and claim reserve run-off as considered necessary by the actuary; and
- Documentation of the assumptions used for contract reserves, other actuarial liabilities, actuarial assets, and related items and any material changes to those assumptions from the assumptions used in the previous memorandum. Such documentation should address any studies which support the adequacy of any margin in such reserves.

Section 4.

The IDENTIFICATION section should specifically indicate the appointed actuary’s relationship to the company, qualifications for acting as appointed actuary, date of appointment, and should specify that the appointment was made by the Board of Directors, or its equivalent or by a committee of the Board.

A person who is not a Member of the American Academy of Actuaries but is recognized by the Academy as qualified must attach, each year, a copy of the approval letter from the Academy.

This section should contain only one of the following:

For a Member of the American Academy of Actuaries who is an employee of the organization, the opening paragraph of the opinion should contain all the following sentences if the appointed actuary is using the prescribed wording:

"I, (name and title of actuary), am an employee of (named organization) and a member of the American Academy of Actuaries. I was appointed by [named organization] and its (name of Board of Directors, or its equivalent, or
committee of the Board) to render an opinion with regard to loss reserves, actuarial liabilities, actuarial assets, and related items on [date of appointment] in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion.”

For a consultant who is a Member of the American Academy of Actuaries, the opening paragraph of the opinion should contain all the following sentences if the appointed actuary is using the prescribed wording:

“I, (name and title of consultant), am associated with the firm of (name of firm). I am a member of the American Academy of Actuaries and have been retained by the (name of organization) to render an opinion with regard to loss reserves, actuarial liabilities, actuarial assets, and related items. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion.”

For an employee other than a member of the American Academy of Actuaries, the opening paragraph of the opinion should contain both the following sentences if the appointed actuary is using the prescribed wording:

“I, (name and title), am an employee of (name of organization) and am recognized by the American Academy of Actuaries as qualified to perform actuarial valuations for organizations of this kind. I was appointed (name of organization) with regard to such valuations on loss reserves, actuarial liabilities, actuarial assets, and related items. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions.”

For a consultant other than a member of the American Academy of Actuaries, the opening paragraph of the opinion should contain all the following sentences if the appointed actuary is using the prescribed wording:

“I, (name and title of consultant), am associated with the firm of (name of firm). I am recognized by the American Academy of Actuaries as qualified to perform actuarial valuations for organizations of this kind and have been retained by the (name of organization) with regard to such valuations on loss reserves, actuarial liabilities, actuarial assets, and related items. I was appointed by (name of organization) with regard to such valuations on loss reserves, actuarial liabilities, actuarial assets, and related items. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions.”

Section 5.

The SCOPE section should contain only the following statement (including all specified lines even if the value is zero) if the appointed actuary is using the prescribed wording:

“I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities, and related items listed below, as shown in the annual statement of the organization as prepared for filing with state regulatory officials, as of December 31, 20__.

A. Claims unpaid (Page 3, Line 1);
B. Accrued medical incentive pool and bonus payments (Page 3, Line 2);
C. Unpaid claims adjustment expenses (Page 3, Line 3);
D. Aggregate health policy reserves (Page 3, Line 4) including unearned premium reserves, premium deficiency reserves and additional policy reserves from the Underwriting and Investment Exhibit, Part 2D,
E. Aggregate life policy reserves (Page 3, Line 5);
F. Property/casualty unearned premium reserves (Page 3, Line 6);
G. Aggregate health claim reserves (Page 3, Line 7);
H. Any other loss reserves, actuarial liabilities, or related items presented as liabilities in the annual statement;
I. Specified actuarial items presented as assets in the annual statement.”

Items H and I are not intended to include the liabilities and assets associated with benefits provided to employees of the organization, or the organization’s directors or trustees, except to the extent that such benefits are provided through insurance or annuity contracts of a type that the organization is authorized to issue in the ordinary course of its business. For example, liabilities for employee pensions generally would not be within the scope of the Actuarial Opinion. However, if the organization is licensed to issue life insurance, then liabilities arising from life insurance policies or certificates issued by the organization to its employees would be within the scope of the Actuarial Opinion just as would the comparable liabilities arising from policies or contracts issued to unrelated parties.

If there are any items included in items H or I, they should be listed using appropriate annual statement captions and line references. The phrase “Not Applicable” should be placed under the item description for either item H or I if there is nothing to be listed. Any listings under items H and I do not constitute either “additional wording” or “revised wording” for purposes of the Table of Key Indicators.

If for either item H or item I there is more than one line item to be listed, the line items under the general H or I heading should be numbered sequentially.

The amounts of any assets listed under item I should be the gross amount of the asset (Page 2, Column 1 of the Annual Statement), not the net admitted amount (Page 2, Column 3).

For items A through G listed in the SCOPE section and each sub-line for items H and I, the item label should be followed by the amount of that item as reported in the annual statement. These stated amounts do not constitute either “additional wording” or “revised wording” for purposes of the Table of Key Indicators. Where the phrase “Not Applicable” is used in item H or item I, it means that there are no such items to be included in the Opinion, so there should be no value shown as a stated amount.

For example:

I. Specified actuarial items presented as assets in the annual statement, as follows:

1. Accrued retrospective premiums (Page 2, line 15.3, column 1)

Section 6.

The RELIANCE section should contain only one of the following if the appointed actuary is using the prescribed wording:

If the appointed actuary has examined the asset and liability records, the reliance section should include only the following statement:

“My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic asset and liability records and such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic liability records to the Underwriting and Investment Exhibit, Part 2B of the company’s current annual statement.”

If the appointed actuary has not examined the underlying records, but has relied upon data (e.g., asset or liability records) prepared by the company, the reliance section should include only the following statement:

“In forming my opinion on [specify types of reserves] I relied upon data prepared by [name and title of company officer certifying liability records or other data] as certified in the attached statements. I evaluated that data for reasonableness and consistency. I also reconciled that data to the Underwriting and Investment Exhibit, Part 2B of the company’s current annual statement. In other respects, my examination included review of the actuarial assumptions and actuarial methods used and tests of the calculations I considered necessary.”

Attached to the appointed actuary’s opinion should be a statement by each person relied upon and a precise identification of the items subject to reliance. In addition, the persons on whom the appointed actuary relies shall
each provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness or reasonableness, as applicable, of the items. This certification shall include the signature, title, company, address and telephone number of the person rendering the certification, as well as the date on which it is signed.

Section 7.

The OPINION section should include only the following statement if the appointed actuary is using the prescribed wording:

“In my opinion, the amounts carried in the balance sheet on account of the items identified above:

A. Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles;

B. Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared;

C. Meet the requirements of the Insurance Laws and regulations of the state of [state of domicile] and:

(Use of one the following phrases, as appropriate, is considered prescribed wording. Replacing “[list states]” with an actual list of states in parentheses is also considered prescribed wording.)

are at least as great as the minimum aggregate amounts required by any state in which the statement is filed

or

are at least as great as the minimum aggregate amounts required by any state with the exception of the following states [list states]. For each listed state a separate statement of actuarial opinion was submitted to that state that complies with the requirements of that state;

D. Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements when such liabilities are considered in combination with any actuarial assets included in the scope of this opinion;

E. Are computed on the basis of assumptions and methods consistent with those used in computing the corresponding items in the annual statement of the preceding year-end; and

F. Include appropriate provision for all actuarial items that ought to be established.

The Underwriting and Investment Exhibit, Part 2B was reviewed for reasonableness and consistency with the applicable Actuarial Standards of Practice.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this statement of opinion.”

Section 9.

If the appointed actuary is able form an opinion that is not qualified, adverse or inconclusive as those terms are defined below, he or she should issue a statement of unqualified opinion. If the opinion is adverse, qualified or inconclusive, the appointed actuary should issue an adverse, qualified or inconclusive opinion explicitly stating the reason(s) for such opinion. In all circumstances the category of opinion should be explicitly identified in the TABLE of KEY INDICATORS section of the Actuarial Opinion.
An adverse opinion is an actuarial opinion in which the appointed actuary determines that the reserves and liabilities, when considered in combination with any assets included in the scope of the opinion, are not good and sufficient. (An adverse opinion does not meet item D of Section 7.)

When, in the actuary’s opinion, the reserves or amount of a certain item (or items) are in question because they cannot be reasonably estimated or the actuary is otherwise unable to render an opinion on those items, the actuary should issue a qualified opinion. Such a qualified opinion should state whether the stated reserve amounts make a good and sufficient provision for the liabilities associated with the specified reserves, when considered in combination with any assets included in the scope of the opinion, except for the item (or items) to which the qualification relates. The actuary is not required to issue a qualified opinion if the actuary reasonably believes that the item or items in question are not likely to be material. (A qualified opinion does not meet one or more of the items A, B, C or F of Section 7.)

The actuary’s ability to give an opinion is dependent upon data, analyses, assumptions and related information that are sufficient to support a conclusion. If the actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions or related information, then the actuary should issue an inconclusive opinion. An inconclusive opinion shall include a description of the reasons a conclusion could not be reached.

https://naiconline.sharepoint.com/:b:/r/sites/NAICSupportStaffHub/Member%20Meetings/Summer%202021/TF/HealthActuarial/Conference%20Calls/4-23%20HATF/Exposure%20Comments/WA%20Comments.pdf?csf=1&web=1&lc=en-US
April 16, 2021

Eric A. Cioppa
Health Actuarial (B) Task Force
National Association of Insurance Commissioners
444 North Capitol St., NW Ste 700
Washington, D.C. 20001-1512

Submitted via email to Eric King at eking@naic.org

RE: Health Statement of Actuarial Opinion Instructions Exposure Draft

Dear Superintendent Cioppa:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the proposed revisions to the Health Statement of Actuarial Opinion Instructions.

BCBSA is a national federation of 35 independent, community-based and locally operated Blue Cross and Blue Shield companies (Plans) that collectively provide health care coverage for one in three Americans. For more than 90 years, Blue Cross and Blue Shield companies have offered quality health care coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

BCBSA agrees that revisions should be made to align the instructions with Actuarial Standard of Practice (ASOP) 28 by including actuarial assets in the scope. We have the following comments to clarify some of the revisions.

Under Section 5, we suggest that the insertion “actuarial assets” should be replaced with “actuarial assets included and identified in the scope of the actuarial opinion” to clarify that the opinion only covers assets specifically identified in the scope.

Under Section 7.C., insert at the beginning of 7.C the words “The loss reserves and actuarial liabilities” and then continue with “meet the requirements……” to clarify that minimum aggregate amounts required by states are typically specific to loss reserves and actuarial liabilities rather than the combination of loss reserves, actuarial liabilities and actuarial assets.

Under Section 9, we suggest that the word “actuarial” be inserted before the word “assets” in the revisions shown in the second and third paragraphs.
We appreciate your consideration of our comments. If you have any questions or want additional information, please contact Barb Klever at barbara.klever@bcbsa.com.

Sincerely,

Barbara Klever, FSA, MAAA
Senior Actuary, Policy

https://naiconline.sharepoint.com/b:/r/sites/NAICSupportStaffHub/Member%20Meetings/Summer%202021/TF/HealthActuarial/Conference%20Calls/4-23%20HATF/Exposure%20Comments/BCBSA_Comment%20Letter%20Actuarial%20Opinion%20HATF%20041621%20final.pdf?csf=1&web=1&src=4GH6nW
April 19, 2021

Eric King
Health Actuary
Health Actuarial (B) Task Force
National Association of Insurance Commissioners (NAIC)

Re: Request for comments on proposal to modify the definition of “actuarial assets” as used in the instructions for the Health Statement of Actuarial Opinion

Dear Mr. King:

I write on behalf of the American Academy of Actuaries (Academy)¹ Financial Reporting and Solvency Committee of the Health Practice Council regarding the blanks proposal to modify the instructions for the Health Statement of Actuarial Opinion to address “actuarial assets,” which we have reviewed. We appreciate the opportunity to provide the following comments.

Generally, we believe the changes are appropriate as they address the inclusion of wording reflecting that actuarial assets need to be covered by the actuarial opinion. We have the following specific comments:

1. The wording modifications in Sections 4. and 5. are fairly minor (addition of words: “actuarial assets”) and sensible considering actuaries are required to opine on both actuarial assets and liabilities.

2. The wording added in Section 7.D: “Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements, when such liabilities are considered in combination with any actuarial assets included in the scope of this opinion…” while a bit cumbersome, would essentially result in the actuary signing off on actuarial assets and liabilities held on the balance sheet considering good and sufficient concepts, so is not objectionable.

3. The revisions in Section 9. incorporate actuarial assets wording into instructions related to considerations when issuing adverse, qualified or inconclusive opinions, which is appropriate.

4. One item that is not addressed in the Instructions to the Annual Health Statement Blank, Actuarial Opinion is the definition of an “actuarial asset.” While actuaries generally can point to other guidance to determine what could reasonably be

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¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
considered an “actuarial asset,” it does not appear to be well defined within the NAIC instructions. The NAIC may want to consider adding some certainty to what is a reasonable approach to determining what constitutes an “actuarial asset” to be included in the Actuarial Opinion.

*****

If you have any questions or would like to discuss further, please contact Matthew Williams, the Academy’s senior health policy analyst, at williams@actuary.org.

Sincerely,

Marc Lambright, MAAA, FSA
Chairperson, Financial Reporting and Solvency Committee
American Academy of Actuaries
April 15, 2021

Ms. Marti Hooper, Chair  
Health Actuarial (B) Task Force  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO  64106-2197

Via electronic mail to Eric King.

Re: Proposed changes to the Health Annual Statement instructions for the Actuarial Opinion.

Dear Ms. Hooper:

I am writing on behalf of UnitedHealth Group with regard to the proposed changes to the Health Annual Statement instructions for the Actuarial Opinion, as exposed for comment by your Task Force on April 6, 2021. Overall, we are supportive of the proposed changes. However, there are two aspects of the proposal that we feel deserve further comment.

First, we would like to emphasize that we believe that the proposal does not represent a change from what is currently required by the existing instructions. In particular:

- Sections 4 and 5 of the instructions refer to “loss reserves, actuarial liabilities, and related items.” We consider the term “related items” to include the actuarial assets that are within the scope of the Actuarial Opinion. Generally speaking, the assets are either claim-related, and therefore can be viewed as supplementing the actuarial liabilities for claims; or they are premium-related, and can be viewed as supplementing the actuarial liabilities for policy reserves. Accordingly, we do not feel that the existing language of Sections 4 and 5 is inconsistent with the inclusion of actuarial assets.

- In Section 7, the prescribed wording begins, “In my opinion, the amounts carried in the balance sheet on account of the items identified above: …” The “items identified above” are all of the items listed in the Scope section of the Actuarial Opinion, including the actuarial assets. Therefore, all of the subsequent statements in Section 7 must be deemed to apply to the actuarial assets, unless clearly inapplicable.
In Section 9, the language regarding qualified Actuarial Opinions certainly could be construed to apply only to actuarial liabilities. However, we believe that as a practical matter, both the Appointed Actuary and any regulatory reviewer of the Actuarial Opinion would recognize that an Actuarial Opinion might be qualified with regard to an actuarial asset, as well.

Therefore, we view the proposed changes to be a clarification of the existing requirements, rather than a change to those requirements. That said, we welcome such a clarification, especially with regard to Section 9, where the existing language is somewhat misleading.

Second, we wish to point out that the statements in the Opinion section of the Actuarial Opinion (Section 7 of the instructions) cannot readily be applied to the net of the actuarial liabilities and assets, as there was some discussion of that issue during your April 6 conference call. Perhaps the clearest case is statement C, which requires the Appointed Actuary to affirm that the amounts identified in the Scope section “are at least as great as the minimum aggregate amounts required by any state.” An amount that has been reduced by netting the actuarial assets against it is unlikely to meet a state’s minimum liability standards. With regard to how each of the statements applies to the combination of liabilities and assets, we note the following.

- Statements A and F could conceivably be applied to the net of the actuarial liabilities and actuarial assets.

- Statements B and E can be considered to apply to the liabilities and assets collectively; they relate to assumptions and methodology rather than the numerical amounts of the actuarial items.

- Statement C typically will apply only to the liabilities. That does not necessarily need to be spelled out explicitly, because there probably are no state minimum requirements applicable to actuarial assets, in which case the requirement is effectively zero. That being the case, the amount of any asset will automatically be at least as great as what’s required (i.e., will be greater than or equal to zero).

- Statement D is the “good and sufficient” statement. In order to meet the “good and sufficient” standard, the assets and liabilities must incorporate a certain degree of conservatism or “margin,” whether implicit, explicit, or both. We believe that in practice, that standard means that the liabilities within the scope of the Actuarial Opinion, in aggregate, must include an adequate provision for a reasonable degree of adverse deviation from the anticipated experience, and that such provision must not be materially impaired by any overstatement of the aggregate assets that are within the scope of the Actuarial Opinion.

Accordingly, it does not seem that there is a uniform way that actuarial assets can be addressed by the statements in the Opinion section. If your Task Force believes that more clarity is needed, we suggest that rather than trying to revise the Opinion statements, you could include guidance in the instructions (just as guidance about the type of Actuarial Opinion is provided in Section 9 of the instructions).
In conclusion, we support the proposed changes, and we suggest that any additional clarification of Section 7 be made through additional instructions rather than through changes to the prescribed wording of the Statement of Actuarial Opinion. The bullet points above concerning statements A through F might serve as a starting point for such instructions, if desired.

We would be happy to discuss these comments with you and the Task Force.

James R. Braue  
Director, Actuarial Services  
UnitedHealth Group

cc: Eric King, NAIC  
Randi Reichel, UnitedHealth Group
## NAIC BLANKS (E) WORKING GROUP

### Blanks Agenda Item Submission Form

| CONTACT PERSON: | Eric King |
| TELEPHONE: | 816-708-7982 |
| EMAIL ADDRESS: | eking@naic.org |
| ON BEHALF OF: | ASOP 28 Task Force, ASB |
| NAME: | Annette James, Chair, ASOP 28 Task Force |

### Agenda Item Information

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<thead>
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<tr>
<td>Agenda Item #</td>
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<tr>
<td>Year</td>
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<tr>
<td>Changes to Existing Reporting [ ]</td>
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<td>New Reporting Requirement [ ]</td>
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### DISPOSITION

[ ] Rejected For Public Comment
[ ] Referred To Another NAIC Group
[ ] Received For Public Comment
[ ] Adopted Date
[ ] Rejected Date
[ ] Deferred Date
[ ] Other (Specify) ____________

### BLANK(S) TO WHICH PROPOSAL APPLIES

[ ] ANNUAL STATEMENT
[ ] QUARTERLY STATEMENT
[ ] Life, Accident & Health/Fraternal
[ ] Property/Casualty
[ ] Health

[ ] INSTRUCTIONS
[ ] Separate Accounts
[ ] Protected Cell
[ ] Health (Life Supplement)

[ ] CROSSCHECKS
[ ] Title
[ ] Other ____________

### ANTICIPATED EFFECTIVE DATE

Annual 2021

### IDENTIFICATION OF ITEM(S) TO CHANGE

See the following page for details of proposed changes.

### REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to revise the language in sections 4, 5, 7 and 9 of the orange blank annual statement instructions related to the actuarial opinion to ensure that all items (actuarial assets and liabilities) within the scope of the statement of actuarial opinion are treated consistently. Currently, reserves and liabilities are referenced in sections 4, 5, 7 and 9 of the orange blank annual statement instructions. Since actuarial assets are included in the scope of the actuarial opinion, it is important that these instructions provide guidance to appointed actuaries that apply to all actuarial items, assets as well as liabilities, included in the scope of the actuarial opinion.

### NAIC STAFF COMMENTS

Comment on Effective Reporting Date: ____________

Other Comments: ____________

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** This section must be completed on all forms. Revised 7/18/2018
IDENTIFICATION OF ITEM(S) TO CHANGE

Instructions to Annual Health Statement Blank, Actuarial Opinion (Actuarial Opinion Instructions):

Modify section 1A. (Definitions), of the actuarial opinion instructions to add definitions of “actuarial asset” and “actuarial liability”.

Modify section 4 (Identification section), section 5 (Scope section), and section 7 (Opinion section) of the actuarial opinion instructions to ensure that the opinion’s prescribed wording clearly indicates that the actuary’s opinion covers actuarial assets as well as actuarial liabilities.

Modify section 9 of the actuarial opinion instructions to ensure that guidance related to the type of opinion rendered by an appointed actuary covers both actuarial assets and actuarial liabilities.

Section 1

1A. Definitions

“Insurer” means an entity authorized to write accident and health contracts under the laws of any state and which files on the Health Blank.

“Actuarial Memorandum” means a document or other presentation prepared as a formal means of conveying the appointed actuary’s professional conclusions and recommendations, of recording and communicating the methods and procedures, of assuring that the parties addressed are aware of the significance of the appointed actuary’s opinion or findings and that documents memorandum is further described in Section 1C.

“Actuarial asset” means an actuarial item presented as an asset in the annual statement and included in the scope of the Statement of Actuarial Opinion.

“Actuarial liability” means an actuarial item presented as a liability in the annual statement and included in the scope of the Statement of Actuarial Opinion.

Section 4

4. The IDENTIFICATION section should specifically indicate the appointed actuary’s relationship to the company, qualifications for acting as appointed actuary, date of appointment, and should specify that the appointment was made by the Board of Directors, or its equivalent or by a committee of the Board. A person who is not a Member of the American Academy of Actuaries but is recognized by the Academy as qualified must attach, each year, a copy of the approval letter from the Academy.

This section should contain only one of the following:

For a Member of the American Academy of Actuaries who is an employee of the organization, the opening paragraph of the opinion should contain all the following sentences if the appointed actuary is using the prescribed wording:

“I, (name and title of actuary), am an employee of (named organization) and a member of the American Academy of Actuaries. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion.”

For a consultant who is a Member of the American Academy of Actuaries, the opening paragraph of the opinion should contain all the following sentences if the appointed actuary is using the prescribed wording:

“I, (name and title of consultant), am associated with the firm of (name of firm). I am a member of the American Academy of Actuaries and have been retained by the (name of organization) to render an opinion with regard to loss reserves, actuarial liabilities, actuarial assets, and related items. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion.”
Section 5:
5. The SCOPE section should contain only the following statement (including all specified lines even if the value is zero) if the appointed actuary is using the prescribed wording:

“I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities, actuarial assets, and related items listed below, as shown in the annual statement of the organization as prepared for filing with state regulatory officials, as of December 31, 20__.

Section 7:
7. The OPINION section should include only the following statement if the appointed actuary is using the prescribed wording:

“In my opinion, the amounts carried in the balance sheet on account of the items identified above:

A. Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles;

B. Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared;

C. Meet the requirements of the Insurance Laws and regulations of the state of [state of domicile] and:
   (Use of one the following phrases, as appropriate, is considered prescribed wording. Replacing “[list states]” with an actual list of states in parentheses is also considered prescribed wording.)
   the loss reserves and actuarial liabilities are at least as great as the minimum aggregate amounts required by any state,
   or
   the loss reserves and actuarial liabilities are at least as great as the minimum aggregate amounts required by any state with the exception of the following states [list states]. For each listed state a separate statement of actuarial opinion was submitted to that state that complies with the requirements of that state;

D. Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements, when such liabilities are considered in combination with any actuarial assets included in the scope of this opinion...”

Section 9:
9. If the appointed actuary is able form an opinion that is not qualified, adverse or inconclusive as those terms are defined below, he or she should issue a statement of unqualified opinion. If the opinion is adverse, qualified or inconclusive, the appointed actuary should issue an adverse, qualified or inconclusive opinion explicitly stating the reason(s) for such opinion. In all circumstances the category of opinion should be explicitly identified in the TABLE of KEY INDICATORS section of the Actuarial Opinion.

An adverse opinion is an actuarial opinion in which the appointed actuary determines that the reserves and liabilities, when considered in combination with any actuarial assets included in the scope of the opinion, are not good and sufficient. (An adverse opinion does not meet item D of Section 7.)

When, in the actuary’s opinion, the reserves or actuarial assets included in the scope of the opinion for a certain item or items are in question because they cannot be reasonably estimated or the actuary is unable to render an opinion on those items, the actuary should issue a qualified opinion. Such a qualified opinion should state whether the stated reserve amount makes a good and sufficient provision for the liabilities associated with the specified reserves, when considered in combination with any actuarial assets included in the scope of the opinion, except for the item or items to which the qualification relates. The actuary is not required to issue a qualified opinion if the actuary reasonably believes that the item or items in question are not likely to be material. (A qualified opinion does not meet one or more of the items A, B, C or F of Section 7.)
The actuary’s ability to give an opinion is dependent upon data, analyses, assumptions and related information that are sufficient to support a conclusion. If the actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions or related information, then the actuary should issue an inconclusive opinion. An inconclusive opinion shall include a description of the reasons a conclusion could not be reached.
The Health Actuarial (B) Task Force met April 6, 2021. The following Task Force members participated: Eric A. Cioppa, Chair, represented by Marti Hooper (ME); Andrew N. Mais, Co-Vice Chair, represented by Paul Lombardo (CT); Jonathan T. Pike, Co-Vice Chair, represented by Jaakob Sundberg (UT); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Jennifer Li (AL); Ricardo Lara represented by Perry Kupferman (CA); Michael Conway represented by Eric Unger (CO); Dean L. Cameron represented by Weston Trexler (ID); Dana Popish Severinghaus represented by Eric Anderson (IL); Anita G. Fox represented by Kevin Dyke (MI); Grace Arnold represented by Julia Lyng (MN); Chlora Lindley-Myers represented by William Leung (MO); Mike Causey represented by David Yetter (NC); Bruce R. Ramge represented by Michael Muldoon (NE); Marlene Caride represented by Seong-min Eom (NJ); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Jim Laverty (PA); Doug Slape represented by Barbara Snyder (TX); Scott A. White represented by David Shea (VA); Mike Kreidler represented by Amy Peach (WA); Mark Afable represented by Brian Brown (WI); and James A. Dodrill represented by Joylynn Fix (WV).

1. Exposed a Proposal to Revise the Instructions for the Health SAO

Annette James (NovaRest Actuarial Consulting) presented a proposal (Attachment One-B1) to revise the language in Section 4, Section 5, Section 7 and Section 9 of the instructions for the health Statement of Actuarial Opinion (SAO) to ensure that all items (actuarial assets and liabilities) within the scope of the SAO are treated consistently.

Ms. Hooper said the Task Force will expose the proposal for a 10-day public comment period ending April 16.

Having no further business, the Health Actuarial (B) Task Force adjourned.
### NAIC BLANKS (E) WORKING GROUP

**Blanks Agenda Item Submission Form**

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<th>DATE: April 6, 2021</th>
<th>FOR NAIC USE ONLY</th>
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<tbody>
<tr>
<td>Eric King</td>
<td></td>
<td>Agenda Item #________</td>
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<tr>
<td>TELEPHONE:</td>
<td>816-708-7982</td>
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<td>EMAIL ADDRESS:</td>
<td><a href="mailto:eking@naic.org">eking@naic.org</a></td>
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<td>ON BEHALF OF:</td>
<td>ASOP 28 Task Force, ASB</td>
<td>New Reporting Requirement [ ]</td>
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<tr>
<td>NAME:</td>
<td>Annette James, Chair, ASOP 28 Task Force</td>
<td>REVIEWED FOR ACCOUNTING</td>
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<td>PRACTICES AND PROCEDURES IMPACT</td>
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**BLANK(S) TO WHICH PROPOSAL APPLIES**

- [ X ] ANNUAL STATEMENT
- [ ] QUARTERLY STATEMENT
- [ ] Life, Accident & Health/Fraternal
- [ ] Property/Casualty
- [ X ] Health
- [ ] Separate Accounts
- [ ] Protected Cell
- [ ] Health (Life Supplement)
- [ ] Title
- [ ] Other ______________________

Anticipated Effective Date: **Annual 2021**

**IDENTIFICATION OF ITEM(S) TO CHANGE**

See the following page for details of proposed changes.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of this proposal is to revise the language in sections 4, 5, 7 and 9 of the orange blank annual statement instructions related to the actuarial opinion to ensure that all items (actuarial assets and liabilities) within the scope of the statement of actuarial opinion are treated consistently. Currently, reserves and liabilities are referenced in sections 4, 5, 7 and 9 of the orange blank annual statement instructions. Since actuarial assets are included in the scope of the actuarial opinion, it is important that these instructions provide guidance to appointed actuaries that apply to all actuarial items, assets as well as liabilities, included in the scope of the actuarial opinion.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: ____________________________

Other Comments: ____________________________

**This section must be completed on all forms.**

Revised 7/18/2018
IDENTIFICATION OF ITEM(S) TO CHANGE

Instructions to Annual Health Statement Blank, Actuarial Opinion (Actuarial Opinion Instructions):

Modify sections 4 (Identification section), section 5 (Scope section), and section 7 (Opinion section) of the actuarial opinion instructions to ensure that the opinion’s prescribed wording clearly indicates that the actuary’s opinion covers actuarial assets as well as actuarial liabilities.

Modify section 9 of the actuarial opinion instructions to ensure that guidance related to the type of opinion rendered by an appointed actuary covers both actuarial assets and actuarial liabilities.

**Section 4**

4. The IDENTIFICATION section should specifically indicate the appointed actuary’s relationship to the company, qualifications for acting as appointed actuary, date of appointment, and should specify that the appointment was made by the Board of Directors, or its equivalent or by a committee of the Board.

A person who is not a Member of the American Academy of Actuaries but is recognized by the Academy as qualified must attach, each year, a copy of the approval letter from the Academy.

This section should contain only one of the following:

For a Member of the American Academy of Actuaries who is an employee of the organization, the opening paragraph of the opinion should contain all the following sentences if the appointed actuary is using the prescribed wording:

“I, (name and title of actuary), am an employee of (named organization) and a member of the American Academy of Actuaries. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion.”

For a consultant who is a Member of the American Academy of Actuaries, the opening paragraph of the opinion should contain all the following sentences if the appointed actuary is using the prescribed wording:

“I, (name and title of consultant), am associated with the firm of (name of firm). I am a member of the American Academy of Actuaries and have been retained by the (name of organization) to render an opinion with regard to loss reserves, actuarial liabilities, actuarial assets, and related items. I was appointed on [date of appointment] in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion.”

**Section 5:**

5. The SCOPE section should contain only the following statement (including all specified lines even if the value is zero) if the appointed actuary is using the prescribed wording:

“I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities, actuarial assets, and related items listed below, as shown in the annual statement of the organization as prepared for filing with state regulatory officials, as of December 31, 20__.”

**Section 7:**

7. The OPINION section should include only the following statement if the appointed actuary is using the prescribed wording:

“In my opinion, the amounts carried in the balance sheet on account of the items identified above:

A. Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles;

B. Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared;
C. Meet the requirements of the Insurance Laws and regulations of the state of [state of domicile] and:
(Use of one the following phrases, as appropriate, is considered prescribed wording. Replacing “[list states]” with an actual list of states in parentheses is also considered prescribed wording.)
are at least as great as the minimum aggregate amounts required by any state,
or
are at least as great as the minimum aggregate amounts required by any state with the exception of the following states [list states]. For each listed state a separate statement of actuarial opinion was submitted to that state that complies with the requirements of that state;

D. Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements, when such liabilities are considered in combination with any actuarial assets included in the scope of this opinion…”

Section 9:

9. If the appointed actuary is able form an opinion that is not qualified, adverse or inconclusive as those terms are defined below, he or she should issue a statement of unqualified opinion. If the opinion is adverse, qualified or inconclusive, the appointed actuary should issue an adverse, qualified or inconclusive opinion explicitly stating the reason(s) for such opinion. In all circumstances the category of opinion should be explicitly identified in the TABLE of KEY INDICATORS section of the Actuarial Opinion.

An adverse opinion is an actuarial opinion in which the appointed actuary determines that the reserves and liabilities, when considered in combination with any assets included in the scope of the opinion, are not good and sufficient. (An adverse opinion does not meet item D of Section 7.)

When, in the actuary’s opinion, the reserves or assets included in the scope of the opinion for a certain item or items are in question because they cannot be reasonably estimated or the actuary is unable to render an opinion on those items, the actuary should issue a qualified opinion. Such a qualified opinion should state whether the stated reserve amount makes a good and sufficient provision for the liabilities associated with the specified reserves, when considered in combination with any assets included in the scope of the opinion, except for the item or items to which the qualification relates. The actuary is not required to issue a qualified opinion if the actuary reasonably believes that the item or items in question are not likely to be material. (A qualified opinion does not meet one or more of the items A, B, C or F of Section 7.)

The actuary’s ability to give an opinion is dependent upon data, analyses, assumptions and related information that are sufficient to support a conclusion. If the actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions or related information, then the actuary should issue an inconclusive opinion. An inconclusive opinion shall include a description of the reasons a conclusion could not be reached.
The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met May 17, 2021. The following Working Group members participated: Perry Kupferman, Chair (CA); Jennifer Li (AL); Paul Lombardo (CT); Benjamin Ben (FL); Nicole Boyd (KS); Marti Hooper (ME); Fred Andersen (MN); Rhonda Ahrens (NE); Anna Krylova (NM); Bill Carmello (NY); Andrew Schallhorn (OK); Jim Laverty (PA); Andrew Dvorine (SC); Barbara Snyder and Mike Boerner (TX); and Tomasz Serbinowski (UT).

1. Discussed an LTCI Data Call

Mr. Kupferman said the purpose of the meeting is to gauge state insurance regulator and industry interest in conducting a mandatory long-term care insurance (LTCI) morbidity data call. He said he is concerned that federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) restrictions will preclude collection of needed data for individuals older than age 90, and this is a block of data that is crucial for the success of the project. Pete Miller (Society of Actuaries—SOA) said he is confident this data can be collected at a level that will not violate HIPPA and be of sufficient granularity to be useful.

Mr. Kupferman said LTCI companies rely on company experience or consultant experience studies for reserving, and he would like the NAIC to sponsor a mandatory LTCI data call to be used for this purpose.

Mr. Andersen said approximately five years ago, the Life Actuarial (A) Task Force’s Experience Reporting (A) Subgroup evaluated whether mandatory company data reporting is warranted for various lines of business, and one of the lines evaluated was LTCI. He said LTCI was ranked as very high for morbidity data usefulness and low to moderate for the usefulness of industry-wide averages. He said there is not currently a tested format for collecting LTCI morbidity data, but recent SOA experience study formats may be convertible to a Valuation Manual (VM)-51, Experience Reporting Formats, structure.

Mr. Andersen gave an overview of a life insurance mortality data call by New York. He said New York and Kansas led the effort, MIB acted as the statistical agent, and the SOA aggregated the data. He said the data call was highly successful, but it took two to three years to complete and required new state laws to be written. He said the data call was conducted annually, and there has never been an annual experience study conducted for LTCI. Ms. Ahrens said an annual LTCI experience study would be too burdensome.

Mr. Carmello asked if authority like that for life insurance principle-based reserving (PBR) is needed for a similar LTCI project. Ms. Ahrens said the scope of the current VM-51 includes health insurance, so authority for LTCI is not an issue. Mr. Boerner noted that the current Health Actuarial (B) Task Force charge to “[d]evelop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the Valuation Manual” allows for conducting an LTCI data call.

Ms. Boyd said an LTCI data call overseen by Kansas went smoothly, but it was expensive. She said the data was collected by MIB and then forwarded to the SOA for analysis. She said there was not much pushback from subject companies concerning providing data.

Mr. Lombardo said Connecticut supports a mandatory LTCI data call, and it is very important for state insurance regulators and industry. He said he believes companies will comply with the request.

Dan Schelp (NAIC) said the NAIC is concerned the study may violate aspects of HIPPPAA and with the availability of needed financial and staff resources for the project.

Pat Allison (NAIC) said the NAIC’s current life insurance PBR data collection goes through a two-step validation process. She said the data is first checked for missing or disallowed values, then a more detailed analysis of the data’s appropriateness is conducted.

Ray Nelson (America’s Health Insurance Plans—AHIP) said he is concerned that requiring companies to submit data to the data call while also voluntarily contributing data to current SOA studies may be overly burdensome. He asked if the SOA...
studies can be expanded to meet the needs of an NAIC data call. Ms. Ahrens said she believes expansion of its studies is the direction the SOA is heading in. She said a feasible way forward is for the SOA to modify the design of its studies to fit into a form that fits the VM-51 statistical plan. She said the SOA has indicated it has the appetite for such an approach.

Mr. Andersen proposed providing the proposal below to be used to survey Working Group members for their opinions on the usefulness of an NAIC mandatory data call. He said he believes taking the time to explore all of these issues and then weighing the pros and cons before making a commitment will lead to a better chance of having a helpful, useful project.

The recommendation is to start laying the groundwork, without 100% commitment at this time, toward collecting the LTCI morbidity data starting in 2024.

The regulatory actuaries can reach out to industry to determine how helpful mandatory data collection resulting in tables of industry averages will be. The question is whether it adds much value when the SOA and Milliman already have voluntary studies and the Valuation Analysis (E) Working Group has access to timely information direct from the companies.

NAIC staff can investigate issues such as resources, technology, operations, legal issues, and money availability. The ultimate decision would be made by NAIC leadership.

Mr. Kupferman agreed to surveying Working Group members on the proposal’s merit.

Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
The Long-Term Care Actuarial (B) Working Group of the Health Actuarial (B) Task Force met March 29, 2021. The following Working Group members participated: Perry Kupferman, Chair (CA); Jennifer Li (AL); Paul Lombardo (CT); Benjamin Ben (FL); Nicole Boyd (KS); Marti Hooper (ME); Fred Andersen (MN); Rhonda Ahrens (NE); Anna Krylova (NM); Bill Carmello (NY); Laura Miller (OH); Andrew Schallhorn (OK); Jim Laverty (PA); Andrew Dvorine (SC); Barbara Snyder (TX); and Tomasz Serbinowski (UT).

1. **Heard a Presentation from the SOA on COVID-19 Impacts on LTCI**

   Mike Bergerson (Milliman) and Robert Eaton (Milliman) gave a presentation (Attachment One-D) on the Society of Actuaries’ (SOA’s) survey of long-term care insurance (LTCI) companies’ reaction to the impact of COVID-19 on LTCI mortality, voluntary lapse and morbidity experience.

   Mr. Kupferman suggested that it may be interesting to analyze the experience data separated by policyholders who were in long-term care (LTC) facilities during the exposure period and those who were not. He also suggested analyzing the data separated by individual versus group LTCI and attained age brackets. He said the effects of the vaccination rate should also be considered.

   Mr. Andersen said recent state insurance regulator analyses of reserves held by LTCI companies shows COVID-19 impacts that are similar to those shown in the SOA survey.

   Having no further business, the Long-Term Care Actuarial (B) Working Group adjourned.
### Background

- The Society of Actuaries (SOA) retained Milliman, Inc. (Milliman) to conduct a survey on the impact of COVID-19 on Long-Term Care (LTC) insurance mortality, voluntary lapse, and morbidity experience.
- The survey studied the emerging impact of COVID-19 for the period from April 1, 2020 through September 30, 2020.
- The survey did not reflect the surge of COVID-19 morbidity and mortality that took place after September 2020; further survey work is necessary to assess the impact of those cases.
- The survey was sent to companies with LTC blocks of insurance. 15 companies participated in the survey, which represented approximately 50% of the insured lives in force at year-end 2019.

### Active Life Mortality

- About half of the respondents reported observing an increase in active life mortality.

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Disabled Life Mortality

• About half of the respondents reported observing an increase in disabled life mortality.

Additional Comments on Mortality

• Three companies observed a higher mortality impact on disabled life mortality than on active life mortality. Two companies observed a smaller impact on disabled life mortality compared to active life mortality.
• A number of companies indicated that mortality levels increased initially but started to regress towards pre-COVID levels by the end of the survey reporting period.

Voluntary Lapse

• Results on voluntary lapse rates were mixed.
• A number of companies indicated that they have not adjusted lapse rates for premium grace period extensions due to COVID-19.

Morbidity
Claim Incidence

- The biggest impact on morbidity observed by companies thus far has been related to claim incidence.
- Seven companies (58%) reported seeing a shift in claim status toward a home health care setting. This was true for both existing claims and new claims but especially so for new claims.
- Some companies indicated that claim incidence levels decreased initially but started to regress toward pre-COVID levels by September 2020.

Claim Reserves

- A majority of the respondents reported observing a decrease in claim reserves.
- This is consistent with the increase in disabled mortality and decrease in claim incidence experience observed by many companies.

Other Reserves

- Half of respondents indicated there was no impact on gross premium reserves (GPR), premium deficiency reserves (PDR), or additional actuarial reserves (AAR). Of the companies that indicated there was an impact, most said one or more of these reserves increased as a result of a decrease in new money interest rates.
- For companies that reported no impact on GPR, PDR, or AAR reserves, we believe that companies are indicating they have not changed valuation assumptions due to COVID-19. However, some companies may be indicating there is no net change (i.e., no impact) due to updates in valuation assumptions from COVID-19.
What’s next?

• Continued research as data emerges on shorter-term impacts
• Watching data closely to see if short-term habits become long-term
• Shift towards home health care instead of facility
• Hygiene/social changes – impact on regular flu in the future
• Following medical research to understand any longer lasting health impacts from COVID-19 and considering potential impact on LTC assumptions
2022 PROPOSED CHARGES

HEALTH ACTUARIAL (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

2. The **Long-Term Care Actuarial (B) Working Group** will:
   - A. Assist the Health Actuarial (B) Task Force in completing the following charges:
     - 1. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices, and rate changes.
     - 2. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a PBR framework.
     - 3. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.

3. The **Long-Term Care Pricing (B) Subgroup** will:
   - A. Assist the Long-Term Care Actuarial (B) Working Group in completing the following charge:
     - 1. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices, and rate changes.

4. The **Long-Term Care Valuation (B) Subgroup** will:
   - A. Assist the Long-Term Care Actuarial (B) Working Group in completing the following charges:
     - 1. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a PBR framework.
     - 2. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.

NAIC Support Staff: Eric King

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SERFF to URR Module Transfer

Presentation for the Health Actuarial Task Force of the National Association of Insurance Commissioners

November 29, 2021

Megan Mason
Dir. Rate Review, CCIO, CMS

The CMS and NAIC development teams have been working on a system connection between the System for Electronic Rates & Forms Filing (SERFF) and the Health Insurance Oversight System Unified Rate Review (HIOS URR) module tentatively scheduled for release in Spring 2022. This connection allows automatic data and file transfers between the two systems to reduce duplicative manual entry work for both Issuers and State reviewers. The new system connection is Not Applicable to States without an Effective Rate Review process, or states that do not utilize the SERFF system. The issuers in these states should continue to submit filings in the HIOS URR module directly.

---

**STEP 1 – New Tab in SERFF**

All rate filing information for the individual and small group markets will be entered directly into SERFF where there will be a new tab added titled URRT. This includes:
- Part I – URRT
- Part II – Written Description Justifying the Rate Increase
- Part III – Rate Filing Documentation (both the Actuarial Memorandum and the Redacted Actuarial Memorandum)

Once validated by the system, the information will be automatically transferred to the URR module of HIOS.

---

**STEP 2 – Is the URRT Required?**

Once the user navigates to the URRT view, they will be asked if URRT is applicable to this rate filing:

The Unified Rate Review Template is required to be submitted by issuers (for both QHPs and non-QHPs) offering a single risk pool plan in the individual or small group market. Issuers can submit quarterly rate changes for the small group market if allowed by the State regulatory authority. Quarterly rate changes must be submitted at least 105 days prior to the effective date of the rate change (or earlier State deadline).

Note: These filings do not include Student Health or Excepted Benefit products, such as Stand-alone Dental products.

Is the URRT required for this filing? ☑️ ☐️ ☐️
STEP 3 – Adding the URRT

The second field is the template itself; additional items cannot be uploaded until the template has been added:

**Actuarial Memorandum**
- Can only be added after the Uniform Rate Review Template is added.
- Actuarial Memorandum - Redacted: Can only be added after the Uniform Rate Review Template is added.

STEP 4 – Validation of the URRT

Once the template has been uploaded, it will be sent to CMS for validation and a message appears to the issuer:

**Uniform Rate Review Template**
To download the latest version of the Uniform Rate Review Template, please visit the CMS website at [https://www.sherrff.org/cms/uploaded URRT template]. Please upload the NRL version of the template created by the issuer and not the text file itself.

**In Progress: URRT validation with CMS in progress. Check back later for validation success or failures.**

STEP 5 – Regenerated URRT

Once the validation request has been processed, the message will update accordingly. If the validation is successful, SERRF also displays the regenerated Excel file:

**Success: CMS URRT validation was successful.**

STEP 6 – Actuarial Memorandum

Issuers will be required to upload the Actuarial Memorandum and Redacted Actuarial Memorandum:

**Actuarial Memorandum**
The actuarial memorandum, including a corresponding actuarial certification, must be submitted with each uniform rate review template. This document should contain all necessary assumptions and methodologies that support the entries in the URRT. This document must be a PDF.

**Actuarial Memorandum - Redacted**
A redacted version of the Actuarial Memorandum. This redacted document will be made available to the issuer and CMS. It should not contain any information that is private, secret or confidential or sensitive to financial information. This document must be a PDF.
STEP 7 – Consumer Justification Narrative

Issuers can upload the Consumer Justification Narrative (CJN) if not above threshold, but if the CJN is required, they will also be required to upload the CJN and the user interface indicates this new requirement:

STEP 8 – Supporting Documentation

Finally, there is the Additional Supporting Documentation section where up to 30 files can be uploaded.

STEP 9 – Other SERFF Functions

Upon submission of the filing, the information from the URRT tab will be submitted to the state but also sent to CMS. The template and supporting URR items can also have the following SERFF functions applied, but these functions will not be transferred to the URR module of HIOS:

- Request Confidentiality
- Objections/Objections Letters
- Change Schedule Items
- Response Letters
- Amendment Letters
- State Public Access

STEP 10 – State Determinations

Finally, once the state review is complete, the state will mark the URRT as complete as their determination. If the filing contains only plans below the threshold:

<table>
<thead>
<tr>
<th>Acknowledge Review</th>
<th>URRT Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOS ID</td>
<td>1234</td>
</tr>
</tbody>
</table>

URRT Documents
STEP 10 – State Determinations (cont.)

If the filing contains at least one plan above the threshold:

Select URRT determination

Comments

Send to CMS

STEP 11 – Determination Display

Once a state regulator enters a final determination, the following information will be displayed. The URRT determination and the comments will be sent to the URR Module of HIOS and displayed on ratereview.healthcare.gov. Once a determination has been sent to CMS, there can be no further action on the URRT tab from the issuer or the state.

QUESTIONS???
## SOA HEALTH EXPERIENCE STUDIES RESEARCH IN PROGRESS - December 2021

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Objective</th>
<th>Expected Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-2015 Individual Disability Income - Experience Modifications to the 2013 Individual Disability Income Valuation Table Claim Termination Rates</td>
<td>Complete a study of claim termination for individual disability and release a report of Experience Modifications to the 2013 Individual Disability Income Valuation Table Claim Termination Rates.</td>
<td>11/18/2021</td>
</tr>
<tr>
<td>2000-2011 LTC Lapse and Mortality Valuation Assumptions</td>
<td>Develop a replacement mortality LTC valuation table and a proposal to replace the current LTC voluntary lapse parameters. Work done in conjunction with the AAA.</td>
<td>11/30/2021</td>
</tr>
</tbody>
</table>

1 https://www.soa.org/resources/experience-studies/2021/analysis-claim-termination/  
2 https://www.soa.org/resources/research-reports/2021/covid-19-impact-ltc/
American Academy of Actuaries
Health Practice Council
2021 Updates
Barbara Klever, MAAA, FSA
Vice Chairperson, Health Practice Council
American Academy of Actuaries

About the American Academy of Actuaries
The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy and its boards also set qualification, practice, and other professionalism and ethical standards for actuaries credentialed by one or more of the five U.S.-based actuarial organizations in the United States.

Public Policy and the Academy
The Academy, through its public policy work, seeks to address pressing issues that require or would benefit from the application of sound actuarial principles. The Academy provides unbiased actuarial expertise and advice to public policy decision-makers and stakeholders at the state, federal, and international levels in all areas of actuarial practice.

Key Health Policy Priorities for 2021
- COVID-19: Implications for Health Care Utilization and Spending
- Health Insurance Coverage and the Affordable Care Act
- Health Equity
- Long-Term Care
- Medicare Sustainability
COVID-19: Implications for Health Care Utilization and Spending

- Issue Briefs / Papers:
  - COVID-19's Impacts on Long-Term Care Insurance
  - Telehealth After COVID-19
  - Medicaid Managed Care Plan Rate Setting as Impacted by COVID-19

- Comment Letters:
  - Comments to Treasury, DOL, and HHS on Insurance and Health Plan Coverage of COVID-19 Testing

Health Insurance Coverage and the Affordable Care Act

- Issue Briefs:
  - Drivers of 2022 Health Insurance Premium Changes

- Comment Letters:
  - Health Practice Council (HPC) Comments on Review of Agency Actions Related to the Affordable Care Act and Medicaid
  - Comments to HHS, DOL, and the Treasury on the No Surprises Act
  - Comments to CMS on Updating Payment Parameters Proposed Rule

Health Equity

- Discussion Briefs:
  - Health Equity From an Actuarial Perspective
  - Health Equity and Premium Pricing
  - Health Equity and Health Plan Benefit Design
  - Health Equity and Provider Contracting/Network Development
  - Health Equity and Managing Population Health

- Comment Letters:
  - Comment Letters on Colorado Senate Bill 21-169 [March] and [April] 2021, a bill to protect consumers from unfair discrimination in insurance practices
  - Request for Information (RFI) on Assessing Whether or How Actuarial Practices Affect Health Disparities — Information due to the Academy by Jan. 14, 2022

Long-Term Care

- Issue Briefs:
  - Regulatory Options for Long-Term Care (LTC) Insurance Innovation
  - Long-Term Care Financing Reform Proposals Involving Public Programs

- Reports:
  - Long-Term Care Insurance Mortality and Lapse Study
  - Request from NAIC Long-Term Care Actuarial Working Group (LTCAWG)

- Practice Notes:
  - Long-Term Care Insurance
Medicare Sustainability

- Issue Briefs:
  - Medicare’s Financial Condition: Beyond Actuarial Balance

Additional Academy HPC Updates

- Practice Note: Actuarial Standard of Practice (ASOP) No. 6—Development of Age-Specific Retiree Health Cost Assumptions, Including Applications to Pooled and Non-Pooled Health Plans
  - Oct. 2021 Presentation at the CCA Annual Meeting

- The Academy formed the Climate Change Joint Task Force in Oct. 2021, and membership is comprised of the HPC, the Casualty Practice Council (CPC), and the Risk Management and Financial Reporting Council (RMFRC).

HPC NAIC Workstreams—HATF

- Health Actuarial (B) Task Force
  - Request for comments on proposal to modify the definition of “actuarial assets” as used in the instructions for the Health Statement of Actuarial Opinion
  - April and May 2021 Academy comment letters

HPC NAIC Workstreams—HRBC

- Health Risk-Based Capital (E) Working Group
  - Request for Analysis to Incorporate Investment Income into the Underwriting Risk Component of the Health Risk-Based Capital Formula
    - Jan. 2021, Feb. 2021, and April 2021 Academy comment letters
  - Request for Comprehensive Review of the H2—Underwriting Risk Component and Managed Care Credit Calculation in the Health Risk-Based Capital Formula
    - July 2021 Academy comment letter
HPC NAIC Workstreams—LTC (EX)

- NAIC Long-Term Care Insurance (EX) Task Force Long-term Care Insurance MSA Framework. Academy comments on:
  - Long-Term Care Insurance (LTC) Multistate Rate Review Framework
  - Actuarial Sections
  - Operational and Actuarial Sections, Sept. 2021 Exposures
- Long-Term Care Insurance Reduced Benefit Options (EX) Subgroup
  - Academy comments on exposure draft, Issues Related to LTC Wellness Benefits

HPC NAIC Workstreams—Special (EX) R&I Workstream #5

- NAIC Special (EX) Committee on Race and Insurance—Workstream 5 (Health)
  - Comments on Exposure Draft of White Paper on Provider Network Outline
  - Comments on the Revised Exposure Draft of Principles for Data Collection

2021 HPC Virtual Hill Visits

- April 15 and 16, 2021, via Zoom
- More than 20 Academy volunteers took part in 24 meetings with Hill and agency staffers
- Issues discussed included: Medicaid and Medicare, health equity, telehealth, COVID-19, surprise billing, prescription drug prices, long-term care (LTC), and the Affordable Care Act (ACA)

Academy Presentations

- Feb. 2021 Senior Health Fellow presentation on “Medicare Solvency Projections and Potential Policy Solutions” webinar sponsored by the Alliance for Health Policy.
- April 2021 presentation to Columbus Actuarial Club on “Long-Term Care Insurance: Public Policy Update”
- May 2021 Academy webinar on “Health Equity: An Actuarial Perspective”
- June 2021 presentation to the SOA on “Health Equity: How Actuaries Are Contributing to Efforts to Reduce Health Disparities”
- Oct. 2021 presentations to the CCA on “Social Determinants of Health & Health Equity” and “ASOP No. 6 Practice Note”
Academy 2021 Annual Meeting and Public Policy Forum

- Nov. 4 and 5, 2021, annual conference
- Three health-specific breakout sessions
  - "Addressing the Risk of Medicare Insolvency"
  - "Regulating the Affordable Care Act: What’s New for 2022"—Presentation from CMS/CCIIO
  - "Expanding Access to Health Insurance Coverage"
- Plenaries covering cross-practice equity and COVID-19 issues

Stay Up-to-Date at actuary.org

Under the Public Policy tab, access Academy:
- Comments and letters
- Issue briefs
- Policy papers
- Presentations
- Reports to the NAIC
- Testimony

Thank You

Questions?

Contact: Matthew Williams, JD, MA
Senior Health Policy Analyst
williams@actuary.org
Requests of the LTC Valuation Work Group

- Develop a replacement mortality table for LTC active life reserves
  - Based on the 2012 Individual Annuity Mortality Table
  - Recommend a margin for conservatism
- Develop a replacement lapse table
  - Recommend a margin for conservatism
- Consider developing tables for valuation on total lives basis as well as active lives basis

Executive Summary

- Developed valuation mortality table
  - Mortality is select and ultimate; all previous valuation mortality tables have been aggregate
  - Optional factors are provided for marital status and risk class
  - Mortality tables are provided for both total lives and active lives (off-claim) exposures
  - Margin for valuation mortality tables is included
  - Tables are included in the report as an Excel file
Executive Summary

- Developed valuation lapse table
  - Valuation lapse tables are developed separately for individual and group coverages; current valuation lapse tables vary for group coverage only for durations 5+ (3% v 2%)
  - Optional factors are provided for marital status and risk class for individual coverages only
  - Lapse tables are provided for both total lives and active lives (off-claim) exposures
  - Margin for valuation lapse tables is included

Recommended Mortality Tables (Total Lives)

Death Counts (Total Lives) By Sex, Risk Class, Attained Age, and Marital Status

Recommended Mortality Table (Total Lives)
### Recommended Marital Status Adjustment Factors for Mortality Table (Total Lives)

<table>
<thead>
<tr>
<th>Age</th>
<th>Not Married</th>
<th>Married</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.80</td>
<td>0.88</td>
<td>0.99</td>
</tr>
<tr>
<td>0.88</td>
<td>0.99</td>
<td>1.00</td>
</tr>
<tr>
<td>0.99</td>
<td>1.00</td>
<td>1.05</td>
</tr>
</tbody>
</table>

### Recommended Underwriting Class Adjustment Factors for Mortality Table (Total Lives)

<table>
<thead>
<tr>
<th>Age</th>
<th>Preferred</th>
<th>0.82</th>
<th>1.49</th>
<th>1.05</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.82</td>
<td>1.49</td>
<td>1.05</td>
<td>1.12</td>
<td>1.20</td>
</tr>
<tr>
<td>1.49</td>
<td>1.05</td>
<td>1.12</td>
<td>1.20</td>
<td>1.28</td>
</tr>
<tr>
<td>1.05</td>
<td>1.12</td>
<td>1.20</td>
<td>1.28</td>
<td>1.37</td>
</tr>
</tbody>
</table>

### Recommended Individual Lapse Table—Total Lives (With Margins)

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>26</th>
<th>27</th>
<th>28</th>
<th>29</th>
<th>30</th>
<th>Ultimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>27</td>
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<td>28</td>
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<td>29</td>
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<tr>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultimate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Recommended Group Lapse Table—Total Lives (With Margins)

<table>
<thead>
<tr>
<th>Issue Age Group</th>
<th>Policy Year</th>
<th>Under 35</th>
<th>35-44</th>
<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60 &amp; Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2021</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>May</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11/29/21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Recommended Individual Lapse Table—Active Lives (No Margins)

<table>
<thead>
<tr>
<th>Issue Age Group</th>
<th>Policy Year</th>
<th>Under 35</th>
<th>35-44</th>
<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60 &amp; Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2021</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>May</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11/29/21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Data Credibility for Individual Lapses

Minimum of Number of Individual Lapses and LMB (Full Credibility) by Issue Age Group and Policy Duration

#### Table—Active Lives

<table>
<thead>
<tr>
<th>Issue Age Group</th>
<th>Policy Year</th>
<th>Under 35</th>
<th>35-44</th>
<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60 &amp; Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2021</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>May</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11/29/21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Table—Total Lives

<table>
<thead>
<tr>
<th>Issue Age Group</th>
<th>Policy Year</th>
<th>Under 35</th>
<th>35-44</th>
<th>45-49</th>
<th>50-54</th>
<th>55-59</th>
<th>60 &amp; Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2021</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>May</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11/29/21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Data Credibility for Group Lapses

Minimum of Number of Group Lapses and 1,082 (Full Credibility) by Issue Age Group and Policy Duration

Mortality Improvement to 2020

Recommended Mortality Improvement
- The study period is 2008 through 2011
- Recommend to apply improvement trend using the 2012 Individual Annuity Mortality Basic tables (2012 IAM) G2 scale from 2010 to 2020 (11 years)
- Recommended tables represent industry experience as of 2020
- G2 scale applies to both total lives and active lives

Alternatives for Mortality Improvement
- The mortality tables can be made dynamic by continuing to apply the G2 scale to future valuation dates
- For first principle valuation approach, G2 scale can be applied to both active lives and disabled lives

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Recommended Margins

- 10% for mortality
- 15% for lapse
- Same for total lives and active lives

Actual Total Lives Mortality to Expected (Based on Recommended Tables) By Company

Actual Individual Total Lives Lapses to Expected (Based on Recommended Tables) By Company
Actual to Expected Mortality Rates
(Expected Based on Recommended Tables)

Actual Total Lives Mortality to Expected by Policy Year

Actual Total Lives Mortality to Expected by Issue Age Group

Actual Total Lives Mortality to Expected by Marital Status and Underwriting Class

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Actual to Expected Lapse Rates
(Expected Based on Recommended)

Actual Individual Total Lives Lapses to Expected by Policy Year

Actual Individual Total Lives Lapses to Expected by Issue Age Group

Actual Individual Total Lives Lapses to Expected by Marital Status and Underwriting Class

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Actual Group Total Lives Lapses to Expected by Policy Year

Actual Individual Active Lives Lapses to Lapses by Policy Year

Actual Group Total Lives Lapses to Expected by Issue Age Group

Actual Individual Active Lives Lapses to Expected by Issue Age Group
Actual Group Total Lives Total Terminations to Expected by Policy Year

Actual Group Total Lives Total Terminations to Expected by Issue Age Group

Additional Information

Matthew Williams, JD, MA
Senior Policy Analyst, Health
American Academy of Actuaries
Email: williams@actuary.org
Phone: (202) 223-8196

https://naiconline.sharepoint.com/b/r/sites/NAICSupportStaffHub/Member%20Meetings/Fall%202021/TF/HealthActuarial/Conference%20Calls/11-29%20HATF/LTC Valuation Work Group Presentation to NAIC_HATF 11.29.21(FINAL)%20(reduced).pdf?csf=1&web=1&e=cZhLrl
Idaho’s Enhanced Short Term Health Plans

Wes Trexler
Deputy Director
Idaho Department of Insurance
doi.idaho.gov

Issues and Objectives

- APTC has limitations and gaps
  - Variable income – risky to lose APTC
  - “Family glitch” – employer offers unaffordable spouse or dependent coverage
  - Even with APTC, can still be unaffordable or higher cost than considered reasonable
- Consumers seeking non-major medical or non-insurance health options due to lower cost
  - Stacked limited benefits
  - Back-to-back short-term
  - Associations
  - Health sharing
  - Direct primary care

Traditional Short-term Plans

- Not guaranteed issue
- Not renewable
- Total duration less than 12 months (per Idaho statute)
- Preexisting conditions excluded
- Any licensed carrier can offer, without major medical presence
- Fewer benefits offered
- Internal limitations on covered benefits
- Fewer applicable consumer protections
- Consumers misunderstand their risks with limitations
- Being utilized for more than short-term needs

Legal Path for Enhanced STPs

2019 Idaho Rule 18.04.15
- Issued as temporary then final
- Applies to both Traditional STLDPs and ESTPs
- Delineates Trad from ESTPs
- Sets out enrollment, eligibility, renewal, reissuance, rating, coverage, and disclosure provisions for both

2019 Idaho House Bill 275
- Modified individual major medical insurance chapter
- Defined ESTP
- Added ESTP to “Health Benefit Plan” definition
- Rules shall include federally-compliant STLDP renewability
- Rules may require Essential Health Benefits
Enhanced vs Nonrenewable

<table>
<thead>
<tr>
<th>Guaranteed issue</th>
<th>Not guaranteed issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guaranteed renewable &amp; convertible to ACA plan</td>
<td>Nonrenewable; cannot be reissued (even by diff carrier) within 63 days of termination</td>
</tr>
<tr>
<td>Total duration (with renewals) may not exceed federally-defined max months</td>
<td>Total duration may not exceed six months</td>
</tr>
<tr>
<td>Carrier must also offer Exchange plans</td>
<td>No requirement for carrier to offer renewable health benefit plans</td>
</tr>
<tr>
<td>Protection against preexisting condition exclusions when coverage is continuous</td>
<td>Preexisting conditions excluded</td>
</tr>
<tr>
<td>More robust coverage and consumer protections</td>
<td>Limited benefits and consumer protection requirements</td>
</tr>
<tr>
<td>Mental Health Parity applies</td>
<td>MHPAEA not applicable</td>
</tr>
<tr>
<td>Offered year-round</td>
<td>Offered year-round</td>
</tr>
</tbody>
</table>

Enhanced vs Nonrenewable (Cont.)

<table>
<thead>
<tr>
<th>Rated by age, tobacco use, same geography as QHPs, underwriting</th>
<th>Rated by age, tobacco use, geography, duration of coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underwriting factor limited by statute</td>
<td>Underwriting only for coverage decision</td>
</tr>
<tr>
<td>Index rate tied to QHP single risk pool</td>
<td>Rates not tied other products</td>
</tr>
<tr>
<td>Meets Idaho Benchmark Medical Plan, including formulary</td>
<td>Rules provide minimum benefit standards</td>
</tr>
<tr>
<td>Preventive and wellness at no cost share</td>
<td>No requirement for preventive and wellness coverage at no cost share</td>
</tr>
<tr>
<td>Provide metal-level actuarial value</td>
<td>Often not comparable</td>
</tr>
</tbody>
</table>

Enrollees by Plan Type

<table>
<thead>
<tr>
<th></th>
<th>Exch</th>
<th>Non-Exch</th>
<th>GF/GM</th>
<th>ESTP</th>
<th>Total</th>
<th>Sharing</th>
<th>STLD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep-2021</td>
<td>65,720</td>
<td>11,186</td>
<td>7,334</td>
<td>5,440</td>
<td>89,680</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2020</td>
<td>67,721</td>
<td>10,906</td>
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<td>2,834</td>
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ACA and EST Plans and Premiums

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Are we achieving objectives?

Thousands of Idahoans finding value
Up from 4 Exchange carriers to 6 in 2022
- Interest expressed in ESTPs
- Agents appreciate another comprehensive option for tentative purchasers

Revised nonrenewable short-term products
- Fewer internal benefit caps
- Clearer application and disclosures
- Reduced issuance of multiple short-term policies

Continued federal regulatory uncertainty

Thank you!
Weston.Trexler@doi.idaho.gov

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REGULATORY FRAMEWORK (B) TASK FORCE

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Draft: 12/20/21

Regulatory Framework (B) Task Force
Virtual Meeting (in lieu of meeting at the 2021 Fall National Meeting)
November 30, 2021

The Regulatory Framework (B) Task Force met Nov. 30, 2021. The following Task Force members participated: Michael Conway, Chair (CO); Glen Mulready, Vice Chair, represented by Mike Rhoads (OK); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by William Rodgers and Yada Horace (AL); Peni Itula Sapini Teo represented by Elizabeth Perri (AS); Evan G. Daniels represented by Erin Klug (AZ); Andrew N. Mais represented by Jared Kosky (CT); David Altmaier represented by Chris Struk and Shannon Doheny (FL); Doug Ommen represented by Andria Seip (IL); Amy L. Beard represented by Alex Peck (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Gary D. Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Timothy Schott and Joanne Rawlings-Sekunda (ME); Anita G. Fox represented by Sarah Wohlford (MI); Grace Arnold represented by Galen Benshoof and Sherri Mortensen-Brown (MN); Clora Lindley-Myers (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Laura Arp (NE); Chris Nicolopoulos represented by Michelle Heaton and Roni Karnis (NH); Marlene Caride represented by Philip Gennace (NJ); Judith L. French represented by Laura Miller and George McNab (OH); Andrew R. Stolfi represented by TK Keen (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Kruger and Candy Holbrook (SD); Cassie Brown represented by Rachel Bowden (TX); Scott A. White represented by Julie Blauvelt, Bob Grissom, and James Young (VA); Mike Kreidler represented by Molly Nollette and Jane Beyer (WA); Mark Afable represented by Nathan Houdek (WI); and Allan L. McVey represented by Joylynn Fix and Ellen Potter (WV).

1. **Adopted its Nov. 9 and Summer National Meeting Minutes**

The Task Force met Nov. 9 to adopt its 2022 proposed charges.

Mr. Keen made a motion, seconded by Ms. Kruger, to adopt the Task Force’s Nov. 9 (Attachment One) and July 28 (see *NAIC Proceedings – Summer 2021, Regulatory Framework (B) Task Force*) minutes. The motion passed unanimously.

2. **Adopted its Subgroup and Working Group Reports**

Mr. Keen made a motion, seconded by Commissioner Clark, to adopt the following reports: the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Nov. 1 (Attachment Two), Oct. 4 (Attachment Three), Sept. 20 (Attachment Four), Aug. 23 (Attachment Five), Aug. 9 (Attachment Six), and July 26 (Attachment Seven) minutes; the Employee Retirement Income Security Act (ERISA) (B) Working Group, including its Oct. 8 (Attachment Eight) and July 30 (Attachment Nine), minutes; the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its Aug. 5 minutes (Attachment Ten); and the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup. The motion passed unanimously.

3. **Heard a Presentation on the NSA Federal Regulations and Implications for the States**

Katie Keith (Out2Enroll) and Jack Hoadley (Georgetown University Health Policy Institute) presented on the recently issued federal No Surprises Act (NSA) interim final rules (IFR), interim proposed rules (IPR) and implications for the states. Ms. Keith provided an overview of the NSA’s scope and its protections, including what types of plans it covers and where its protections apply for plan years beginning on or after Jan. 1, 2022. She said the NSA’s IFR was issued July 1 with an effective date of Sept. 13. The IFR was issued jointly by the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS), the U.S. Department of the Treasury (Treasury Department), and the U.S. Office of Personnel Management (OPM).

Ms. Keith said the IFR includes provisions focused on both patients and regulated entities. She explained that the patient-focused provisions outline how patients can calculate cost-sharing, include notice-and-consent waivers provisions, and establish a consolidated complaints process. The regulated entities-focused provisions outline how to calculate the qualifying payment amount and include disclosure requirements and provisions related to communications between insurers and providers.

Ms. Keith said the DOL, the HHS, the Treasury Department, and the OPM jointly issued IPR Sept. 10 concerns the submission of information about air ambulance services and the process the HHS will take to investigate and enforce NSA violations. She
said the IPR highlights the states as being the primary enforcers for state-regulated insurers and providers. The DOL is the primary enforcer for self-insured health plans. The federal government is backup enforcer if a state fails to substantially enforce. Ms. Keith said that it is anticipated that the federal agencies will provide enforcement letters to each state outlining provision-by-provision whether the state and federal government will enforce that particular NSA provision.

Ms. Keith said the DOL, the HHS, the Treasury Department, and the OPM jointly issued a second IFR Sept. 30. She said the major focus of this IFR is on the independent dispute resolution (IDR) process. Other provisions include requirements related to good-faith cost estimates for uninsured patients and patients who have insurance coverage but do not wish to submit a claim for services to their insurer and requirements related to the patient-provider dispute resolution process when cost estimates are wrong.

Mr. Hoadley detailed the major provisions in the first IFR. He discussed the scope of the NSA’s balance billing protections with respect to the types of payers and providers subject to its requirements. He explained that IFR sets out provisions to determine the qualifying payment amount (QPA) for purposes of the federal IDR process. The IFR spells out definitions and methodology for determining the QPA. It also includes additional provisions affecting the QPA, including minimizing the influence of outlier prices that could skew the QPA higher. Mr. Hoadley also explained that the IFR defines what a “specified state law” is for purposes of determining what method will be used to determine the amount of payment to an out-of-network provider, which could be either a payment standard or arbitration or a combination of both. The IFR also specifies that states with self-funded opt-in programs can maintain those programs. If state law does not apply, the NSA applies.

Mr. Hoadley discussed the different state approaches to determining QPAs. Some states take a hybrid approach using both a payment standard or rule and an IDR process. Other states use a payment statement standard only or an IDR process only. He also discussed the federal agencies’ requirements for entities conducting the IDR process to use in making payment determinations.

Mr. Hoadley reiterated that the IFR confirms that state departments of insurance (DOIs) are the primary enforcers of provisions that apply to insurers and fully insured health products. He also noted that state officials are responsible for enforcing the law against providers, but the HHS will enforce the NSA’s requirements in states that choose not to or that fail to substantially enforce the law. The DOL will enforce the NSA’s provisions for self-funded group health plans. Mr. Hoadley said that it is anticipated that the HHS will enter into collaborative enforcement agreements with many states. He said the IFR proposes a consolidated complaints process for patients and others.

Mr. Hoadley discussed provisions in the second IFR concerning the good-faith cost estimates for uninsured patients and patients who have insurance coverage but do not wish to submit a claim for services to their insurer and requirements related to the patient-provider dispute resolution process when cost estimates are wrong. He said the federal agencies are still working on federal rules for insured patients with respect to these provisions. It is anticipated these rules will be issued sometime in early 2022. He said that due to this delay in rulemaking, the federal agencies have agreed not to enforce these provisions during 2022, but entities subject to these provisions must still comply and adopt a good faith, reasonable interpretation of the law.

Mr. Hoadley discussed provisions in the NSA concerning data reporting and other mechanisms for purposes of determining the NSA’s effect on various health care-related factors, such as its effect on health care costs, provider networks, and provider consolidation. He noted that for the states having balance billing protection laws prior to the enactment of the NSA, analyses trying to determine those laws’ effect on similar health care-related factors is limited. Depending on the state approach taken to determine payment amount, some studies of these state laws indicate little impact, while others indicate mixed impacts.

Commissioner Conway asked about the good faith attempt to participate in a carrier’s network a provider can cite and use in the provider’s arguments for determining the appropriate QPA. He asked if this provision is tied to a specific carrier or the market, generally. Mr. Hoadley said he does not believe the IFR addresses that issue, but the provision most likely is tied to the specific carrier that is the subject of the arbitration process.

Commissioner Conway asked if the federal rules address the situation when a provider enters into the federal IDR process, but later it is determined that the plan involved is state-regulated and the state has its own IDR process. Mr. Hoadley said he believes the arbitrator, as one of its responsibilities, will screen cases and ultimately tell the parties they will need to use the state IDR process. He acknowledged that other situations could be more complex, including cases involving multiple state IDR processes. He said in such complex cases, the federal rules seem to indicate the federal IDR process would be used.

Mr. Keen asked about the notices the federal Centers for Medicare & Medicaid (CMS) sends out as part of its petition process about organizations applying to become a certified independent dispute resolution entity (IDRE). He noted that from a state
insurance regulator’s perspective, the given short time frame included in the petition process and the sparse information CMS provides on these organizations make it hard to evaluate them. He asked if Mr. Hoadley or Ms. Keith had any thoughts on what state insurance regulators should be looking in their evaluation of these applicants. Mr. Hoadley said he has no insight on the issue, but he said it would be important for the states to discuss whether any state is familiar with an applicant and provide their experiences with that organization to other states. Ms. Keith said that from her perspective, the certification criteria in the federal rules is quite strong, which could be evidenced by the fact that only a small number of organizations have applied to date. She said that from her experience in talking to the states, the states are looking for organizations that have medical and billing expertise and understand market dynamics, among other things. Commissioner Conway asked about the ability for the parties to challenge the choice of arbitrator. Mr. Hoadley said the federal rules contemplate the parties agreeing on a particular arbitrator, but if the parties cannot agree, the federal agencies would select. He said that he does not believe the federal rules provide for a party to object to the selected arbitrator, unless possibly due to a conflict-of-interest concern. Mr. Hoadley said that for some states that use the arbitration process, the state has a list of potential arbitrators, and the parties can object to one or more being selected, but the federal IDR process is not structured this way.

Commissioner Conway asked for those states that had a surprise bill law prior to the NSA and are now thinking about aligning these sorts of issues and ways to address them will evolve over time. and because of this, the IDRE would need to be aware of, and address, any actual or perceived conflicts of interest. He said to how some of organizations applying to be IDREs are structured. He said that certainly an IDRE would need medical expertise and to use the federal IDR process and as such, eliminate the need to maintain a parallel and potentially duplicative process. She said the federal agencies implementing the NSA have not been discussing this issue. Commissioner Conway agreed that in some cases, allowing an “opt-in” could be more efficient.

Commissioner Conway asked for those states that had a surprise bill law prior to the NSA and are now thinking about aligning the state law with the NSA, what provisions should the state focus on as part of this process. He said Colorado has focused on those provisions it thinks would be preempted by the federal law to avoid confusion. Mr. Hoadley agreed that there will be confusion about which law applies, state or federal, in some situations. He said the states may look at the types of services, providers, and facilities covered under their laws versus the NSA as provisions to focus on. Ms. Keith agreed. She said states also will have to think about retaining those provisions in their laws that are more protective, such as Colorado’s more protective ground ambulance provisions. Ms. Keith said one question has been raised is if those states with a state IDR process could opt to use the federal IDR process and as such, eliminate the need to maintain a parallel and potentially duplicative process. She said the federal agencies implementing the NSA have not been discussing this issue. Commissioner Conway agreed that in some cases, allowing an “opt-in” could be more efficient.

4. Discussed Model #76 and the NSA

Jolie Matthews (NAIC) said Section 110 of the NSA expands the scope of external review to include adverse benefit determinations related to disputes under the NSA, such as whether a plan or insurer complied with the NSA’s cost-sharing and other protections. She said that because the NSA applies to grandfathered health plans, external review extends to those plans as well. She explained that federal Affordable Care Act (ACA) requires non-grandfathered group health plans and insurers offering group and individual coverage to comply with state external review processes so long as those processes met certain standards. She said that to meet the ACA’s standards, state laws on external review must, at a minimum, reflect the consumer protections included in the Uniform Health Carrier External Review Model Act (#76), and external review must be available for adverse benefit determinations based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. She said the NSA expands the scope of the adverse benefit determinations currently provided under Model #76. She said the Task Force has at least four options to consider to address the issue: 1) substantively revise Model #76 to expand its scope to cover NSA disputes; 2) non-substantively revise Model #76, such as adding a drafting note alerting the states about the issue; 3) develop a memorandum or directive to the states to alerting them about the issue; or 4) take no action.

Commissioner Conway suggested that the Task Force form an ad hoc group to work with NAIC staff to develop a recommendation for the Task Force’s consideration to address the issue. There was no objection to his suggestion. Commissioner Conway asked Task Force members to send an email to NAIC staff expressing interest in serving on the ad hoc group. Ms. Matthews said she intends to have the ad hoc group meet sometime in January 2022 for it to make a recommendation to the Task Force on next steps in February.

Having no further business, the Regulatory Framework (B) Task Force adjourned.
The Regulatory Framework (B) Task Force met Nov. 9, 2021. The following Task Force members participated: Michael Conway, Chair (CO); Glen Mulready, Vice Chair, represented by Cuc Nguyen (OK); Lori K. Wing-Heier represented by Sarah Bailey (AK); Jim L. Ridling represented by Jimmy Gunn, Yada Horace, and William Rodgers (AL); Evan G. Daniels represented by Jon Savary and Erin Klug (AZ); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods represented by Howard Liebers (DC); David Atmjaier represented by Chris Struk and Shannon Doheny (FL); Doug Ommen (IA); Dean L. Cameron represented by Weston Trexler (ID); Dana Popish Severinghaus (IL); Amy L. Beard represented by Alex Peck and Meghann Leaird (IN); Vicki Schmidt represented by Julie Holmes and Tate Flott (KS); Sharon P. Clark represented by Daniel McIlwain (KY); Gary D. Anderson represented by Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by Renee Campbell and Sarah Wohlford (MI); Grace Arnold represented by Galen Benshoof (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Ted Hamby (NC); Jon Godfred represented by Chrystal Bartuska (ND); Eric Dunning represented by Laura Arp (NE); Chris Nicolopoulos represented by Michelle Heaton (NJ); Marlene Caride represented by Channell McDevitt (NJ); Judith L. French represented by Theresa Schaefer and George McNab (OH); Andrew R. Stolfi represented by TK Keen (OR); Jessica K. Altman represented by Katie Merritt (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Hilary Sayre and Michael Nored (TX); Jonathan T. Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt, Bob Grissom, and Bradley Marsh (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek and Jennifer Stegall (WI); and Allan L. McVey (WV).

1. Adopted its 2022 Proposed Charges

Commissioner Conway said prior to the meeting, NAIC staff distributed the Task Force’s 2022 proposed charges for a public comment period that ended Oct. 22. He said the Task Force received comments from the American Bankers Association (ABA) Health Savings Account (HSA) Council, the NAIC consumer representatives, and the Obesity Action Coalition (OAC). He said the comments suggest that the Task Force add two new charges and revise the Task Force’s existing charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup.

Commissioner Conway said at this point, he is not inclined to recommend that the Task Force add the additional suggested charges given the NAIC’s incoming president’s desire to have NAIC groups focus on their core work. He said the nature of the suggested new charges do not seem to quite fit into the Task Force’s core work and could be better suited for other NAIC groups. He said despite his inclination against adding the suggested new charges, he believes the Task Force should hear from each of the commenters beginning with the ABA HSA Council.

Jeffrey Klein (McIntyre & Lemon PLLC), speaking on behalf of the ABA HSA Council, remarked on the ABA HSA Council’s prior work with the NAIC and the states on several matters relevant to cost-sharing in general and on rules governing third-party payments on behalf of enrollees or insureds. He said the ABA HSA Council has been particularly cognizant of the recent federal Internal Revenue Service (IRS) correspondence with the Illinois Department of Insurance (DOI), its distribution, and awareness of it by other state DOIs. He said because so much of the NAIC’s efforts in this area are on consumer protection, the ABA HSA Council is concerned that well-intended but misguided proposals can have an unintended consequence on HSA account owners and their ability to contribute to their HSA, because the cost-sharing legislation of concern does not conform to IRS guidance. He said because the NAIC should, and does, share its concern in that regard, the ABA HSA Council suggests that the Task Force add a new 2022 proposed charge for the Task Force to “monitor, analyze, and report to the states the effect of cost-sharing legislative mandates and the efficacy of Health Savings Accounts (HSAs) and the relevancy of recent Internal Revenue Service (IRS) guidance about such mandates.”

Carl Schmid (HIV+Hepatitis Policy Institute) said over the past few years, many of the NAIC consumer representatives have raised the issue of insurers and pharmacy benefit managers (PBMs) not counting copayment assistance as part of an enrollee’s deductible and cost-sharing requirements. He said these policies significantly increase consumer costs and reduce access to prescription drugs and other covered services. He said given this, in response to the ABA HSA Council’s suggested new 2022 proposed charge relative to copayment assistance for prescription drugs, the NAIC consumer representatives submitted an additional comment letter suggesting that if the Task Force adds the charge, the Task Force should consider broadening the charge to explore the impact of high prescription drug cost-sharing on consumers on their medication adherence along with the
value of copayment assistance. He also said the NAIC consumer representatives disagree with the ABA HSA Council’s interpretation of the IRS guidance.

Commissioner Conway said this discussion, including the differences of opinion related to the IRS guidance letter detailed in the comment letters, indicates that before the Task Force actively discusses adding any new charges related to this issue, the Task Force needs to discuss them further. He said if he remains the Task Force chair for 2022, he will include a discussion of the copayment accumulator adjustment program and the IRS guidance for the Task Force’s meeting prior to or during the 2022 Spring National Meeting. There was no objection to his suggestion.

Joe Nadglowski (OAC) said the OAC suggests that the Task Force add a new 2022 proposed charge, much like the Task Force’s current charges related to mental health parity (MHP) and substance use disorder (SUD), to explore the effects of obesity on state-regulated health insurance. He said specifically, the OAC recommends that the Task Force explore: 1) obesity discrimination; 2) access to treatment and specialists; 3) costs on the health care system, particularly the insurance industry; and 4) insurer considerations for treating obesity as a chronic condition. Commissioner Conway said he appreciates the OAC bringing these issues to the Task Force for its consideration because they are issues that everyone should be discussing more. He said he believes the states have been individually looking at these issues and have taken different approaches to try to address them. He said Colorado is looking at incorporating an obesity component for its standardized plan, which it plans to launch sometime next year.

Commissioner Conway said as he indicated at the beginning of the meeting, he believes the Task Force needs more discussion on these issues before considering a new charge. He said he believes there will be additional opportunities for the Task Force to have such discussions. He also said he would like to have additional time to reach out to other NAIC groups that might be more appropriate to take on these issues instead of the Task Force. There was no objection from the Task Force for not adding the OAC’s suggested 2022 proposed charge.

Commissioner Conway said the NAIC consumer representatives’ first comment letter on the Task Force’s 2022 proposed charges suggests revising the charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup to flip the current charges such that the charge concerning the white paper is the first charge and the charge to develop a possible NAIC model regulating PBMs is the second charge. Mr. Schmid said the NAIC consumer representatives also suggest adding language to the second sentence in that charge as follows, “[b]ased on issues identified in the white paper.” He said the NAIC consumer representatives’ comments suggest that the Subgroup develop the white paper first and then consider moving forward with the new NAIC model after the white paper is completed. Mr. Keen expressed support for the NAIC consumer representatives’ suggested revisions to the Subgroup’s charges. He noted, however, that given the rejection of the proposed NAIC model regulating PBMs at the Summer National Meeting, after the Subgroup completes the white paper, he anticipates that there will be a lot of discussion on whether it makes sense for the Subgroup to develop the model due to differences of opinion on the scope and breadth of PBM regulation and whether state DOIs are the appropriate entity to regulate PBMs.

Mr. Keen made a motion, seconded by Mr. Trexler, to adopt the Task Force’s 2022 proposed charges (Attachment One-A). The motion passed unanimously.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

RFTF Nov 9 Minutes
2022 PROPOSED CHARGES

REGULATORY FRAMEWORK (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products and Services

1. The Regulatory Framework (B) Task Force will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority, and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2022.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze, and report developments related to association health plans (AHPs).
   F. Monitor, analyze, and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.

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

3. The ERISA (B) Working Group will:
   A. Monitor, report, and analyze developments related to the federal ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate with the states and the U.S. Department of Labor (DOL) efforts related to sham health plans.
   C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.

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

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

RFTF 2022 Proposed Charges
The Accident and Sickness Insurance Minimum Standards (B) Subcommittee of the Regulatory Framework (B) Task Force met Nov. 1, 2021. The following Subcommittee members participated: Laura Arp, Co-Chair and Martin Swanson (NE); Andy Schallhorn, Co-Chair (OK); Debra Judy (CO); Howard Liebers (DC); Chris Struk (FL); Robert Wake (ME); Frank Opelka (LA); Sherri Mortensen-Brown (MN); Camille Anderson-Weddelle, Cynthia Amann, Amy Hoyt and Carrie Couch (MO); Glynda Daniels (SC); Rachel Bowden (TX); Tanji Northrup (UT); Anna Van Fleet, Christine Menard-O’Neil, Mary Block, and Jamie Gile (VT); Mary Schaefer (WA); and Nathan Houdek (WI).

1. **Continued Discussion of Products Regulated Under Model #171**

Mr. Schallhorn said the purpose of this meeting is for the NAIC consumer representatives provide a consumer perspective on the products regulated Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171). However, before the Subcommittee hears that presentation, the Subcommittee will provide an opportunity for Jackson Williams (Dialysis Patients Citizens—DPC) ask his additional questions of the industry representatives related to their presentations during the Subcommittee’s Sept. 20 meeting.

Mr. Williams asked Cindy Goff (American Council of Life Insurers—ACLI) to discuss which category or categories of products, if any, regulated by the Supplementary and Short Term Health Insurance Minimum Standards Model Act (#170) (formerly known as the Accident and Sickness Insurance Minimum Standards Model Act) and Model #171 pose the greatest risk of consumers being unable to seek and find value among competing vendors. Ms. Goff said she could not think of any category or categories of products that consumers could not seek and find value among competing vendors. She said all of the products regulated under Model #170 and Model #171 offer value to consumers. There are a large number of insurers in the market selling these products, which provides for a competitive market and keeps premiums at an affordable rate. Mr. Jackson asked the extent employers are active purchasers or in other words, the extent to which these products are put out for competitive bidding. Ms. Goff said group sales of these products are done through competitive bidding like other kinds of insurance products, such as major medical products. She said the ACLI has compiled figures showing that employer involvement in the sale of these products they offer to their employees on a voluntary basis is about 96% if those group products sold. Mr. Jackson asked if such sales are on an annual basis. Ms. Goff said that depends on the employer. Each employer differs on how long they keep the products in place. She noted that some products are sold with rate guarantees that can be in effect for three to five years. As such, in those cases, there would be no changes in the offering during that time frame.

Mr. Jackson asked Ms. Goff about the average commission expense ratio for supplemental products. Ms. Goff said the answer to this question depends on how a carrier sells the product. She said some carriers do not use independent agents to sell their products. Their employees who are agents sell them. She said if independent agents sell the products for a carrier, depending on the intensity of work required of the agent, for the first year, the commission could range from zero to 50% of premium. Ms. Goff said that generally, the premium for supplemental products is very low, typically $50 to $100 dollars per month. As such, the percentage commission paid on that premium is very low. She also explained that typically the first year the commission is high because the work is more intense. Over time, the commission levels off quite a bit. Mr. Jackson asked if the average commission has risen over the past 10 years. Ms. Goff said the answer to this question depends on how a carrier sells the product. She said some carriers do not use independent agents to sell their products. Their employees who are agents sell them. She said if independent agents sell the products for a carrier, depending on the intensity of work required of the agent, for the first year, the commission could range from zero to 50% of premium. Ms. Goff said that generally, the premium for supplemental products is very low, typically $50 to $100 dollars per month. As such, the percentage commission paid on that premium is very low. She also explained that typically the first year the commission is high because the work is more intense. Over time, the commission levels off quite a bit from that high. Mr. Williams asked Ms. Goff about the average commission expense ratio for supplemental products. Ms. Goff said the answer to this question depends on how a carrier sells the product. She said some carriers do not use independent agents to sell their products. Their employees who are agents sell them. She said if independent agents sell the products for a carrier, depending on the intensity of work required of the agent, for the first year, the commission could range from zero to 50% of premium. Ms. Goff said that generally, the premium for supplemental products is very low, typically $50 to $100 dollars per month. As such, the percentage commission paid on that premium is very low. She also explained that typically the first year the commission is high because the work is more intense. Over time, the commission levels off quite a bit from that high. Mr. Jackson asked if the average commission has risen over the past 10 years. Ms. Goff said that based on a polling of some ACLI members, the ACLI has not seen any increase in average commission during that time frame. She explained how commissions must be filed and approved providing little flexibility for carriers to lower and increase them. Mr. Williams said in asking these questions, he is trying to figure out why the loss ratios for supplemental products are going down. Ms. Goff expressed disagreement with Mr. Williams assertion that loss ratios are going down. She said there are loss ratio can fluctuate over the course of 10 to 20 years; and when an insurer sees such a trend, they try to make adjustments to address it. She also pointed out that supplemental products are very low premium products and cannot be compared with other types of products, particularly comprehensive health insurance products.

Mr. Williams asked about payments made under critical illness plans for COVID-related illnesses. Ms. Goff said depending on the type of policy and whether the services are covered under the policy, payments are being made for COVID-related illnesses. She said many insurers have made adjustments in their plans, such as in their hospitalization benefits, to clarify to consumers that services provided in relation to COVID are covered. Mr. Williams asked if the ACLI knows with respect to critical illness
plans, how much insurers have paid out for COVID-related expenses. Ms. Goff said that for the ACLI to obtain this information, it would have to probably conduct a formal survey of its members. She explained that even if she conducted such a member survey, it would not complete because there are some insurers, who are not members of the ACLI, such as UnitedHealthcare and Aetna, that have big blocks of this kind of business. The ACLI does not have access to their information.

Mr. Schallhorn asked Ms. Goff if she has seen insurers specifically add COVID as a benefit trigger in their critical illness plans. Ms. Goff said she has not seen specific language, but insurers have made it clear to consumers that COVID is one of the triggers.

Mr. Williams said that in the ACLI’s presentation, Ms. Goff said that a survey found that 89% of enrollees who made a claim agree that the purchase of the product was a valuable investment. He asked Ms. Goff if such a survey was taken at the time an enrollee switched jobs and terminated coverage, would a smaller percentage of enrollees agree that the product was a valuable investment. Ms. Goff said that for any type of insurance product, she would imagine that there would be a smaller percentage of enrollees agreeing that a product was a valuable investment under such a scenario. She said the important question is whether the product performed as promised and whether at the time the consumer needed it if the consumer found value in having the product, which would be an important question for any type of insurance product, not just for supplemental products.

Mr. Williams asked if the ACLI knew how much money a middle-aged enrollee would pay in premiums over eight years for the average supplemental benefits plan. Ms. Goff said the ACLI does not have that information. Mr. Williams asked about the typical claim payout for such an enrollee over the same timeframe. Ms. Goff said the ACLI does not have that information either. She would have to conduct a survey answer both questions.

The Subgroup discussed a question concerning the application of the Coordination of Benefits Model Regulation (#120), which was answered during the Subgroup’s Oct. 4 meeting. Chris Petersen (Arbor Strategies LLC) reiterated that supplemental benefit product plans do not coordinate with other plans. These plans pay regardless of whether the consumer has other plans that would cover the same benefit. He said that except for dental and vision plans, Model #120 prohibits such coordination to ensure the consumer gets the full benefit of the premium dollars paid from both plans. Bonnie Burns (California Health Advocates—CHA) said Model #120 allows insurers to coordinate as secondary coverage when an individual is eligible for Medicare Part B, whether the individual is enrolled or not. She said this applies to limited benefit policies as well. Mr. Petersen said there are different coordination rules for Medicare. He said case law has determined that Medicare is always primary. Ms. Burns said she has raised an issue with the NAIC on several occasions regarding COBRA coverage, which limited benefit plans can use to coordinate coverage whether the individual is actually enrolled in COBRA coverage or not. Mr. Petersen said he would have to look at the issue before providing a definitive answer, but he believes that the issues Ms. Burns is raising is a Model #120 issue not an issue for Model #170 or Model #171. The Subgroup discussed what products Ms. Burns is referencing when using the term “limited benefit plan” because there are different interpretations of what that term means. Model #170 and Model #171 specifically define “limited benefit plan.” However, “limited benefit plan” has been interpreted to mean other types of products such as so-called “mini-meds” and in some cases, thought of as “short-term, limited-duration plans.”

Ms. Goff said the coordination of benefits process is very labor intensive. As such, with respect to products like hospital indemnity, accident-only and specified disease, except for possibly in some cases with respect to workers compensation, these plans do not coordinate even if there is some state law or rule that would permit such coordination.

Lucy Culp (Leukemia & Lymphoma Society—LLS) discussed the NAIC consumer representatives’ perspective on the products covered under Model #171. She said it should not be a surprise to anyone that consumer without access to employer-based health insurance coverage are faced with a complex mix of options to obtain such coverage on their own. She said some of these plans may offer high quality coverage and be very expensive while other plans may be less expensive and appear to offer high quality coverage for the types of services a consumer might assume a comprehensive health insurance plan would cover. She said this complexity hinders the ability of consumers to make informed decisions in purchasing such coverage.

Ms. Culp said many of the products covered under Model #171 on their face could look like comprehensive health insurance coverage to consumers. She said although some of the products covered under Model #171 do appear to be supplemental coverage, if they are packaged and offered in a certain way, these products also could appear to be comprehensive health insurance coverage. Ms. Culp said that prior to the enactment of the federal Affordable Care Act (ACA), products covered under Model #170 and Model #171 had a clearer place in the health insurance market as being supplemental products that consumers could use for a short time to bridge the time in between jobs or after graduating from college and obtaining a job with employer-based health insurance coverage. She explained that today, post-ACA enactment, consumers have more high-quality options to obtain health insurance coverage, such as obtaining such coverage through the ACA health insurance.
marketplaces and Medicaid expansion. She said the availability of these high-quality coverage options prompted the NAIC consumer representatives to urge the NAIC to review and revise Model #170 and Model #171 to address consumer confusion about these supplemental products, including the type of benefits they offer and their purpose in the marketplace. Ms. Culp highlighted the differences in requirements for ACA plans and, products Model #170 and Model #171 cover, non-ACA plans. She detailed the impact, particularly the out-of-pocket costs, of an individual undergoing lymphoma treatment who is covered under one of these non-ACA plans, a short-term, limited-duration (STLD) plan. She highlighted the differences in out-of-pocket costs for consumers enrolled in STLD plans for other diagnoses, such as lung cancer, as compared with ACA plans.

Ms. Culp also said STLD plans also on average have significantly lower loss ratios than ACA plans, which makes them highly profitable.

Sarah Lueck (Center on Budget and Policy Priorities—CBPP) said indemnity plans also raise concerns. She discussed some of the features of these plans that resemble traditional major medical health insurance plans that can confuse consumers, such as using “networks” of providers, the use of plan benefit schedules and using words such as “insurance” or “health plan” in marketing materials. Ms. Lueck said plans sold to employees can be just as problematic. She discussed the aggressive marketing of some of the products covered under Model #170 and Model #171 and consumer confusion. She also noted that even when information about these plans is disclosed, consumer testing shows that people do not understand the limits of some of these products, such as STLD plans. Ms. Lueck said the NAIC consumer representatives do not see the supplemental product market as one that everyone is working from the same set of information and is on a level playing field. There is a lot of confusion in this market making it difficult for consumers to make informed decisions.

Ms. Lueck pointed out a recent Georgetown University Health Policy Institute, Center on Health Insurance Reforms (CHIR) study “Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period.” She said the authors of this study created two sample applicants for a variety of different types of plans to test out what these applicants were being told and shown when searching for coverage. She said what the authors found through a number of telephone calls with brokers and agents and representatives of these plans was the lack of accurate information disclosed about a plan’s affordability, particularly as related to ACA marketplace coverage. She said that in some cases, these sample applicants were steered away from the ACA marketplace coverage even though these applicants had quite low incomes and were eligible for ACA plans at a very low cost, such as a bronze plan at $0 premium and a silver plan with reduced cost-sharing starting at $2 premium. Ms. Lueck said that in some cases, these sample applicants were offered alternative plans, such as STLD plans. She said that although some of these non-ACA plans are characterized as having really low premiums, even if that is the case for some consumers, given the changes in the marketplace, this is not true for everyone anymore. For the sample applicants in the study, these non-ACA plans, such as STLD plans, were expensive possibly $70 - $100 per month, which is not an insignificant cost. She said consumers, such as those like the sample applicants, can find quite affordable comprehensive coverage in the ACA marketplace, but they might not know it.

Ms. Lueck provided several key takeaways for the Subgroup to consider: 1) non-ACA plans covered by Model #171 often pose risks to consumers; 2) while some products, such as dental plans, are clearly not comprehensive coverage, many plans are structured in ways that blur the lines with comprehensive health insurance coverage; 3) too often, these plans are marketed in an aggressive, even predatory manner; and 4) this market may serve insurers and brokers and agents well, but it often does not serve consumers well.

Mr. Schallhorn asked Ms. Culp if some of the differences in out-of-pocket costs for STLD plans and ACA plans was due to assumptions related to preexisting conditions. Ms. Culp said she did not believe those differences reflected an assumption. She said what she believes the Milliman study assumed was that consumers would need services that were not covered under the STLD plan and as such, would be paying out-of-pocket for these services.

Mr. Petersen said he believes many of the NAIC consumer representatives brought to the Subgroup’s attention during this meeting will most likely be address through the work of the Improper Marketing of Health Insurance (D) Working Group. Mr. Swanson, co-chair of the Working Group, said the Working Group is meeting at the Fall National Meeting. He said the Working Group is in the process of developing its agenda for that meeting. J.P. Wieske (Health Benefits Institute—HBI) said that some of the issues the NAIC consumer representatives raised during their presentation are issues that the industry also is concerned about. He said some of the HBI’s members also have conducted secret shopping, found some issues and followed up with agents and brokers to address those issues. He said the HBI agrees that these plans are not comprehensive health insurance coverage and should not be marketed as such. Ms. Goff agreed with Mr. Wieske’s comments.

Ms. Arp asked Ms. Culp and Ms. Lueck if the recent federal rule under the federal No Surprises Act (NSA), which requires agents and brokers to disclose their commissions for STLD plans, will help to address some of the issues raised in their
presentation. Ms. Lueck said any type of disclosure is helpful if it leads to more understanding and provides more information to assist consumers in understanding the how STLD plans work. However, she does not believe there is any mystery about STLD plans given the high agent and broker commissions associated with this product, which seems to incentivize their sale. Ms. Culp said she disagreed slightly with Mr. Petersen’s comments that the Improper Marketing of Health Insurance (D) Working Group was the only NAIC group appropriate for some of the concerns raised in her presentation. She said particularly with respect to materials, including disclosures, provided to consumers about the products covered under Model #170 and Model #171 is important as well to address their concerns. Ms. Arp agreed. She said when the Subgroup begins its review of the provisions in Model #171 on disclosures, she anticipates a robust discussion of these provisions considering the issues that have been raised during these meeting and other Subgroup meetings. She said, however, that some issues most likely are not going to address the problems of bad actors in the market who intentionally try to confuse and mislead consumers about the some of the benefits associated with non-ACA plans versus ACA plans, but she believes the Subgroup can as part of its work in revising Model #171 make sure consumers know how these non-ACA products differ from ACA plans.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
1. Continued Discussion of Products Regulated Under Model #171

Mr. Schallhorn said the purpose of this meeting is to allow questions from Subgroup members, interested state insurance regulators, and interested parties about the information provided during the Subgroup’s Sept. 20 meeting on: 1) the different types of products covered under the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171); 2) how they pay benefits; 3) what they are designed to do; 4) how they are marketed; and 5) how they are sold. During that meeting, the Subgroup also heard about the products Model #171 currently covers and, based on the revisions to the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170) (formerly known as the Accident and Sickness Insurance Minimum Standards Model Act), which is the companion model law to Model #171, what products Model #171 will be revised to cover.

Recognizing that most of the supplemental benefit products subject to Model #171 are sold through the workplace, Ms. Arp asked about those products sold to individuals through associations. She asked why these products are sold through an association and, functionally, how it works. J.P. Wieske (Health Benefits Institute—HBI) explained that associations provide such benefits as a value add-on to their members. He said some associations also use these benefits as a way to attract members and an opportunity to provide these benefits on a less expensive basis than it would be if purchased in the individual market. He said that typically, the association purchases the benefit on behalf of its members, but in some cases, members may pay directly for the benefit as part of their membership or as an add-in to their health plan coverage. Cindy Goff (American Council of Life Insurers—ACLI) discussed examples of different associations that have approached some ACLI members, and those associations desire to provide these benefits at lower costs. She also said ACLI members have become more sophisticated in researching organizations to ensure an association has been in business for a significant enough time and not recently created solely for the purpose of offering insurance particularly due to the federal Affordable Care Act’s (ACA) provisions related to associations. Chris Petersen (Arbor Strategies LLC) explained that the Group Health Insurance Standards Model Act (#100) sets out many of the provisions Ms. Goff just discussed with respect to what it means to be a “true” association. Given this, Model #100 is the appropriate NAIC model, not Model #171, for determining what it means to be a “group,” how to define an “association” or “employer group,” and how an association or employer group can offer benefits, such as supplementary products. Mr. Wieske pointed out that Model #100 also includes provisions to ensure the association is indeed separate from an insurer and can make its own decisions independent of the insurer.

Ms. Arp asked about bundling supplemental benefit products. Ms. Goff said the ACLI has had a lot of discussions with the states about bundling and how a package of products is put together and marketed to consumers. She discussed two different ways such packaging can happen: 1) the consumers themselves select more than one product to address areas where they would like to mitigate their financial risk with respect to expenses not covered under their major medical plan; and 2) when an insurer puts together a “package” of products and markets them to consumers as though they are not distinct products with different and distinct roles to possibly lead the consumer to believe what is being offered is more comprehensive than it is or that these products are some kind of alternative to comprehensive major medical coverage. Ms. Goff said for the second method of bundling, she believes there are ways to address it. She said the Antifraud (D) Task Force recently established a new working group, the Improper Marketing of Health Insurance (D) Working Group, to discuss and consider different regulatory approaches to address this issue. Ms. Goff also noted that this issue of improper marketing of supplemental benefit plans goes to the issue of what is a minimum standards model and the purpose of such a model versus addressing inappropriate market behavior and ensuring state insurance regulators have the tools they need to address those issues as well. She said the ACLI has noticed that in some states, it appears they are looking to impose severe restrictions on what benefits can be included in these supplemental benefit products to prevent them from being inappropriately marketed to consumers. She said the ACLI believes that such an approach devalues these products with respect to the protections they offer to consumers to help pay costs not covered by their...
major medical insurance. Ms. Goff said the ACLI believes that instead of imposing severe restrictions on benefits, the focus should be on making sure consumers understand each product they are purchasing and its distinct function and benefits.

Mr. Wieske explained that some supplemental benefit products are very low dollar. He said that in such cases, it makes sense for a producer to bundle them together to be able to sell them. He explained that although these products are bundled as a package, the producer will sell them as distinct products. Mr. Wieske noted that such packaging is particularly the case for associations that want to be able to offer a menu of products, while also having the ability to offer them separately. Mr. Wieske said that in situations where supplemental benefit products are bundled to make them appear to be ACA-compliant products, he supports Ms. Goff’s comments. He said the HBI has taken action against producers who have engaged in such deceptive practices. The HBI believes that supplemental benefit products should not be developed, marketed, or sold as a replacement for major medical insurance.

Mr. Wieske also said that limiting the ability of producers to bundle products probably creates a bigger problem in the market because consumers want to buy certain products together. As such, producers are going to satisfy this desire by bundling products together from different insurers, which means insurers will most likely not be able to track such behavior. He said this is because the producer will sell each product individually, and given this, insurers will not be able to detect certain patterns of behavior and will be unable to take action to stop it. Mr. Wieske added that he believes prohibiting the bundling of products could result in an availability issue from a product perspective, an insurer perspective, and a consumer perspective. Mr. Petersen pointed out a few common product bundles, such as vision and dental insurance bundles. He explained that these products are commonly bundled together and offered to employers for their employees because many major medical policies do not include these benefits. Given this, Mr. Petersen suggested caution in using the term “bundling.” He also suggested that the bundling of supplemental benefit products is not really the core issue; the issue is how supplemental benefit products are presented to consumers, which he believes is an unfair trade practices issue addressed in the Unfair Trade Practices Act (#880). Mr. Petersen also pointed out the importance of not confusing “bundling” with the idea of combining two federal Health Insurance Portability and Accountability Act (HIPAA)-excepted benefits products. He said HIPAA and the NAIC minimum standards models—Model #170 and Model #171—contemplate the combining of these products.

Bonnie Burns (California Health Advocates—CHA) asked if there was a clear linkage between Model #171 and the other NAIC models discussed as vehicles for addressing the bundling and marketing issues. Mr. Petersen said he believes there is a stronger linkage between Model #171 and Model #100 because the current version Model #171 applies to the group market whereas prior versions of it only applied to the individual market. As such, for a group to be able to offer the products regulated under Model #171, the group must be a “permitted” group recognized by the state as provided in Model #100. Ms. Burns suggested that as the Subgroup discusses revisions to Model #171, it should add references to those NAIC models that might apply to a particular model section. Ms. Arp said that from a state insurance regulator perspective, state departments of insurance (DOIs) use the NAIC minimum standards models when reviewing form filings to determine whether the filing complies with the models’ coverage and disclosure and notice requirements. She said issues related to bundling and marketing would be within the scope of a DOI’s consumer affairs division or market conduct division, not its form filing division. She said that with respect to the “group” issue, the Nebraska DOI includes in its form review checklist provisions for the review of whether the group that is to offer the product is a “permitted” group under state law and regulations. Ms. Arp said she believes the NAIC minimum standards models are linked with other relevant NAIC models depending on who and what DOI division is reviewing the product at a particular point in time. Ms. Goff said that she believes over the last few years, there have been some gaps identified in regulatory authority to address certain marketing practices. She said she believes the new Improper Marketing of Health Insurance (D) Working Group will work to address those gaps, which could involve reviewing and revising several NAIC models.

Ms. Amman asked if supplemental benefit product plans can coordinate with other plans. Mr. Petersen said supplemental benefit product plans do not coordinate with other plans. These plans pay regardless of whether the consumer has other plans that would cover the same benefit. He said that except for dental and vision plans, the Coordination of Benefits Model Regulation (#120) prohibits such coordination to ensure the consumer gets the full benefit of the premium dollars paid from both plans. Mr. Petersen discussed the purpose and nature of supplemental benefit products and how they are marketed to help the consumer mitigate financial risk by paying costs other than medical care costs. Ms. Goff noted that disability income plans coordinate with workers’ compensation.

Ms. Arp asked for an explanation of calculating medical loss ratios (MLRs) for products, such as supplemental benefit and long-term care insurance (LTCI) products, that do not end after one year. Mr. Wieske explained that the MLRs in such situations are calculated over the course of a lifetime rather than the three-year loss ratio calculation for ACA plans. Ms. Goff noted that

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Lucy Culp (Leukemia & Lymphoma Society—LLS) asked Mr. Petersen about information he provided in his chart concerning the products currently regulated under Model #171 and those to be regulated under the revised Model #171. She asked how he determined that group short-term, limited-duration (STLD) plans are not to be regulated under the revised Model #171. Mr. Petersen said he believes group STLD plans do not exist because HIPAA provides that “individual” STLD plans are not individual health insurance. This means that these plans are not subject to HIPAA’s requirements for individual health insurance, such as guaranteed renewability. He said HIPAA provides no such exception for group STLD plans. He said he interprets this to mean that group STLD plans would be subject to certain requirements, such as guaranteed renewability and the ACA requirements, which is contrary to how STLD plans operate functionally. Ms. Arp said the Nebraska DOI reviews and approves group STLD plan forms. She explained the DOI’s rationale and process for the review and approval of such plans. The Subgroup discussed this issue and determined that STLD plans are a different kind of animal, not clearly individual market insurance and not clearly group market insurance, but they fall somewhere in between. Mr. Wieske said that with respect to STLD plans sold to individuals through an association, most state insurance regulators would consider those plans to be individual market insurance and subject to the requirements for the individual market. He pointed out a provision in Model #170, which permits a state to extend its jurisdiction to an STLD plan not delivered in the state, such as an STLD plan sold to an individual through an association. The same language is not provided for other products regulated by the NAIC minimum standards models. Mr. Petersen said language in Section 2A supports his conclusion that the NAIC minimum standards models do not apply to group STLD plans.

Jackson Williams (Dialysis Patients Citizens—DPC) asked Mr. Wieske about supplemental benefit product MLR trends and whether, as reflected in NAIC experience reports, the decline in MLR for these products over time is an actual trend. Mr. Wieske explained that he has not examined the underlying data for such findings. He said that given this, he cannot definitively state whether that assumption is true or not. He said that this is a snapshot in time and could reflect a higher number of new policies sold, enrollment numbers, or some other variable. He reiterated that MLRs for supplemental benefit products cannot be compared to MLRs for major medical policies.

Mr. Williams asked Mr. Wieske what information a consumer should have access to when shopping for STLD plans. Mr. Wieske said that from his perspective, it is important for the consumer to understand what the plan covers and does not cover, what the risks are, and time frames. Mr. Williams asked if consumers should be able to comparison shop for an STLD plan like they can for a mortgage or a credit card. Mr. Wieske said he believes consumers can currently comparison shop. He also noted that consumers have different needs and that STLD plans have some variation to meet those different needs. Mr. Wieske also said he believes that state insurance regulators should be looking at the information being provided to consumers and figure out if that information is intentionally confusing or misleading. Mr. Williams asked if consumers should have the ability to compare STLD plans on an apples-to-apples basis like they can for credit cards because of the federal Truth in Lending Act (TILA), which promotes the informed use of consumer credit by requiring disclosures about its terms and cost. Mr. Wieske also said that state insurance regulators should be looking at the information being provided to consumers and figure out if that information is intentionally confusing or misleading. Mr. Williams asked if consumers should have the ability to compare STLD plans on an apples-to-apples basis like they can for credit cards because of the federal Truth in Lending Act (TILA), which promotes the informed use of consumer credit by requiring disclosures about its terms and cost.

Mr. Williams said he has several questions for the ACLI. Mr. Schallhorn said the Subgroup would make time on its agenda for its next meeting for additional questions.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

Oct 4 Minutes
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Sept. 20, 2021. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Debra Judy (CO); Chris Struk (FL); Robert Wake (ME); Sherri Mortensen-Brown (MN); Cynthia Amman and Camille Anderson-Weddle (MO); Shari Miles and Kathleen Kellock (SC); Rachel Bowden (TX); Tanji J. Northrup (UT); Anna Van Fleet, Christine Menard-O’Neal, Mary Block, and Jamie Gile (VT); Ned Gaines (WA); and Jennifer Stegall and Nathan Houdek (WI).

1. **Heard Presentations on Products Regulated Under Model #171**

Ms. Arp said as discussed during its Aug. 23 meeting, the Subgroup will hear presentations during this meeting on: 1) the different types of products covered under the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171); 2) how they pay benefits; 3) what they are designed to do; 4) how they are marketed; and 5) how they are sold. She said the Subgroup will also hear about the products Model #171 currently covers, and based on the revisions to the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), which is the companion model law to Model #171, what products Model #171 will be revised to cover.

Chris Petersen (Arbor Strategies LLC) provided an overview of the type of products that are subject to Model #171 based on the current version and what products will be subject to Model #171 after it is revised. He said the chart he developed identifies each of the products subject to the Model #171 requirements and whether the product is covered under Model #171 based on being offered in the individual market, the group market, or both. He said the biggest change as far as the products Model #171 currently regulates and will regulate after the revisions is the addition of individual short-term, limited-duration (STLD) plans. He said this product is not regulated in any NAIC model prior to revisions to Model #170, which added STLD plans. He explained that because of language in the federal Affordable Care Act (ACA), only individual STLD plans are covered under the models. Group STLD plans are considered comprehensive major medical coverage subject to the ACA’s requirements. Mr. Petersen said another product added is fixed indemnity plans. He said fixed indemnity is recognized as an excepted benefit under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the ACA, but it was never included in Model #170 or Model #171, the minimum standards models. He said because STLD plans and fixed indemnity plans were never included, the Subgroup will have to develop minimum standards for them, such as minimum notice and disclosure requirements. He pointed out that for STLD plans only, the revisions to Model #170 allow for extraterritorial jurisdiction, which means a state can have its requirements apply to STLD plans issued outside of the state.

Mr. Petersen discussed the addition of group disability income protection products. He said when considering revisions related to these products, the Subgroup will have to keep in mind that they are establishing minimum standards because group disability income protection plans are very different from individual disability income protection plans. He explained that limited benefit vision plans and limited benefit dental plans were always included in the minimum standards models, but the definitions for these plans have been revised for consistency with the definitions of these products in HIPAA. He noted that the minimum standards models do not apply to group for these plans. He said the products he has not discussed, such as accident-only plans and specific disease plans, are products the minimum standards models currently cover and will continue to cover without much change. He said products that are considered comprehensive coverage and subject to the ACA’s requirements have been removed from the minimum standards models. He explained that because these coverages were in the models, the Subgroup will have to carefully review provisions in Model #171 that might relate to comprehensive coverage, but because they relate to comprehensive coverage, it might not make sense for supplemental coverage.

J.P. Wieske (Health Benefits Institute—HBI) provided a history of Model #170 and Model #171. He said Model #170 was developed as part of state health reform efforts in the late 1980s and early 1990s to set up a regulatory structure for non-major medical health insurance products. He said the initial focus was to set minimum standards for these products to assist consumers in understanding them prior to purchase. He said at the time the Subgroup began work on revising Model #170, work on revising network adequacy standards had just been completed after approximately two years and work on revisions to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) was ongoing. He said because of issues related to
STLD plans, fixed indemnity plans, and stakeholder requests to address those issues in an NAIC model, a decision was made to make revising the minimum standards models as the next priority project. He said the Subgroup moved quickly to complete the Model #170 revisions. He explained that one of the main issues in the Model #170 revisions, particularly with respect to state regulatory authority over STLD plans, was what provisions belong in Model #170 and what belongs in Model #171. He said the Subgroup had extensive discussions on STLD plans from both a product and regulatory perspective, which led the Subgroup to specifically decided to treat STLD plans differently in the minimum standards models than the other products covered under the models.

Mr. Wieske suggested that as the Subgroup works on the Model #171 revisions, it keep in mind the following with respect to the products covered under the model: 1) most supplemental products sold through the individual market are guaranteed renewable; 2) many products sold through an employer are issued on a guaranteed issued basis, which means they are not medically underwritten; 3) unlike major medical products, consumers do not necessarily access the benefits of these products each year; 4) the products typically provide payment to the insured person and not to a medical provider; 5) payments can be used for any expenses the insured person wishes to use them for, and these payments are not coordinated with the consumer’s major medical plan; and 6) the products are priced based on lifetime loss ratios. He said for some of these products, there is evidence that some consumers are buying them to use in conjunction with their high deductible health plans as one way to build up funds in their health savings accounts (HSAs) over time and then cancel the coverage. He explained that given rising deductibles and cost sharing in individual and employer-sponsored plans, the coverage provided by these products provides consumers with coverage for those cost-sharing amounts when they cannot afford it. However, he said the HBI strongly believes these products should not be developed, marketed, and sold as replacements for ACA coverage.

Cindy Goff (American Council of Life Insurers—ACLI) said in looking at the products Model #171 currently regulates and will be regulating following the revisions, as Mr. Petersen described, she would categorize those products as HIPAA-excepted benefits products and non-HIPAA-excepted benefits products. Most of the products subject to Model #171 are HIPAA-excepted benefits products. STLD plans are the only non-HIPAA-excepted benefits products.

Ms. Goff explained what HIPAA-excepted benefits are; the federal agencies that define how benefits qualify as HIPAA-excepted benefits for individual products and group products; and the primary regulator for such benefits, which are the states. Ms. Arp asked about the significance of being a HIPAA-excepted benefits. Ms. Goff said due to the ACA, one of the main benefits is products considered to be HIPAA-excepted benefits are not subject to the ACA’s requirements because these products are not intended to be a form of primary coverage. She also discussed the differences between the group market and individual market, such as who holds the policy, whether the product is noncancellable or guaranteed renewable, and whether the product is medically underwritten. She said some of these differences, particularly with respect to the individual market, support the importance of the model setting clear minimum standards to allow insurers to assess the risk of providing coverage from the beginning because the insurer is setting the premium rate at the outset that will be in place for decades for some individuals.

Ms. Goff discussed what is meant by the term “supplemental benefits,” explaining that industry and state insurance regulators have defined the term differently than HIPAA. Generally, “supplemental benefits” are considered financial products that are triggered by health events but are not expense-based and not specifically meant to replace income. She explained that disability income, as well as dental and vision coverage are often considered “supplemental” because they provide additional benefits not covered by major medical plans, but she noted that dental and vision coverage is often expense-based and uses provider networks. Given these differences, for the purposes of this discussion, she will not include them in her discussion of “supplemental benefits.”

Ms. Goff discussed the supplemental benefit product categories, which include accident-only, specified disease, and hospital indemnity or other fixed indemnity. She discussed the type of benefits they provide and other characteristics of these types of supplemental benefit products, noting that they are financial protection products that help pay costs not covered by medical insurance. She also discussed what these supplemental benefit products are not, including that: 1) they are not comprehensive medical coverage and not intended to be sold as such; 2) they do not pay directly for medical expenses or claims; 3) they cannot pay benefits on an expense-incurred basis; and 4) they are not mini-meds or other types of medical expense coverage eliminated under the ACA.

Ms. Goff said supplemental products are popular, and based on a 2020 survey, consumers are highly satisfied with their purchase and the services they received. She said the ACLI believes the survey reflects such high consumer satisfaction, which is typically not the case with other health insurance products when the product is sold properly and used as intended. She also
discussed the importance and value of supplemental products due to the fragility of household budgets, particularly given their low premiums.

Ms. Goff next discussed dental and vision insurance, explaining how they are sold; the typical benefits offered; how the benefits are provided, which is typically provider network-based; and other characteristics of these coverages. She next discussed disability income insurance. She explained that this type of coverage is used to protect income by replacing a portion of an individual’s salary when they must take off from work due to a serious illness or injury. This coverage can be short-term or long-term. Ms. Goff explained the characteristics of both types of coverages, including the typical benefits they provide.

Ms. Goff next discussed the only type of non-HIPAA-excepted benefits product in Model #171; i.e., STLD plans. She said this product does not neatly fit into any category. It sort of stands alone because it is defined in HIPAA as “not health insurance.” STLD plans are also not considered excepted benefits under HIPAA. Ms. Goff said the ACA does not mention STLD plans, and as such, it is exempt from most ACA requirements. She said STLD plans are meant to be temporary primary coverage for individuals in transition into or out of major medical coverage. She described the characteristics of STLD plans, such as the typical length of such coverage and that medical underwriting is permitted.

Ms. Arp said the Subgroup has reserved its Oct. 4 meeting to take questions from stakeholders about the information provided in these presentations. She asked stakeholders who have any questions and would like to speak during that meeting to let NAIC staff know.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

Sept 20 Minutes
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Aug. 23, 2021. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Chris Struk (FL); Frank Opelka (LA); Robert Wake (ME); Sherri Mortensen-Brown (MN); Cynthia Amman and Carrie Couch (MO); Kathleen Kellock (SC); Rachel Bowden (TX); Tanji J. Northrup (UT); Anna Van Fleet, Christine Menard-O’Neil, Mary Block, and Jamie Gile (VT); Ned Gaines (WA); and Jennifer Stegall and Nathan Houdek (WI).

1. Discussed its Next Meeting Agenda

Ms. Arp said prior to the meeting, she and Mr. Schallhorn discussed pausing the Subgroup’s discussions of revisions to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) to hold one or two meetings to educate everyone participating in the Subgroup discussions on: 1) the different types of products covered under Model #171; 2) how they pay benefits; 3) what they are designed to do; 4) how they are marketed; and 5) how they are sold. She said this discussion will be beneficial to everyone because it will provide a better understanding of the Subgroup’s work as it moves forward in its discussions about revisions to Model #171. She said such a discussion is needed, particularly due to the turnover of Subgroup members since the Subgroup last met in December 2019. She said Cindy Goff (American Council of Life Insurers—ACLI) volunteered to facilitate a presentation to cover these topics, including which of these products are more frequently sold, how they are designed, the most selected dollar amount of coverage and dollar amount of claims. Ms. Arp said she believes the types of products to be covered under the revised model fall into at least three different groups: 1) short-term, limited-duration (STLD) products; 2) dental and vision products, which are excepted benefit products under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and 3) supplemental products, such as accident-only policies, specified disease policies, and hospital indemnity policies. She said the goal of the presentation is for everyone to better understand what each of these groups of products are, what they do, and how they pay. She also said following this presentation, the Subgroup is open to hearing from other stakeholders, particularly consumer representatives, on their concerns with these products.

Ms. Arp also discussed the approach the Subgroup could take with respect to STLD products. She said there has been discussion of separating the STLD plan provisions from the other types of products covered under Model #171. She said she believes this approach has been discussed particularly with respect to Model #171’s consumer disclosure requirement provisions because due to the nature of STLD plans, they do not fit with the other types of products covered under Model #171. The Subgroup agreed. Ms. Arp also discussed other potential differences between STLD plans and the other types of products covered under Model #171, such as group versus individual coverage and guaranteed renewability requirements.

Ms. Arp also noted that the purpose of Model #171 is to set minimum standards for the types of products it covers. Ms. Goff agreed. She said the Subgroup needs to keep this purpose in mind as it considers revisions, and it should not include prescriptive provisions that could affect the ability of insurers, particularly for group coverage, to build on the model’s minimum standard provisions. If the Subgroup chooses to do so, it should offer innovative product designs and benefits.

Chris Petersen (Arbor Strategies LLC) said the Subgroup also needs to be cognizant of what Model #171 covers and what it should cover. He explained that technically, Model #171 currently covers individual major medical products, but because of the revisions to the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170) (formerly known as the Accident and Sickness Insurance Minimum Standards Model Act), which is the companion model law to Model #171, the provisions related to individual major medical products in Model #171 need to be removed and other provisions revised for consistency with Model #170. He also noted that Model #171 does not cover STLD plans, but because the Subgroup agreed to add these products to Model #170, provisions related to these products will have to be added to Model #171. He also discussed other potential inconsistencies in the model’s current provisions involving dental and vision products and disability products. Ms. Arp asked about the possibility of creating a document to assist in the Subgroup’s discussion that would outline what products were covered in Model #171 prior to the Model #170 revisions and what products are to be covered in Model #171 after the Model #170 revisions. Mr. Petersen volunteered to create such a document.
Ms. Goff agreed that such a document would be useful. She also recalled the Subgroup’s discussions when revising Model #170 on whether to add STLD products and how to do it given the differences in these products from the other types of products covered under the models. She said she believes this is the reason why the Subgroup’s initial approach in revising Model #171 was to keep STLD plans separate from the other types of products.

Ms. Arp agreed with Ms. Goff’s comments. She said she envisions the Subgroup moving through Model #171; making revisions for the supplemental-type products; and considering, when appropriate, different provisions for STLD plans. She said if, at the end of its review, the Subgroup determines there are too many of these provisions, the Subgroup might have to reconsider this approach and develop a separate section for STLD plans. She said she knows the Subgroup will have to develop different provisions for consumer disclosures for STLD plans. J.P. Wieske (Health Benefits Institute—HBI) expressed support for Ms. Arp’s approach regarding STLD plans and the Subgroup’s plan to pause its work for one or two meetings to discuss the products covered under Model #171, including the different product designs and purposes.

After discussion, the Subgroup decided to hold its next meeting on Sept. 20. Ms. Arp also asked that if anyone has any materials they believe would be useful to the Subgroup as it begins its level-setting discussions, they should send them to NAIC staff for distribution prior to the Sept. 20 meeting.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

Aug 23 Minutes
Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
August 9, 2021

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Aug. 9, 2021. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Debra Judy (CO); Chris Struk (FL); Robert Wake (ME); Sherri Mortensen-Brown (MN); Amy Hoyt, Cynthia Amman, and Carrie Couch (MO); Rachel Bowden (TX); Heidi Clausen and Shelley Wiseman (UT); Anna Van Fleet, Emily Brown, Christine Menard-O’Neil, and Jamie Gile (VT); Jane Beyer (WA); and Nathan Houdek and Jennifer Stegall (WI).

1. Discussed Revisions to Model #171

The Subgroup continued its discussion of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)* in relation to the guaranteed renewability and noncancellable requirements of most of the policies covered under Model #171. To address this issue, the Subgroup confirmed its intent to add language to Section 4—Effective Date.

The Subgroup next continued its discussion on whether to add language to Section 5A to address the issue of using language in the policy definitions in Section 5—Policy Definitions, such as “shall not be more restrictive” or “shall not be defined more restrictively than.” The Subgroup discussed Mr. Wake’s suggested language: “[e]xcept as provided in this regulation, to the extent these definitions are used in a policy or certificate, definitions used in a policy or certificate may vary from the definitions in this section, but not in a manner that restricts coverage.” The Subgroup discussed whether this language would in effect set a minimum floor for the policy definitions in Section 5 while also permitting insurers to provide more coverage to consumers if they choose to do so. The Subgroup discussed other language that could possibly require state departments of insurance (DOIs) to review policy definitions to determine whether an insurer’s changes to a policy definition are more favorable or less favorable to the consumer. After additional discussion, the Subgroup decided to accept Mr. Wake’s suggested language.

The Subgroup returned to its discussion of Section 5G and the Missouri DOI’s suggested revisions to the policy definition of “mental or nervous disorder.” The Subgroup discussed Mr. Wake suggested language: “[e]xcept as provided in this regulation, to the extent these definitions are used in a policy or certificate, definitions used in a policy or certificate may vary from the definitions in this section, but not in a manner that restricts coverage.” The Subgroup discussed whether this language should be a drafting note or substantive language. After additional discussion, the Subgroup agreed to accept the Missouri DOI’s suggested language and add a drafting note clarifying that insurers may use other terminology for this policy term. The Subgroup also agreed to add the words “or its successor” just in case the “Diagnostic and Statistical Manual of Mental Disorders (DSM)” is ever replaced with another source.

The Subgroup revisited its discussion of Section 5G and the Missouri DOI’s suggested revisions to the policy definition of “mental or nervous disorder.” The Subgroup discussed if “nervous” disorder is currently used, because Section 4A(14) of the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170)* (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), which is the companion model law to Model #171, refers to “mental or nervous disorder,” the Subgroup would have to use the same terminology in Section 5G. Mr. Wake suggested that the Subgroup consider adding language to Section 5G to clarify that insurers may use other terminology such as “mental health condition or substance use disorder.” The Subgroup discussed whether this language should be a drafting note or substantive language. After additional discussion, the Subgroup agreed to accept the Missouri DOI’s suggested language and add a drafting note clarifying that insurers can use other terminology for this policy term. The Subgroup also agreed to add the words “or its successor” just in case the “Diagnostic and Statistical Manual of Mental Disorders (DSM)” is ever replaced with another source.

The Subgroup next discussed the policy definition of “nurse” in Section 5H. The NAIC consumer representatives suggested adding “advance practice nurse.” Jolie H. Matthews (NAIC) said during its previous discussions, the Subgroup agreed to accept the NAIC consumer representatives’ suggested revision. J.P. Wieske (Health Benefits Institute—HBI) asked about adding advance practice nurses to this policy definition, given that insurers can use it in at least two ways—coverage determinations and qualifications to perform certain duties. He said it makes sense to add advance practice nurses to the policy definition, given that they have more authority, such as the authority to prescribe medications, than a registered nurse. He asked whether including advance practice nurses in this policy definition could somehow limit that authority. Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) explained that the NAIC consumer representatives suggest adding advance practice nurses to the policy definition of “nurse” to ensure that depending on how insurers use this policy definition, given the broad scope of their practice, they are somehow excluded from being considered a “nurse” for the purposes of the policy
definition. Ms. Arp pointed out that Section 4A(14) of Model #170 requires Model #171 to include a policy definition of “physician,” which is in Section 5K. She asked if anyone believes that a reference to “advance practice nurses” should be added to the policy definition of “physician” in Section 5K instead of the policy definition of “nurse.” Mr. Wieske said he believes this could be a state-by-state scope of practice issue. Given this, he suggested that the Subgroup might want to consider adding a drafting note to Section 5H alerting states to this possible scope of practice issue. After additional discussion, the Subgroup agreed to accept the NAIC consumer representatives’ suggested revision and add the drafting note.

The Subgroup next discussed the policy definition of “one period of confinement” in Section 5I. Ms. Matthews explained the Subgroup’s previous discussions related to this term. She said those discussions included deleting the term and moving it to a substantive provision in Model #171 because the term is not used in Model #171. However, she noted that because this is a policy definition and not a regulatory definition, the Subgroup most likely would change its mind about removing the term from Section 5. She also said during the Subgroup’s previous discussions, the Subgroup sought clarification on what this term means and how it is used in a policy. Mr. Wieske said he believes the term is used in a number of ways depending on the type of policy. Bonnie Burns (California Health Advocates—CHA) explained that she has seen this term used in policies to define the distance between one period of confinement and another period of confinement to determine whether it is a benefit period for which benefits have been paid or a new benefit period. She asked for clarification about this policy definition and whether it is tied to an in-hospital stay. The Subgroup discussed the nuances of how this policy definition is used and applied in different types of policies. After additional discussion, the Subgroup decided to leave the policy definition of “one period of confinement” unchanged. Ms. Howard stated from a consumer perspective that the Subgroup should consider adding language related to this policy definition in the substantive provisions of Model #171, given the potential varying uses and applications of the definition depending on the type of policy. The Subgroup discussed Ms. Howard’s suggestion and decided that it is not necessary to have varying definitions for the term because the terms defined in Section 5 are a minimum standard and meant to be a common policy definition across all policies if that term is used in the policy, and it may not be changed in a manner that restricts coverage.

The Subgroup decided to begin its discussion of the policy definition of “partial disability” in Section 5J during its next meeting Aug. 23.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

Aug 9 Minutes
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met July 26, 2021. The following Subgroup members participated: Laura Arp, Co-Chair (NE); Andy Schallhorn, Co-Chair (OK); Debra Judy (CO); Chris Struk and Shannon Doheny (FL); Robert Wake (ME); Sherri Mortensen-Brown (MN); Amy Hoyt and Carrie Couch (MO); Rachel Bowden (TX); Tanji J. Northrup (UT); Anna Van Fleet, Emily Brown, Christine Menard-O’Neil, and Jamie Gile (VT); Ned Gaines (WA); and Nathan Houdek and Jennifer Stegall (WI).

1. **Discussed Revisions to Model #171**

The Subgroup continued its discussion of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)* beginning with Section 5B. The Subgroup discussed the NAIC consumer representatives’ suggested revisions to Section 5B, which would add additional facility types, such as “assisted living facility” and “continued care retirement community.” Sarah Lueck (Center on Budget and Policy Priorities—CBPP) said the NAIC consumer representatives suggested this revision as an update to the existing language. The Subgroup discussed the suggested revision and whether it had preliminarily accepted the suggested revision during its prior discussions of this provision. Jolie H. Matthews (NAIC) said during its Sept. 16, 2019, meeting, the Subgroup decided to accept the NAIC consumer representatives’ and the Missouri Department of Insurance’s (DOI’s) suggested revisions to Section 5B. Based on this information, the Subgroup decided to again accept the suggested revisions.

The Subgroup next discussed Section 5C and the Washington DOI’s suggestion to delete it. Ms. Matthews said during its Oct. 7, 2019, meeting, the Subgroup accepted the suggestion to delete Section 5C. She said at the time, the Subgroup reasoned that a definition of “disability” was unnecessary because other terms in the model would better determine what a “disability” is, such as “partial disability,” “total disability,” and “residual disability.” However, she said the Subgroup agreed to revisit this decision, if necessary. The Subgroup discussed whether to accept its previous decision to delete Section 5C. During this discussion, Subgroup members said an additional reason for deleting Section 5C is to avoid any possible confusion with how some states use the term “disability” to refer to “accident and sickness insurance.” After additional discussion, the Subgroup decided to again delete Section 5C.

The Subgroup next discussed Section 5D. Ms. Matthews said during its Oct. 7, 2019, meeting the Subgroup decided to accept the Missouri DOI’s suggested revisions to Section 5D(2). The Subgroup also decided to revise the language in Section 5D(2)(c) to reflect current terminology by deleting “drug addicts or alcoholics” and replacing it with “individuals with a substance use disorder.” The Subgroup decided not to accept the NAIC consumer representatives’ suggested revisions. Ms. Matthews said the Subgroup deferred deciding on whether to add America’s Health Insurance Plans’ (AHIP’s) suggested language “facilities existing primarily to provide psychiatric services” to Section 5D(2). AHIP suggests this language because these types of facilities are not hospitals.

Chris Petersen (Arbor Strategies LLC) said the Subgroup’s discussion about removing obsolete language and replacing it with current terminology raises a larger issue the Subgroup needs to consider and address in some manner. He explained that most of the types of policies subject to Model #171 are guaranteed renewable and noncancelable. Because of this, the Subgroup needs to consider how to address the application of any revisions to Model #171 on these types of policies. Mr. Petersen suggested that the Subgroup consider adding language to Section 3—Applicability and Scope to apply any revisions to Model #171 to policies issued after the effective date of a state’s adoption of the revised model. The Subgroup discussed Mr. Petersen’s suggestion. The Subgroup also discussed generally how policies covered under Model #171 operate, considering their guaranteed renewability and noncancelable requirements, which the *Uniform Individual Accident and Sickness Policy Provision Law (#180)* addresses. After additional discussion, the Subgroup agreed to add language to Section 4—Effective Date to address the issue. Cindy Goff (American Council of Life Insurers—ACLI) volunteered to work with other stakeholders to provide language for the Subgroup’s consideration later.

The Subgroup returned to its discussion of the suggested revisions to Section 5D. Ms. Arp expressed concern with AHIP’s suggested revision because of the lack of clarity as to what is means by “psychiatric services,” which could include, for example, services related to Alzheimer’s disease. Mr. Petersen asked about the Subgroup’s previous discussions related to this suggested...
revision. He suggested that if the Subgroup has already discussed this and decided to accept it or reject it, then in accordance with the Subgroup’s previous agreement to not revisit settled decisions, the Subgroup should not revisit this suggested revision. Ms. Matthews said during its previous discussions of this suggested revision, the Subgroup deferred deciding. Mr. Petersen said given the Subgroup’s previous decision to defer deciding, AHIP will submit new language to address the Subgroup’s concerns for its consideration later.

The Subgroup next discussed Section 5E, the policy definition for “injury.” Ms. Matthews said during the Subgroup’s Oct. 28, 2019, meeting, the Subgroup agreed to delete “bodily injury” in Section 5E(1) because it was contradictory to other language in Section 5E and delete Section 5E(2). The Subgroup decided not to make any changes from its previous discussions on this provision.

Ms. Lueck asked for clarification on what Mr. Petersen meant by the four principles the Subgroup decided to accept with respect to its discussion of revisions to Model #171 and the revised Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170) (formerly known as the Accident and Sickness Insurance Minimum Standards Model Act), which is the companion model law to Model #171. Mr. Petersen explained that he believed the Subgroup had agreed to not revisit decisions made with respect to Model #170 in its discussions of revisions to Model #171. Ms. Lueck said she was unaware of any specific Subgroup discussions on this issue, and many of the issues the Subgroup discussed while revising Model #170 were deferred and to be addressed when the Subgroup revised Model #171. Mr. Petersen said in his opinion, if that was the case, it would not be considered revisiting the issue. Ms. Lueck suggested that the Subgroup rediscuss the so-called four principles so that everyone knows what they are, particularly if the Subgroup plans to follow them as it moves forward with its discussions of revisions to Model #171.

Mr. Petersen said he would recirculate his letter outlining the four principles. Ms. Arp said she recalls the Subgroup agreeing to the so-called four principles. J.P. Wieske (Health Benefits Institute—HBI) agreed with Ms. Arp. He said he believes nothing in the four principles is out of the ordinary. The agreed upon general guidelines suggest that the Subgroup should: 1) not reopen issues discussed and settled upon during its work revising Model #170; 2) acknowledge that Model #171 sets minimum standards; 3) not include topics not included in Model #170; and 4) acknowledge that the current supplemental market works and revise Model #171 in a manner to avoid market disruption. Ms. Arp said to date, the Subgroup’s discussions of the proposed revisions relate to what the Subgroup agreed to during its previous discussions in late 2019, as reflected in the NAIC staff working draft. Mr. Schallhorn agreed.

Ms. Arp said despite this agreement to not revisit previous decisions, if there are things that someone strongly feels are wrong or if it is a procedural issue, they should let the Subgroup know so it can decide whether it wants to discuss the issue or not. Ms. Lueck said she did not have any real issues with the Subgroup’s stance to not revisit issues, but given that this was discussed in late 2019, she believes the Subgroup should rediscuss the four principles so everyone knows what they are. Lucy Culp (Leukemia & Lymphoma Society) and Yosha Dotson (Georgians for a Healthy Future) agreed with Ms. Lueck’s comments.

The Subgroup next discussed Mr. Wake’s comments on Section 5F, the definition of “Medicare.” Mr. Wake said his comments on this provision relate to the Subgroup’s previous discussions and decision to create a new section in Model #171 for definitions of regulatory terms. The definition of “Medicare” looks like a regulatory definition, and if the Subgroup agrees, it should be included in this new section and removed from Section 5—Policy Definitions. The Subgroup agreed.

The Subgroup discussed Section 5G, the definition of “mental or nervous disorder.” The Subgroup discussed its previous discussions of this provision, which decided to revise the definition to state, “mental health condition or substance use disorder means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).” Mr. Petersen suggested that the proposed revision definition for this term reads more like a “regulatory” definition, not a “policy” definition, because the suggested language does not use the words “shall not be defined more restrictively than.” The Subgroup discussed his comments, including whether the revised language should refer to the most recent version of the DSM “at the time the policy is issued” to avoid making changes in the policy if the DSM is subsequently updated after policy issuance. The Subgroup also discussed this language to set a floor to allow insurers to be more expansive. Mr. Wieske said he did not believe it would be an issue if the language is not added, because he did not believe a revised DSM would require insurers to have to refile a policy because the coverage would not be changed. After additional discussion, the Subgroup agreed not to include the additional language.

Ms. Lueck asked if this definition, for the types of policies Model #171 applies to, is generally used to restrict coverage. Mr. Wieske said for disability income protection coverage, this definition would most likely be considered more expansive from a coverage viewpoint. He also pointed out that the NAIC consumer representatives’ suggested revision to this definition is also
rather broad; however, he said the suggested revision to reference the DSM was probably a cleaner way to define this term because it does not require an interpretation of what terms such as neurosis, psychoneurosis, or mental or emotional disease mean. Mr. Wake said this discussion suggests that the Subgroup might want to consider adding language to Section 5A stating, “[e]xcept as provided in this regulation, to the extent these definitions are used in a policy or certificate, definitions used in a policy or certificate may vary from the definitions in this section, but not in a manner that restricts coverage.” The Subgroup discussed the merits of including such language. The Subgroup decided to continue the discussion during its next meeting on Aug. 9.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

July 26 Minutes
The ERISA (B) Working Group of the Regulatory Framework (B) Task Force met Oct. 8, 2021. The following Working Group members participated: Robert Wake, Chair (ME); William Rodgers (AL); Johanna Nagel (IA); Craig Van Aalst (KS); Victoria Bares (MN); Amy Hoyt (MO); Ted Hamby (NC); Stephanie Canter (NV); Laura Miller (OH); Landon Hubbart (OK); Jill Kruger (SD); Rachel Bowden (TX); Tyler Robbins (WA); and Richard Wicka (WI).

1. **Discussed Rutledge v. Pharmaceutical Care Management Association**

Mr. Wake said the purpose of the Working Group’s meeting is to discuss revising the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) to include a summary of the Supreme Court’s 2020 decision in the case of *Rutledge v. Pharmaceutical Care Management Association*, 141 S.Ct. 474 (2020). Mr. Wake said a preliminary draft of a summary to add to the ERISA Handbook was distributed prior to the meeting.

Mr. Wake said that the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup has a charge to develop a white paper on issues related to the state regulation of certain pharmacy benefit manager (PBM) business practices. He said the Working Group plans to focus on the case summary at this time and will wait for additional guidance from the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup before undertaking any additional analysis of the ERISA implications on other state PBM laws.

A number of state insurance regulators and interested parties expressed concern with the tone of the draft, stating that it did not match the tone in the rest of the ERISA Handbook and that the summary should focus more on the preemption analysis rather than opining on the particulars of PBMs.

Mr. Wake explained that the draft was intended to generate discussion, and he agreed that there needs to be substantial revisions to the substance and tone of the draft. He explained that the draft was developed for a continuing legal education class, so it needs to be modified to parallel the other case summaries in the ERISA Handbook. Ms. Arp said she found another Rutledge case summary by the NAIC that she thinks can be a starting point for the ERISA Handbook update. Ms. Arp, Mr. Wake, and Jennifer Cook (NAIC) agreed to work on a draft summary to expose for public comment.

Having no further business, the ERISA (B) Working Group adjourned.
The ERISA (B) Working Group of the Regulatory Framework (B) Task Force met July 30, 2021. The following Working Group members participated: Robert Wake, Chair (ME); Jennifer Li and Anthony L. Williams (AL); Jason Lapham (CO); Angela Burke Boston and Johanna Nagel (IA); Julie Holmes (KS); Victoria Bares (MN); Cynthia Amann and Amy Hoyt (MO); Ted Hamby (NC); Laura Arp and Martin Swanson (NE); Laura Miller (OH); Andrew Schallhorn (OK); David Bolduc (TX); Jaakob Sundberg (UT); Mandy Weeks-Green (WA); and Richard Wicka (WI).

1. Discussed Rutledge v. Pharmaceutical Care Management Association

Mr. Wake said the purpose of the Working Group’s meeting is to discuss addressing the Supreme Court’s 2020 decision in the case of Rutledge v. Pharmaceutical Care Management Association, 141 S.Ct. 474 (2020). He suggested, and the Working Group agreed, to include this case in the Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation (ERISA Handbook) in the section summarizing seminal ERISA preemption cases. Mr. Wake said a preliminary draft of a summary to add to the ERISA Handbook has been developed. He asked state insurance regulators to email Jennifer Cook (NAIC) if they are interested in participating in a drafting group to develop a draft to circulate for public comment.

Mr. Wake said, in addition, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force has a charge to develop a white paper on issues related to the state regulation of certain pharmacy benefit manager (PBM) business practices. He said the Working Group has been identified to assist with addressing the ERISA preemption aspects of the Rutledge decision in the white paper. Ms. Arp said she would like the Working Group to explore the ERISA preemption implications of the Rutledge decision on other state laws, like laws that affect pricing. She said that there are state laws that are written to say “except to the extent they are preempted.” She said this raises questions about the application of such a law in light of the holding in Rutledge that the Arkansas pharmaceutical pricing law was not preempted. She suggested that the Working Group develop a list of factors that states need to consider in analyzing their state laws to determine whether the Rutledge decision has an impact and what that impact might be. She said it would be helpful to include the U.S. Department of Labor (DOL) in any discussions and get their feedback. Mr. Wake asked and Ms. Arp agreed to chair a drafting group to look at developing a “preemption road map” for states on this issue. Mr. Wake asked state insurance regulators interested in participating on this drafting group to email Ms. Cook.

Ali Khawar, who is the Acting Assistant Secretary for the Employee Benefits Security Administration (EBSA) at the U.S. Department of Labor (DOL), introduced himself to the Working Group. He explained that he has previously served in a variety of roles at the DOL, including as an EBSA investigator, in EBSA’s Office of Enforcement, as EBSA’s Chief of Staff in two administrations, and as a Counselor to the 26th Secretary of Labor, Thomas E. Perez. Mr. Khawar said he is looking forward to continuing the important collaborative relationship the DOL has established with the NAIC over the years. He said whether collaborating over regulations or enforcement matters, the ability to share best practices and tips on what states are seeing has been very valuable to the DOL. Mr. Wake agreed that the relationship the Working Group and the NAIC has enjoyed with the DOL over the years has been mutually beneficial, and he said that they look forward to continuing the relationship.

Having no further business, the ERISA (B) Working Group adjourned and reconvened in regulator-to-regulator session pursuant to paragraph 1 (potential or pending litigation or administrative proceedings), paragraph 2 (pending investigations), paragraph 3 (specific companies, entities or individuals), and paragraph 9 (any other subject required to be kept confidential) of the NAIC Policy Statement on Open Meetings.

July 30 Minutes
The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met Aug. 5, 2021. The following Working Group members participated: Katie Dzurec, Chair (PA); Jane Beyer, Vice Chair (WA); Donna Lambert (AR); Mary Boatright, Leanne Henagan, Erin Klug, and Catherine O’Neil (AZ); Christopher Citko and Doris Walker (CA); Cara Cheever, Damion Hughes, and Debra Judy (CO); Kurt Swan (CT); Howard Liebers and Mary Beth Senkewicz (DC); Melissa Carter and Sarah Crittenden (GA); Cynthia Banks Radke, Andria Seip, and Sonya Sellmeyer (IA); Ryan Gillespie and Erica Weyhenmeyer (IL); Chris Hollenbeck, Julie Holmes, Brenda Johnson, Kenneth Scott, Barbara Torkelson, and Craig Van Aalst (KS); Mary Kwei, Theresa Morfe, and Natalie Nelson (MD); Sherri Mortensen-Brown (MN); Cheryl Allen-Bivens, Tracy Biehn, and Teresa Knowles (NC); Maureen Belanger and Michelle Heaton (NH); Ralph Boeckman, Chaneil McDevitt, Erin Porter, and Gale Simon (NJ); Diane Bilodeau, Paige Duhamel and Viara Ianakieva (NM); Todd Oberholtzer, Laura Miller, Molly Mottram, and Guy Self (OH); Cuc Nguyen (OK); Shari Miles (SC); Lisa Harmon, Candy Holbrook, and Jill Kruger (SD); Rachel Bowden, Valerie Brown, Debra Diaz-Lara, Katelyn Marak, Kenisha Schuster, and Matt Wall (TX); Carrie Backus, Heidi Clausen, Tanji J. Northrup, Jaakob Sundberg, and Shelley Wiseman (UT); Julie Blauvelt and James Young (VA); Diane Dambach and Darcy Paskey (WI); Joylynn Fix (WV); and Denise Burke and Mavis Earnshaw (WY).

1. **Heard Presentations from Health Care Providers on Mental Health Parity**

Ms. Dzurec said that the Special (EX) Committee on Race and Insurance has charged the MHPAEA (B) Working Group with researching disparities in mental health and substance use disorder parity and access to culturally competent care. She said state insurance regulators must incorporate equity and inclusion in their everyday work, appreciating the histories of discrimination, exclusion, incarceration, and the use of mental health as a weapon. She said past practices have skewed understanding and data sets and that history can make many people blind to inequities. She said the speakers could help state insurance regulators ask the right questions.

Dr. Edwin Chapman (addiction specialist internist) provided a profile of his patient population, showing they have disproportionate mental health, substance use, HIV, and hepatitis diagnoses. He said African-Americans represent only 5% of physicians and 2% of psychiatrists. He said different states and insurance companies allow different doses for medication-assisted treatment, so there is no consistent standard of care. He shared the limited availability of buprenorphine to Black and urban populations. He said there is confusion in standards for prescribing as they are interpreted by insurance companies, pointing out differences in standards from those allowed by the Substance Abuse and Mental Health Services Administration (SAMHSA). He said the No. 1 barrier to care is prior authorizations, followed by access to treatment, lack of integration, payment limits, same-day billing restrictions, and disconnects between the health care system and criminal justice system. Dr. Chapman said the complexity of his patients require integrated care delivery or coordinated care. He shared a hybrid model he developed to integrate primary care, mental health services, and community care for social determinants of health. He outlined how his system integrates care with the goals of reduced medical costs and non-medical costs. He compared the system costs of untreated patients, in-treatment patients who are not abstinent, and stable patients in treatment, with untreated patients costing the most. He said the American Society of Addiction Medicine (ASAM) recommends patient-centered treatment rather than standard fee-for-service evaluation and management billing. He said insurance company algorithms can be biased. He said among his patients alone, he has achieved $8 million in savings from the criminal justice system.

Ms. Beyer asked whether the ASAM treatment model has been adopted by payers. Dr. Chapman said adoption has been a problem in Washington, DC, and he encouraged state insurance regulators to contact the American Medical Association (AMA) to find out more about where it has been adopted. Ms. Duhamel asked whether Dr. Chapman has worked with commercial payers to remove restrictions on buprenorphine restrictions. Dr. Chapman said he has presented to the federal Centers for Medicare & Medicaid Services (CMS) with that goal.

Dr. Walter Wilson (HealthPoint Family Care) presented on challenges and recommendations in mental health equity. He defined behavioral health equity and identified barriers to equity. The barriers include ethnic/racial/demographic disparities, geographic disparities, psychosocial barriers, and insurance-related barriers. He said there is stigma associated with mental health care generally, but some research suggests it is a larger problem in minority communities. He said language barriers can be significant and that electronic medical records systems can lack the ability to print visit summaries in Spanish. He shared SAMHSA data showing that, among those with mental illness, patients from minority populations access treatment at lower...
rates than white people. He identified fragmented access as a barrier when patients can access one type of provider, but not others in their health system. He described the steps patients must navigate to access mental health services, from awareness of mental health itself to awareness of the resources available, resources for payment, service location, and quality. He recommended that state insurance regulators support insurers’ educational initiatives, require up-to-date provider directories, promote easy-to-use website information that meets populations’ health literacy, and use feedback from patients. He identified several reasons why providers may not join insurer networks and several recommendations for insurers to improve the provider experience.

Cheryl Fish-Parchman (Families USA) asked about inappropriate discharges from hospitals. Dr. Wilson said that in his experience, clinicians consider how many hospital days insurers will cover and that he has seen hospitals discharge patients who were not ready.

Having no further business, the MHPAEA (B) Working Group adjourned.

Aug 5 Meeting Minutes
SENIOR ISSUES (B) TASK FORCE

Senior Issues (B) Task Force Nov. 30, 2021, Minutes ....................................................................................................... 7-162
Senior Issues (B) Task Force Oct. 6, 2021, Minutes (Attachment One) ................................................................. 7-165
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Long-Term Care Insurance Model Update (B) Subgroup Nov. 3, 2021, Minutes (Attachment Two) ....................... 7-170
  Long-Term Care Insurance Model Update (B) Subgroup Oct. 13, 2021, Minutes (Attachment Two-A) .............. 7-174
The Senior Issues (B) Task Force met Nov. 30, 2021. The following Task Force members participated: Marlene Caride, Chair (NJ); Lori K. Wing-Heier, Vice Chair (AK); Jim L. Ridling represented by Steve Dozier (AL); Evan G. Daniels represented by Tyler McKinney (CA); Michael Conway represented by Peg Brown (CO); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods (DC); Trinidad Navarro represented by Susan Jennette (DE); David Altimair represented by Chris Struk (FL); John F. King represented by Matthew Padova (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Rebecca Vaughan (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Stephanie McGaughey-Bowker (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Joy Hatchette (MD); Eric A. Cioppa represented by Sherry Ingalls (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Fred Andersen (MN); Chlora Lindley-Myers (MO); Troy Downing (MT); Mike Causey represented by Garlinda Taylor (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning and Laura Arp (NE); Chris Nicolopoulos represented by Roni Karnis (NH); Barbara D. Richardson (NV); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready represented by Mike Rhoads (OK); Andrew R. Stolfi represented by Gayle Woods (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Chris Herrick (TX); Jonathan T. Pike (UT); Scott A. White represented by Bob Grissom (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Jennifer Stegall (WI); and Allan L. McVey represented by Ellen Potter (WY). Also participating were: Sara Stanberry (IL); Kay Warrington (MS); Bogdanka Kurahovic (NM); Martin Wojcik (MO); Troy Downing (MT); Mike Causey represented by Garlinda Taylor (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning and Laura Arp (NE); Chris Nicolopoulos represented by Roni Karnis (NH); Barbara D. Richardson (NV); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready represented by Mike Rhoads (OK); Andrew R. Stolfi represented by Gayle Woods (OR); Jessica K. Altman (PA); Larry D. Deiter represented by Jill Kruger (SD); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Chris Herrick (TX); Jonathan T. Pike (UT); Scott A. White represented by Bob Grissom (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Jennifer Stegall (WI); and Allan L. McVey represented by Ellen Potter (WY). Also participating were: Sara Stanberry (IL); Kay Warrington (MS); Bogdanka Kurahovic (NM); Martin Wojcik (MO); Patrick Smock (RI); Andrew Dvorine (SC); Isabelle Keiser (VT); and Mavis Earnshaw (WY).

1. **Adopted its Oct. 6 Minutes**

The Task Force met Oct. 6 and took the following action: 1) adopted its 2022 proposed charges; and 2) heard a presentation on the WA Cares Fund.

Ms. Karnis made a motion, seconded by Director Wing-Heier, to adopt the Task Force’s Oct. 6 minutes (Attachment One). The motion passed unanimously.

2. **Adopted the Report of the Long-Term Care Insurance Model Update (B) Subgroup**

The Long-Term Care Insurance Model Update (B) Subgroup met Nov. 3 and Oct. 13. During its Nov. 3 meeting, the Subgroup continued its cursory review of Section 7 through Section 12 of the *Long-Term Care Insurance Model Regulation* (#641). During its Oct. 13 meeting, the Subgroup began its cursory review Model #641, beginning with Section 1 through Section 6. The Subgroup plans to meet Dec. 1 to continue its cursory review of Section 13 through Section 19.

Director Wing-Heier made a motion, seconded by Ms. Kruger, to adopt the report of the Long-Term Care Insurance Model Update (B) Subgroup (Attachment Two). The motion passed unanimously.

3. **Discussed DME, Medicare Supplement, and Excess Charges**

Ms. Arp began the discussion by noting there appears to be a loophole being exploited by durable medical equipment (DME) suppliers. She said it may not be fraud, but it is certainly waste. She referred to the slide deck, pointing out that the slide refers to the same patient and the same DME provider for a nasal prothesis. She pointed out that the charges jumped from $4,850 to $91,274 in a span of five years.

Ms. Arp cited another example involving scooters and power wheelchairs. She said, for example, in 2019, Medicare was billed $43,485.10 for a power wheelchair and Medicare approved $4,702, leaving the insurer to pay the balance of $38,783.10. She cited another example where Medicare was billed $44,422.83 for a power wheelchair and Medicare approved $4,706.58, leaving the insurer to pay the balance of $39,716.25. She said in another example from 2021, Medicare was billed $10,841.04 for a hospital bed and Medicare approved a monthly rental charge only, which left the insurer to pay the balance after the approved charge of $10,767.18. She said a call was made on this claim, and the insurer was told that the scooter store billed for the cost of the bed, and they billed it again as not assigned, and they will bill Medicare the monthly rental of the bed. She
Ms. Arp said the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651) states in the excess charges section, have coverage for either 80% or 100%, depending on the plan of excess charges, and it is not to exceed any charge limitation established by the Medicare program or state law. She said Plan F and Plan F High Deductible shall include 100% of the excess charges, and Plan G shall include 80% of the excess charges. She said the next step is to look at what limitations exist. She said in the relevant sections of the federal Social Security Act (SSA), a person is not liable for payment of amounts billed for the service in excess of the limiting charge. She said that is a kind of balance billing application. It then sends it to the federal Centers for Medicare & Medicaid Services (CMS) to send the Medicare card to the

Ms. Arp said if one looks back at the limitation on beneficiary liability in the SSA, it states, “In the case of a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1395u(i)(2) of this title) who does not accept payment on an assignment-related basis for a physician’s service furnished with respect to an individual enrolled under this part, the following rules apply …” She said the rules are the limiting charge, and the insured is not liable for any difference, so it begs the question: If this 115% limitation is applicable to physician billing, why does it say “…nonparticipating physicians, or nonparticipating suppliers, or other persons”? Ms. Arp said providers are operating on the assumption that 115% only applies to physicians and that they are free to charge whatever they want.

Ms. Arp said there are options to address this. She said state laws could be changed. She said eight states have done this already. She said Medigap regulations could be changed. She said the other option is to provide some kind of interpretation or bulletin that explains that the term physician service can be read to include the physician service of writing the prescription for the DME for which the supplier fills, and that would make more sense with the limiting charge language that includes both nonparticipating physician and nonparticipating suppliers or other persons.

Commissioner Caride asked if there are any comments from Task Force members. Director Wing-Heier said she appreciates this being discussed and dislikes price gouging. She said when people take advantage of a loophole, it destroys the system. She said issues like this are the reasons consumers pay what they are paying. Commissioner Caride agreed.

Meghan Stringer (America's Health Insurance Plans—AHIP) presented her slides and said some of AHIP’s Medigap members brought this to her team’s attention. She said there are other DME items, other than scooters, that are subject to these excess charges, such as dental devices for sleep apnea and knee therapy devices. She said there is an issue with advertisements where the ads state if you have a Medigap plan, these items are no cost to the consumer. She said some of the carriers think there is misleading information in these advertisements. She said on the scooters in particular, the supplier website will indicate that standard parts are included, but items that one would think are standard, like wheels or batteries, are billed separately. She said AHIP’s members are seeing reports across the country in nearly every state. She said in some instances, if the Medigap plan tries to push back, the supplier then says it will balance bill the beneficiary, which cannot happen, so the plan eats the costs.

4. Heard a Federal Update

David Torian (NAIC) provided the Task Force with a federal update. He said funding for the State Health Insurance Assistance Program (SHIP) is operating under fiscal year (FY) 2021 levels, and SHIP funding is at $55 million. He said the U.S. House of Representatives (House) did pass its FY 2022 Labor, Health and Human Services, Education and Related Agencies funding bill on July 29, and it included an increase to SHIP to a level of $57,115,000. He said the U.S. Senate (Senate) has not acted on its appropriation bills. He said the U.S. Congress is looking at doing a short continuing resolution (CR) to keep the government funded through December.

Mr. Torian said the House passed the reconciliation bill on Nov. 19, which included language to provide for coverage of hearing aids under Medicare Part B for individuals with severe or profound hearing loss in one or both ears, once every five years and if furnished through a written order by a physician, qualified audiologist, hearing aid professional, physician assistant, nurse practitioner, or clinical nurse specialist qualified to write such order by the state. He said it is unclear when the Senate will consider this measure and if any of the hearing provisions may be changed.

Mr. Torian discussed an issue brought to the attention of the NAIC regarding delays with Medicare cards. He said the Social Security Administration (SSA) mails out (usually initiated by a phone call) the application and receives and processes the application. It then sends it to the federal Centers for Medicare & Medicaid Services (CMS) to send the Medicare card to the
enrollee. He said since many SSA field offices have been closed due to the pandemic, almost all applications are being mailed to seniors, and then they must mail the application and supporting materials back to the SSA. He said the CMS and the SSA have found that serious mail delays (three to four weeks for each mailing) have resulted in significant delays in the final application being received by the SSA. He said the mail delivery and the slow down at the U.S. Postal Service (USPS) seems to be the main issue. The CMS and the SSA are looking at ways to address this, but this may take some time to resolve. He said the NAIC continues to monitor the matter and is in communication with the SSA and the CMS.

Having no further business, the Senior Issues (B) Task Force adjourned.
The Senior Issues (B) Task Force met Oct. 6, 2021. The following Task Force members participated: Marlene Caride, Chair (NJ); Lori K. Wing-Heier, Vice Chair (AK); Jim L. Ridling represented by Anthony L. Williams (AL); Evan G. Daniels represented by Erin Klug (AZ); Ricardo Lara represented by Tyler McKinney (CA); Andrew N. Mais represented by Paul Lombardo (CT); Karima M. Woods represented by Michael Ross (DC); Trinidad Navarro represented by Fleur McKendell (DE); David Altmayer represented by Chris Struk (FL); John F. King represented by Teresa Winer (GA); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Amy L. Beard represented by Rebecca Vaughan (IN); Vicki Schmidt represented by Shannon Lloyd (KS); Sharon P. Clark represented by Stephanie McGaughey-Bowker (KY); James J. Donelon represented by Ron Henderson (LA); Gary D. Anderson represented by Kevin Beagan (MA); Kathleen A. Birrane represented by Joy Hatchette (MD); Eric A. Cioppa represented by Sherry Ingalls (ME); Anita G. Fox represented by Renee Campbell (MI); Grace Arnold represented by Sherri Mortensen-Brown (MN); Chlora Lindley-Myers (MO); Troy Downing (MT); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Yuri Venjohn (ND); Eric Dunning (NE); Chris Nicopolous represented by Roni Karnis (NH); Barbara D. Richardson represented by Jack Childress (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Andrew Schallhorn (OK); Jessica K. Altman represented by Shannen Logue (PA); Carter Lawrence represented by Brian Hoffmeister (TN); Cassie Brown represented by Chris Herrick (TX); Jonathan T. Pike represented by Jaakob Sundberg (UT); Scott A. White represented by Bob Grissom (VA); Mike Kreidler represented by Molly Nollette (WA); Mark Afable (WI); and Allan L. McVey represented by Ellen Potter (WV). Also participating were: Eric Anderson (IL); Bogdanka Kurahovic (NM); Martin Wojcik (NY); Andrew Dvorine (SC); Mary Block (VT); and Mavis Earnshaw (WY).

1. **Adopted its 2022 Proposed Charges**

Director Wing-Heier raised last minute language proposed by Birny Birnbaum (Center for Economic Justice—CEJ) to be added to the 2022 Proposed Charges. The language Mr. Birnbaum proposed would add a subsection to the 2022 Proposed Charges that reads, “[c]onduct an examination of the effects of structural racism and the COVID-19 pandemic on access, affordability, and outcomes for older insurance consumers.”

Mr. Birnbaum said he notes that the mission of the Task Force is to consider policy issues on insurance issues affecting older Americans. He said two of the most prominent policy issues affecting the insurance industry today are the effects of structural racism and the pandemic on access, affordability, and outcomes for insurance consumers, particularly insurance consumers in communities of color. He said he does not see any mention of these policy issues in the charges, so he suggests either adding to existing charges or creating a new charge to examine the impacts of structural racism and the pandemic on the specific subject matter of the Task Force, namely the impacts on older insurance consumers.

Ms. Miller asked if structural racism and the COVID-19 pandemic in terms of the new charge are to be considered in conjunction with each other or separate issues. Mr. Birnbaum said the intent of the charge is that there are two separate policy issues for consideration on their impact on older insurance consumers, and there is likely to be some overlap given that the pandemic has disproportionately affected communities of color. Mr. Lombardo said he wanted to make sure the new language is placed in the proper location and spot.

Director Wing-Heier made a motion, seconded by Ms. Nollette, to add Mr. Birnbaum’s proposed added language to the 2022 Proposed Charges and label it as Subsection H. The motion passed unanimously.

Bonnie Burns (California Health Advocates—CHA) offered language to include complimentary language about the Task Force being a clearing house for Medicare Supplement (Medigap), as well as Medicare Advantage. She said the last sentence in Subsection B in the Task Force charges states, “[a]ssists the states and serve as a clearinghouse for information on Medicare Advantage plan activity.” She said there should be a similar line for Medigap.

Mr. Trexler said he did not see the need for such language, as Medicare Advantage and Medigap are different in structure. He said the states administer Medigap, whereas Medicare Advantage is run by the federal Centers for Medicare and Medicaid Services (CMS); therefore, coordination between the CMS and the Task Force is necessary. Peggy Camerino (United American
Insurance Company) said she agreed with Mr. Trexler, as the information on innovative benefits are already on the Task Force web page. Director Wing-Heier and Ms. Karnis also expressed that the 2022 Proposed Charges are sufficient without the additional language.

Ms. Mortensen-Brown made a motion, seconded by Director Wing-Heier, to adopt the 2022 proposed charges, as amended (Attachment One-A). The motion passed unanimously.

2. Heard a Presentation on the WA Cares Fund

Todd Dixon, Washington Deputy Commissioner for Consumer Protection, said the WA Cares Fund is struggling. He said the Washington Office of the Insurance Commissioner (WAOIC) is not part of the WA Cares Fund in terms of administration or implementation. He said the WAOIC is only involved because of the provision in the WA Cares Fund law that allows persons to be exempted from the law.

Mr. Dixon said the WA Cares Fund is run by the Aging and Long-Term Support Administration of the Washington State Department of Social and Health Services (DSHS). He said the WA Cares Fund is a universal long-term care (LTC) program. He said it is an earned benefit; i.e., only those who contribute are eligible. He said it is self-funded from worker contributions, reducing the need to raise taxes to pay for Medicaid Long-Term Services and Supports (LTSS) costs associated with the coming age wave. He said there is a lifetime maximum benefit of $36,500; contributions begin Jan. 1, 2022, and benefits begin Jan. 1, 2025.

Mr. Dixon said workers contribute 0.58% of their wages, and premiums go into a dedicated trust fund that can only be used for this program. He said if a person has private long-term care insurance (LTCI), that person can either keep it and use it to supplement the WA Cares Fund $36,500 benefit or apply to permanently withdraw from the WA Cares Fund Oct. 1, 2021, through Dec. 31, 2022. He said employers collect premiums from employee wages beginning Jan. 1, 2022. He said employers do not contribute to the WA Cares Fund. He said if an employee has LTCI and does not want additional coverage through the WA Cares Fund, the employee can opt out by applying through the Washington State Employment Security Department (ESD). He said employers do not process the opt-out applications; the ESD processes them. He said self-employed earners may opt into the WA Cares Fund through the ESD.

Mr. Dixon explained the vesting criteria for the WA Cares Fund. He said an individual must have earned their WA Cares Fund benefit by working and contributing: 1) at least 10 years at any point in their life without a break of five or more years; or 2) three of the last six years. They must also have worked and contributed at least 500 hours per year during those years. Mr. Dixon said to be eligible for benefits, the individual must require assistance with at least three activities of daily living (ADLs). He said the benefit is flexible; i.e., a person can: 1) spend up to $36,500 on a combination of services and supports; 2) choose how they want to use it; and 3) hire a home-care aide, pay a family member, make home modifications, etc.

Mr. Dixon said federal employees are not included, the self-employed can opt in beginning Jan. 1, 2022, and the tribes have the option to opt in at any time. He said there are circumstances where certain people may be unable to claim benefits. He said under the current statute, people who live in border states and work in Washington will pay in but cannot access benefits unless they reside in Washington when they need care. He said people who will retire before they permanently vest will be unable to claim if they need care beyond three years of retiring, and people who move out of state will not be able to access benefits unless they return. He said the LTSS Trust Commission Benefit Eligibility Workgroup is considering policy options to address these issues.

Mr. Dixon said the WAOIC is not an administering agency for the WA Cares Fund by statute. He said the WAOIC acts as a partner as the official regulator for LTCI in Washington and acts as a partner to the WA Cares Fund by providing consumer protection. He said the main involvement of the WAOIC involves those seeking exemptions. He said workers who have their own private LTCI may apply for an exemption, and exemptions are permanent. If an exemption is approved, the worker will not have premiums assessed, and they forfeit their right to the benefit for life. He said workers seeking an exemption must apply themselves through the ESD; employers cannot apply on behalf of an employee. He said policies must meet the definition for LTCI in law for an exemption. He said under Washington law, LTCI is an insurance policy, contract, or rider that provides coverage for at least 12 consecutive months to an insured person if they experience a debilitating prolonged illness or disability. He said employers who apply for an exemption must attest that they have purchased LTCI before Nov. 1, 2021, and must provide notification of exemption to all current and future employers, and the only acceptable notification is a copy of the employee’s approved exemption letter from the ESD.
3. **Discussed Other Matters**

Commissioner Caride asked if there are any other matters or issues to be raised before the Task Force. None were heard.

Having no further business, the Senior Issues (B) Task Force adjourned.

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2022 Proposed Charges

SENIOR ISSUES (B) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Senior Issues (B) Task Force will:

   A. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on Medicare supplement insurance, senior counseling programs, and other insurance issues that affect older Americans. Work with federal agencies to advance appropriate regulatory standards for Medicare supplement and other forms of health insurance applicable to older Americans. Review the Medicare Supplement Insurance Minimum Standards Model Act (#650) and the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651) to determine if amendments are required based on changes to federal law. Work with the federal Centers for Medicare & Medicaid Services (CMS) to revise the annual joint publication, Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.

   B. Monitor the Medicare Advantage and Medicare Part D marketplace. Assist the states, as necessary, with regulatory issues. Maintain a dialogue and coordinate with the CMS on regulatory issues, including solvency oversight of waived plans and agent misconduct. Assist the states and serve as a clearinghouse for information on Medicare Advantage plan activity.

   C. Provide the perspective of state insurance regulators to the U.S. Congress (Congress), as appropriate, and the CMS on insurance issues, including those concerning the effect and result of federal activity on the senior citizen health insurance marketplace and regulatory scheme. Review and monitor state and federal relations with respect to senior health care initiatives and other impacts on the states.

   D. Monitor developments concerning State Health Insurance Assistance Programs (SHIPs), including information on legislation affecting the funding of SHIPs. Assist the states with issues relating to SHIPs and support a strong partnership between SHIPs and the CMS. Provide the perspective of state insurance regulators to federal officials, as appropriate, on issues concerning SHIPs.

   E. Monitor, maintain, and review, in accordance with changes to Model #651, a record of state approvals of all Medicare supplement insurance new or innovative benefits for use by state insurance regulators and others. Review state-approved new or innovative benefits and consider whether to recommend that they be made part of standard benefit plan designs in Model #651.

   F. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on LTCI, including the study and evaluation of evolving LTCI product design, rating, suitability, and other related factors. Review the existing Long-Term Care Insurance Model Act (#640), the Long-Term Care Insurance Model Regulation (#641), the Limited Long-Term Care Insurance Model Act (#642), and the Limited Long-Term Care Insurance Model Regulation (#643) to determine their flexibility to remain compatible with the evolving delivery of long-term care (LTC) services and the evolving LTCI marketplace. Work with federal agencies, as appropriate.

   G. Examine examples of health-related financial exploitation of seniors and work with other NAIC committees, task forces, and working groups on possible solutions.

   H. Examine the effects of structural racism and the COVID-19 pandemic on access, affordability, and outcomes for older insurance consumers.
2. The **Long-Term Care Insurance (LTCI) Model Update (B) Subgroup** will:
   A. Review and update Model #640 and Model #641 to determine their flexibility to remain compatible with the evolving delivery of LTC services and the evolving LTCI marketplace.
   B. Update Model #642 and Model #643 to correlate with Model #640 and Model #641.
   C. Consider recommendations referred from the Long-Term Care Insurance (EX) Task Force and/or its subgroups.

NAIC Support Staff: David Torian

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The Long-Term Care Insurance Model Update (B) Subgroup met Nov. 3, 2021. The following Subgroup members participated: Philip Gennace, Chair (NJ); Sarah Bailey (AK); Emily Smith (CA); Roni Karnis (NH); Jill Kruger (SD); Tomasz Serbinowski and Jaakob Sundberg (UT); Bob Grissom (VA); and MaryKay Schaefers (WA). Also participating were: Willard Smith (AL); Eric Unger (CO); Paul Lombardo (CT); Susan Jennette (DE); Teresa Winer (GA); Jason Asaeda (HI); Cynthia Banks Radke (IA); Kristen Finau (ID); Eric Anderson (IL); Mary Ann Williams (IN); Tate Flott (KS); Ron Kreiter (KY); Jeff Ji (MD); Sherry Ingalls (ME); Renee Campbell (MI); Fred Andersen (MN); Michelle Vickers (MO); Bob Williams (MS); Ashley Perez (MT); Ted Hamby (NC); Yuri Venjohn (ND); Bogdanka Kurahovic (NM); Jack Childress (NV); Martin Wojcik (NY); Tynesia Dorsey (OH); Cuc Nguyen (OK); Colette Hittner (OR); Jim Laverty (PA); Andrew Dvorine (SC); Vickie Trice (TN); Mary Block (VT); Julie Walsh (WI); and Mavis Earnshaw (WY).

1. **Adopted its Oct. 13 Minutes**

The Subgroup met Oct. 13 and heard presentations on the current long-term care insurance (LTCI) marketplace and what products are being seen, filed, and produced in the marketplace.

Ms. Kruger made a motion, seconded by Ms. Karnis, to adopt the Subgroup’s Oct. 13 minutes (Attachment Two-A). The motion passed unanimously.

2. **Discussed Comments Received on Sections 7–12 of Model #641**

Mr. Gennace asked Mr. Serbinowski to explain his comment to Section 7 of the Long-Term Care Insurance Model Regulation (#641). Mr. Serbinowski said additional guidance may be appropriate regarding the application of Section 7 to the long-term care (LTC) benefits provided through a policy or contract without specified premiums. He said when LTC benefits are provided through a universal life insurance policy, there is no required premium; and typically, by the time the policy enters the grace period, the premium required to continue the policy is prohibitive. He said at the time, life insurance and hybrid products were kind of an afterthought, but they are now a major piece of LTCI, and this may be more of an important issue than it was at the time. Bonnie Burns (California Health Advocates—CHA) said she is supportive of the comments. Birny Birnbaum (Center for Economic Justice—CEJ) said this is part of a broader set of issues as to what type of guidance is needed for hybrid products in general, and there is nothing really in the model that addresses that.

Mr. Gennace asked Ms. Burns to explain the NAIC Consumer Representatives’ comment on Section 7A(1). Ms. Burns said insurers should be required to send any changes in their contact information to the third party as well as an insured. She said there have been instances when there was a change in address for an insurer, and consequently, past due premiums and notices of an impaired policyholder were returned to the third party, as they were mailed to an outdated address. She said adding a confirmation notice to be sent to the current third party every two years would be helpful, and insurers should be required to notify policyholders of the right to change a third party for notification of a lapse in premium payment. She said there is no current requirement that an insurer periodically confirm the current contact information for the third party who is to be notified of a pending lapse, and she knows of instances where a third party has moved or died, or the notice went to an outdated or even wrong address. Mr. Birnbaum agreed with Ms. Burns and said there has been a lot of work done on plain language and user-friendly approaches to providing disclosures to consumers, and this example illustrates that there is a better way than simply calling it a notice of lapse or termination. He said the requirement to send first-class mail should be updated to include electronic delivery, particularly for the third party.

Mr. Gennace asked Ms. Burns to explain the NAIC Consumer Representatives’ comment on Sections 8A(2) and 8E. Ms. Burns said policyholders often do not see the language about premium increases buried in the paragraph about guaranteed renewability, and a notice of the right to increase premiums should be in a separate paragraph from guaranteed renewability. She said there also should be a requirement for a clear notice of waiver of premium, and the notice should describe any benefits covered by a premium waiver; a clear notice of the benefits not covered by a premium waiver; and a clear notice of how and when the premium waiver will be credited or refunded. She said policy language generally describes that premium payment will be owed when benefits are no longer payable but may not clearly describe how and when waived premiums will be credited.
or returned. She said generally, a premium waiver is described in one place in a policy, while the return or credit of the waived premium is described separately.

Mr. Birnbaum said there should be a glossary or a table of contents to help consumers navigate the model, and the definition of class, as discussed on the last call, should be included in this part as well. He said the history of the company’s rate increases, itemized and cumulative, should be included.

Mr. Gennace asked if this is something that has changed in the LTCI marketplace that would require or precipitate the need for these changes or something where the regulation could be improved. Ms. Burns said it is two-fold. She said these are experiences people have had with their policies, so improvements are needed; but going forward, it also illustrates how the marketplace needs to work better. Mr. Birnbaum said he agrees with Ms. Burns, the nature of the products have changed significantly, and significant advances have developed since the model was developed.

Ray Nelson (American Association of Health Insurance Plans—AHIP) said he understands Ms. Burns’ concerns about rating practices, and Section 9 added a lot of rating practices notices and disclosures for consumers that are beyond what is just in the policy. He said, as Mr. Birnbaum noted, there are a lot of disclosure requirements already, and most of them are regarding the sales process, so many of the concerns are addressed, and any changes should be looked at in total.

Mr. Gennace asked Ms. Burns to explain the NAIC Consumer Representatives’ comment on Section 9. Ms. Burns said life and annuity contracts that provide for LTC benefits have internal costs associated with the policy and the benefits paid by the policy, and there is no mention in this section of how those costs might change. She said, for instance, the cost of insurance charged in a policy might change, or the cost of LTCI might change, which could affect the earnings in a policy and the daily benefit amount paid for care, and while this is not a change in premium, changes in internal costs affect the benefit a policyholder will receive.

Mr. Serbinowski said it is not clear why in Section 9B(5)(a) the rate increase history is limited to 10 years when most prospective buyers will keep their policies for much longer than that. He said a cumulative rate increase for each policy form might be preferable to a long list of individual increases. He said for Section 9B(5)(d), one should consider if this provision allows some rate increases to not be reflected. He said if every company transferred business after the first increase, no company would be required to disclose more than one increase on a policy form.

Mr. Gennace asked Mr. Serbinowski to discuss his comments on Section 10. Mr. Serbinowski said one should consider adopting retention requirements for actuarial assumptions, similar to those in Section 10C of the Limited Long-Term Care Insurance Regulation (#643). He said it can create problems as to how much assumptions change and produce projections based upon prior filing assumptions. He said this is not a reason alone to open the model, but should the model be open for updating or editing, retention language would be a good addition.

Mr. Birnbaum said he had a comment on a part of Section 10. He said the section requires that insurers develop their best estimate of future claim costs under moderately adverse experience, then pad that estimate by at least 10%. He said the theory seems to be that insurers not only did not know what they were doing in the 1990s, but they have not learned anything given historically low interest rates, extensive lapse, and claims experiences. He said insurers are already using conservative values for estimating future claim costs, so it is unclear why this 10% padding is still needed, and there is no requirement for the insurers to return the excess profits resulting from the 10% padding. He said an insurer can raise rates of claimed costs that are worse than expected, but there is no requirement to lower rates of claim costs that are as good or better than expected before the 10% padding. He said Section 10 also provides for a margin greater than 10% if the company has less than credible experience to support its assumptions. He said eliminating this 10% margin is consistent with AHIP’s justification for limiting rate increase history to 10 years.

Mr. Serbinowski said he disagrees with Mr. Birnbaum. He said perhaps if rate stability does not work, the Subgroup could rethink the model altogether and think of a different way to do LTC, but if there is an expectation that the Subgroup wants an actuary to certify that the rates are expected to be good for the lifetime of the product, then the Subgroup wants to have a margin.

Mr. Nelson asked Mr. Birnbaum if he believes the 10% margin is in addition to the moderately adverse experience because one has to certify that the rates are sufficient under moderately adverse experience, and this moderately adverse experience has to be at least 10% of lifetime claims unless the company can justify reasons to have lower margins; therefore, the 10% margin is
not on top of the moderately adverse experience. Mr. Serbinowski and Mr. Gennace agrees with Mr. Nelson’s reading of that section.

Mr. Gennace asked Ms. Burns to discuss the comments on Section 11C(1). She said insurers have begun to ask questions about family health history as part of the application process, and that could lead to misinformation or mistaken information that could be used later to rescind coverage. She said insurers and others have access to information and data from many sources that could contain erroneous information or information and data that are different from what the policyholder entered on the application. She said, for instance, an applicant might know anecdotally about the cause of death of a family member, but that might be inconsistent with the medical cause of death listed on a death certificate. She said some older family members might conceal a health condition from other family members, leading to an erroneous response on an application.

Mr. Birnbaum agreed with Ms. Burns and said the insurer should be required to provide evidence as to why there may have been a denial of benefits and disclosure any third-party databases used in that decision. Mr. Gennace asked whether there have been cases of this happening where a policy is rescinded or if this is more of a general concern. Ms. Burns said she had been involved with cases where answers on the application were challenged, but the use of third-party databases is a new area, and she could see this happening more frequently.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) said there are cultural issues involved as well, especially with older relatives. She said in quite a few cultures, it is difficult to get information from relatives, especially older relatives, about how a family member may have died. She said she has experienced this personally, and in some cultures, how a death or serious illness has occurred or what occurred is just not spoken about. She said this could be a serious impact on certain groups of people.

Mr. Birnbaum said while the Fair Credit Reporting Act (FCRA) requires disclosures of sources, it does not cover third-party databases like social media; therefore, there is no opportunity for the consumer to address erroneous information found through these third-party databases.

Ms. Arp asked if big data should be part of this discussion. Mr. Birnbaum said in the last decade, insurers have been using third-party databases to not only obtain or verify information given by the consumer but to also speed up the application process. He said he raised this issue in this section, as it could hurt the consumer having a denial based upon information that is not true coming from these third-parry data sources. Ms. Arp asked if language in this section needs to be changed or if it is a matter of keeping an eye on denials and cancellations of coverage based upon the information insurers receive that was not available 20 or 30 years ago. Mr. Birnbaum said two things need to be addressed. He said the first is what it means to make an untrue statement that can result in a claim denial, and giving the consumer some examples of what an untrue statement would be that could cause a denial would be useful. He said the second is disclosure to a consumer that third-party sources are going to be used and providing the consumer with what those sources are in the event of a denial so that the consumer is on notice and can correct incorrect information found through a third-party data source.

Mr. Gennace asked Ms. Burns to discuss the comments on Section 12. Ms. Burns said the dollar amount of $25 should probably be increased, as a home health care benefit that provides $25 a day would be illusory based on costs today. She said in addition, the drafting note seems to conflict with the language in Section 12B. Mr. Nelson said industry has typically been against having a minimum dollar amount because there are occasions where a policyholder buys a second or third policy to add to the previous policy, and they are sometimes buying $25 worth to just add on. He said that would be the concern of putting in higher minimums, but the $25 figure is small. Ms. Yee agreed and said the language in Section 12B is outdated, as making a distinction between home health and nursing home care and the language in the section stating “at least one-half of one year’s coverage” is in conflict.

Mr. Gennace asked if Mr. Serbinowski wished to further clarify his comments from the last meeting on Section 6D. Mr. Sundberg said Mr. Serbinowski had to get off the call, but he said Mr. Serbinowski believes there is a need to specify what is meant by “continue” in Section 6D. He said the plain reading of the section suggests that there ought to be a conversion policy on the group policies, and most policies do not include one. He said the concern is not that there is no conversion policy, but whenever these policies are reviewed and a group policy is seen without a conversion policy, then it is objected to even though the group policy continues, so Mr. Serbinowski believes there needs to be some clarity about what it means to continue the policy.

Ms. Burns asked if there were not a conversion and that group policy continues, whether the certificate holder who is no longer part of the group would be in danger of having their certificate terminated if the group policy is terminated. Mr. Sundberg said
he has not dealt with enough group LTC to know, but he would be interested in a response from industry on this. Ms. Burns said it is her understanding that a conversion is required so that the person then has what constitutes an individual policy separate from whatever action the group policy takes later. Mr. Hamby agreed with Ms. Burns and said they would hold that continuation should be allowed for the individual person. Ms. Bailey said one of the things she has been seeing across all lines of business is portability, and it may be messy and not a good fit for LTC. She said the insurer creates a trust, and if the group policyholder terminates the plan, then they move the certificate holder to the portability trust and the portability certificate is issued to the consumer so that they can continue the same benefits that they previously had. Mr. Hamby said he has seen this arrangement as well.

Mr. Gennace said the next meeting will be Dec. 1, and the Subgroup will cover comments received on Section 13–19. He asked that comments be sent to David Torian (NAIC) by close of business on Nov. 23.

Having no further business, the Long-Term Care Insurance Model Update (B) Subgroup adjourned.
The Long-Term Care Insurance Model Update (B) Subgroup met Oct. 13, 2021. The following Subgroup members participated: Philip Gennace, Chair (NJ); Mayumi Gabor (AK); Tyler McKinney (CA); Roni Karnis (NH); Jill Kruger (SD); Tomasz Serbinowski (UT); and Elsie Andy (VA). Also participating were: William Rodgers (AL); Carroll Astin (AR); Erin Klug (AZ); Emily Smith (CA); Shirley Taylor (CO); Jared Kosky (CT); Susan Jennette (DE); Benjamin Ben (FL); Teresa Winzer (GA); Jason Asaeda (HI); Andria Seip (IA); Kathy McGill (ID); Eric Anderson (IL); Scott Shover (IN); Craig VanAalst (KS); Ron Kreiter (KY); Fern Thomas (MD); Sherry Ingalls (ME); Karen Dennis (MI); Fred Andersen (MN); Amy Hoyt (MO); Bob Williams (MS); Ashley Perez (MT); Ted Hamby (NC); Yuri Venjohn (ND); Bogdanka Kurahovic (NM); Sean Becker (NY); Tynesia Dorsey (OH); Cuc Nguyen (OK); Jim Laverty (PA); Andrew Dvorine (SC); Vickie Trice (TN); Barbara Snyder (TX); Mary Block (VT); Julie Walsh (WI); Dena Wildman (WV); and Mavis Earnshaw (WY).

1. **Adopted its July 15 Minutes**

The Subgroup met July 15 and heard presentations on the current long-term care insurance (LTCI) marketplace and what products are being seen, filed, and produced in the marketplace.

Ms. Kruger made a motion, seconded by Ms. Karnis, to adopt the Subgroup’s July 15 minutes (see NAIC Proceedings – Summer 2021, Senior Issues (B) Task Force, Attachment Two). The motion passed unanimously.

2. **Discussed Comments Received on Sections 1–6 of Model #641**

Mr. Gennace asked Jan Graeber (American Council of Life Insurers—ACLI) to discuss the ACLI’s comments on Sections 1–6 of the Long-Term Care Insurance Model Regulation (#641). Ms. Graeber said the ACLI believes the language currently contained in Sections 1–6 remains flexible and compatible with the current LTCI marketplace, and new language is unnecessary. She said as the Subgroup continues its review of the remaining sections of Model #641, the ACLI recognizes that changes needed to those sections could result in a need to reconsider their position regarding the opening of Sections 1–6.

Birny Birnbaum (Center for Economic Justice—CEJ) said Ms. Graeber should show evidence that Model #641 works and Sections 1–6 remain flexible and compatible with the current LTCI marketplace. Ms. Graeber said she has not seen anything in the marketplace being stifled by Sections 1–6. Mr. Serbinowski said it is difficult to prove a negative, and Sections 1–6 are mostly definitions.

Mr. Gennace asked if someone from California cares to explain their comment to Section 3. Ms. Smith said this section singles out one type of other product that may come within the scope of Model #641—disability income insurance with a benefit triggered by activities of daily living (ADLs)—but it does not address other types of products in the marketplace today that have triggers based on ADLs or confinement in a facility. She said inclusion or exclusion of these other products within the scope of Model #641 should be considered. Mr. Serbinowski said it would be helpful if the Subgroup could look at or see examples of these products that skate on the edge of being LTCI. Ms. Smith said she is unable to give specific examples at this time, but she could provide generic examples.

Mr. Gennace asked Bonnie Burns (California Health Advocates—CHA) to explain the NAIC Consumer Representatives’ comment on Section 3. Ms. Burns said this section singles out one type of other product that may come within the scope of Model #641—disability income insurance with a benefit triggered by activities of daily living (ADLs)—but it does not address other types of products in the marketplace today that have triggers based on ADLs or confinement in a facility. She said inclusion or exclusion of these other products within the scope of Model #641 should be considered. Mr. Serbinowski said it would be helpful if the Subgroup could look at or see examples of these products that skate on the edge of being LTCI. Ms. Smith said she is unable to give specific examples at this time, but she could provide generic examples.

Mr. Gennace asked Bonnie Burns (California Health Advocates—CHA) to explain the NAIC Consumer Representatives’ comment on Section 4. Ms. Burns said it is like California’s comment in that this section should be reviewed to determine if any part of it should apply to newer products that trigger benefits on ADLs and cognitive impairment, not just DI. Ms. Graeber said it would be helpful to see what these products are so products that are not really LTCI are not pulled in. Mr. Gennace said should Model #641 be opened for editing, the Subgroup can take a deeper look into these products.

Mr. Gennace asked Ms. Burns if the NAIC Consumer Representatives’ comment on Section 4 is like the previous section. Ms. Burns said it is similar, and she believes this section should be reviewed to determine if it covers newer products that provide benefits for long-term care (LTC) expenses.
Mr. Gennace asked Mr. Serbinowski to discuss his comment to Section 4B(1). Mr. Serbinowski said of the definition of the “exceptional increase,” it incorporates requirements that go beyond defining the term, and Utah would move the requirements outside of the section that defines the term. He said he merely is making an observation and has no real concern.

Mr. Gennace asked Mr. Serbinowski to discuss his comment to Section 4F. Mr. Serbinowski asked if there is a reason to require membership in a specific organization rather than maybe an actuary that is subject to the American Academy of Actuaries’ (Academy’s) “Qualification Standards.” He said the Academy does not recognize a status of “in good standing.” Ms. Snyder said a qualified actuary could be defined as an actuary and is a member of the Academy and qualified under its qualification standards. She said the Academy has a particular document that defines the standards to be met. Mr. Serbinowski said it might be more useful to have alternative language, and that could be addressed should Model #641 be opened.

Mr. Gennace asked Ms. Burns to discuss the comment received on Section 5. Ms. Burns said the section should be reviewed to consider definitions for reduced benefit options (RBOs). She said the phrase is used often in NAIC discussions, but there is no definition, and a definition should be included if it is being used in Model #641 and elsewhere. Mr. Serbinowski said RBOs is not the exact term used. He said the language requires that a policy offers the option to reduce benefits. He said RBOs may be used by the NAIC, but it is not in Model #641. Ms. Burns said if the term is being used, it should have a definition, and she suggested the definition used by J.P. Wieske (Horizon Government Affairs). Mr. Serbinowski said it is hard to determine whether a definition is needed just based on Sections 1–6 and how it relates to any parts of Model #641 with respect to the options to reduce benefits. He said while the term RBOs is not used in Model #641, should it be opened, a determination of whether a definition is needed can be decided.

Mr. Gennace asked Ms. Burns to discuss the comment on Section 5E. Ms. Burns said this section should be reviewed to consider changing the wording “safety awareness” to a more specific definition. She said it seems to be a very outdated term, and there must be a better way to describe it, so the definition should be revised. Ms. Karnis asked how changing the term safety awareness or using a different term would foster increased flexibility, as the goal of the Subgroup is to determine whether the language in Model #641 no longer remains flexible and compatible with the current LTCI marketplace. Ms. Burns said she did not know what “safety awareness” means. She said that terminology is more like a risk to oneself or others, but it does not make sense. Mr. Gennace said it seems like the issue is a matter of perhaps tightening up or increasing the clarity of the language, but he asked whether it is also a matter of just modernizing or if there is a need to address that as an improvement. Ms. Andy asked if this term could be a federally defined term, and if so, if it could even be adjusted. Ms. Burns said she is pretty sure it is not a federally defined term. Mr. Gennace asked Mr. Torian if he could find some history on the term “safety awareness.”

Mr. Gennace asked the Subgroup to look at Section 6, and he asked the NAIC Consumer Representatives to discuss their comment on Section 6A(4). Ms. Burns said the section refers to a “class” regarding rate increases, and there should be a definition of a class for the purpose of imposing a premium increase. Mr. Serbinowski said the Subgroup is not opposed to examining this, but defining class could be a very tricky issue. Mr. Gennace asked whether this has been an issue, there have been problems, or if it is inadequate in some way. He said he could see why it may need to be defined, but he asked if there have been issues or concerns from it not being defined. Mr. Birnbaum said this issue has been a source of litigation.

Ms. Burns said her comment may not have been totally clear, and she has concerns about guaranteed renewable even though the section in question states the use of a class basis. She said on the front page of all policies is a visible guaranteed renewable section, but the right to raise premiums is buried in the section. She said policyholders do not see that and do not know it is there from her experience in counseling consumers. She said there should be two separate paragraphs that pertain to the right to raise premiums and the guaranteed renewability. Ms. Graeber said the standard definition of guaranteed renewable, and it starts to get problematic once defining class. She said the class concept would be covered under a state’s anti-discrimination statutes because any kind of class that is developed must have an actuarial support for it. Ms. Burns said there are three entirely different issues at play. She said there is the language on guaranteed renewability; the language on the right to raise premiums, which is not clear to policyholders; and the language on what constitutes a class for the purposes of premium increases.

Mr. Birnbaum said an increase in premiums is based on class, and there should be some definition of class but also some requirement that the policy states what one’s class is. Mr. Serbinowski asked, supposing that there is one class and then there is an increase for some people by 0.5% and some others by 200%, if the definition would prevent that. He also asked, supposing that the class are policyholders who are males, age 57, lifetime benefits, 3% inflation, 90-day elimination period, preferred underwriting, and there are 17 persons at that moment in that class, if that is what is being sought. Mr. Birnbaum said what the insurance company has used to determine the rate is the class the consumer is in. He said the insurance company must identify
some rating class to issue a policy, so it should be made clear to the consumer what their class is. Mr. Serbinowski said the purpose of the term is to offer protection so a class cannot be people named Tomasz who speak Polish, because the narrower the class, the less protection exists.

Mr. Gennace asked Ms. Burns to discuss her comment on Section 6A(4) and level premium. Ms. Burns said level premium and the other terms discussed are confusing for consumers. She said consumers do not understand the terms and many times are unaware of what these terms mean for them. She said the term level premium needs more definition in the policy. She said all state insurance regulators encourage consumers to read their policies, but the main reason people do not read their policies is they do not understand what these terms mean.

Mr. Gennace summarized Mr. Serbinowski’s comment on Section 6B(2). Mr. Gennace said the section allows exclusions or limitations based on “mental or nervous disorders,” and it specifically disallows exclusion based on Alzheimer's disease. He said Mr. Serbinowski asked if there is a better definition since if someone Googles “nervous disorder,” the search comes up with “nervous system disorders” that include things like Parkinson's or stroke. Mr. Gennace said the term may be problematic and not exactly clear, and should Model #641 be opened, the Subgroup may want to redefine this section. Ms. Burns said the section does not include other dementias, and this definition needs work.

Mr. Gennace asked Ms. Burns to discuss the comment on Section 6B(4)(c). Ms. Burns said the section allows for an exclusion for conditions related to military service and discriminates against members of the military who may have been exposed to conditions that cause a disabling condition later in life. She said it is long past time to remove this discriminatory exclusion.

Mr. Gennace asked Ms. Burns to discuss the comment on Section 6B(8). Ms. Burns said the drafting note contains language that is specific and should be added to Section 6B(8). She said the specific language in the drafting note is “…if the claim would be approved but for the licensing issue, the claim must be approved.” Mr. Gennace said Mr. Serbinowski had a comment on Section 6B(8)(a) that the language “the state of policy issued” in the third line should be “the state of policy issue.” Mr. Gennace asked Ms. Burns to discuss the comment on Section 6B(9). Ms. Burns said it was merely to point out that if there are changes made to the Long-Term Care Insurance Model Act (#640) regarding extraterritoriality, then changes must be made to the Model #641.

Mr. Sundberg spoke on behalf of Mr. Serbinowski’s comment on Section 6D. He said the Subgroup should probably look at this section, as in practice, most group LTC policies do not have any formal “conversion” provision. He said the coverage under the same certificate continues when the person leaves the group or the group terminates as if the certificate was an individual policy, and the section should probably reflect what is happening in practice.

Ms. Graeber asked Mr. Sundberg if he means the conversion provision does not allow for a company to convert to an individual policy. Mr. Sundberg said if a person purchased a policy though their company and then retires, that person maintains the same policy. He said there is no real conversion from group to individual. He said they just maintain coverage with that same group. Ms. Graeber said some companies do that, and there may be instances where a conversion to an individual policy happens, but she asked if the current language would allow for both. Ray Nelson (TriPlus Services Inc.) said the language allows for either a conversion or a continuation. Ms. Graeber said she is not sure what sort of change is being envisioned for the language. She said there is not a lot of true group policies in the marketplace, but conversions exist. Mr. Sundberg said if there are conversions happening, then leaving the language as it is would not be an issue, but he said Mr. Serbinowski can clarify his comments at the next meeting.

Ms. Karnis said with an eye toward thinking about whether more flexibility is needed in Model #641 and whether adding something about portability in this section would be helpful. She said she does not know if that is practical, but perhaps getting some input from industry might be helpful. She said it may not be necessary if the majority of consumers remain on their former employers group policy, but it may be something to think about in terms of flexibility. Mr. Gennace said it could be helpful if Ms. Graeber or someone else from industry cares to provide some insight at the next meeting.

Having no further business, the Long-Term Care Insurance Model Update (B) Subgroup adjourned.
PROPERTY AND CASUALTY INSURANCE (C) COMMITTEE

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The Property and Casualty Insurance (C) Committee met in San Diego, CA, Dec. 15, 2021. The following Committee members participated: Vicki Schmidt, Chair (KS); Mike Chaney, Vice Chair (MS); Jim L. Ridling (AL); Ricardo Lara (CA); Andrew N. Mais and George Bradner (CT); Colin M. Hayashida (HI); Amy L. Beard (IN); James J. Donelon and Tom Travis (LA); Kathleen A. Birrane represented by Greg Derwart (MD); Grace Arnold and Julia Dreier (MN); Larry D. Deiter (SD); Tregenza A. Roach (VI); Michael S. Pieciak represented by Kevin Gaffney (VT); Mike Kreidler (WA); and Allan L. McVey (WV). Also participating were: Anoush Brangaccio (FL); and Don Beatty (VA).

1. **Adopted its Nov. 10 Minutes**

   Commissioner Mais made a motion, seconded by Commissioner McVey, to adopt the Committee’s Nov. 10 minutes (Attachment One). The motion passed unanimously.

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

   a. **Casualty Actuarial and Statistical (C) Task Force**

   Ms. Dreier reported that the Casualty Actuarial and Statistical (C) Task Force assisted the Blanks (E) Working Group in evaluating a proposal (2021-11BWG) submitted by the Center for Economic Justice (CEJ). The proposal was to add data reported on policy writings for private passenger auto (PPA) and homeowners insurance to the Property/Casualty (P/C) Annual and Quarterly Statements. Ms. Dreier said the Task Force never took a vote on whether to support the Blanks proposal; however, the Task Force sent state-by-state feedback on the proposal and sent the Statistical Data (C) Working Group’s research on how much earlier statistical agents could provide premium and exposure data similar to the Blanks proposal. The Blanks (E) Working Group ultimately rejected this Blanks proposal.

   Ms. Dreier said the Task Force was charged to evaluate whether P/C Appointed Actuaries were maintaining competence in years after passing exams. The Casualty Actuarial Society (CAS) conducted a study and found no issues with continuing education (CE) of Appointed Actuaries, so the Task Force deemed that charge completed with no further action regarding maintaining competence. With the charge complete, the Task Force will remove some temporary reporting requirements needed to conduct the CE study, which will be for 2023.

   Ms. Dreier said the Task Force also drafted a response letter to the American Academy of Actuaries’ (Academy’s) second exposure draft for U.S. qualification standards. The Academy has adopted these standards, and the Task Force is going to follow up with the Academy to discuss why some changes were not made to better align with state insurance regulators’ requirements for the P/C Appointed Actuaries. A proposed response in answer to the referral Project #2019-49: Retroactive Reinsurance Exception is now exposed for a 45-day public comment period ending Jan. 20, 2022.

   Ms. Dreier also said a regulatory review of random forest models has been exposed for a 60-day public comment period ending Feb. 4, 2022. The proposal takes the appendix of generalized linear model (GLM) information items from the adopted Regulatory Review of Predictive Models white paper and modifies it to apply to the review of random forest models. A proposed glossary of random forest model terminology was also exposed.

   b. **Surplus Lines (C) Task Force**

   Mr. Travis said the Surplus Lines (C) Task Force has been working on modernizing the Nonadmitted Insurance Model Act (#870). A drafting group was formed and has met four times since the Summer National Meeting, and it is hoping to have a draft for the Task Force in early 2022. The Task Force has also adopted revisions to the Trust Agreement for Alien Excess or Surplus Lines Insurers that update the trust language and allow for a more streamlined approach after an insurer has left the Quarterly Listing of Alien Insurers. The Task Force has also adopted changes to the Quarterly Listing of Alien Insurers that will allow state insurance regulators access to alien insurer contact information. In 2022, the Task Force is planning to make improvements and updates to the International Insurers Department (IID) Plan of Operation.
c. Title Insurance (C) Task Force

Ms. Brangaccio said the Title Insurance (C) Task Force met Oct. 19 to: 1) discuss proposed charges; 2) hear a presentation from Demotech on observed and reported impacts of defalcations and escrow theft on the title industry; and 3) hear a presentation from the American Land Title Association (ALTA) on its new forms of Commitment, Owner’s Policy, and Loan Policy, effective July 1. Ms. Brangaccio said the Task Force also met Nov. 16 to: 1) hear a presentation from AM Best on how the robust homeowners housing market has driven historic title industry performance and a presentation from ALTA on key changes to the homeowners policy of title insurance and ALTA endorsements; and 2) adopt its 2022 charges. She said revisions reflect removing outdated or completed charges and minor editorial changes for clarification of intent. She said late submissions by the CEJ were deferred and subsequently submitted to the Committee for consideration.

d. Workers’ Compensation (C) Task Force

Commissioner Schmidt said the Workers’ Compensation (C) Task Force has not met since the Summer National Meeting.

e. Cannabis Insurance (C) Working Group

Commissioner Lara said the Cannabis Insurance (C) Working Group met Oct. 21 to discuss the draft outline for an appendix to the Understanding the Market for Cannabis Insurance white paper. The appendix will provide an update on the regulatory issues related to insurance in the cannabis industry that have occurred since the white paper’s adoption in July 2019. The appendix is anticipated to be adopted by the 2022 Summer National Meeting. The Working Group also discussed its 2022 charges, including a recommendation to collaborate with the Producer Licensing (D) Task Force to study whether cannabis-related convictions in states where cannabis is legalized for medical and/or recreational use are preventing individuals from being licensed as an agent or broker.

Commissioner Lara said the Working Group met Dec. 1 to hear a presentation from the University of Colorado on emerging scientific issues in the cannabis space. The Working Group learned the landscape of legality and received information that shows commercial cannabis products are constantly changing, with minor tetrahydrocannabinol (THC)-like cannabinoids (such as Delta-8 and Delta-10) able to be synthesized from legal hemp, thereby creating new legal, science, and health-related questions. The Working Group heard a presentation from the Cannabis Regulators Association (CANNRA) on cannabis policy and regulation trends. The Working Group learned there is now a broader focus on how policy is made, with an increased focus and prioritization of social equity, restorative justice, and public health and safety issues. The Working Group discussed the potential for information from the Task Force and its related NAIC databases that can assist the Working Group in assessing whether equity concerns exist. Commissioner Lara said the drafting group met several times to develop the outline and begin drafting an appendix for the Understanding the Market for Cannabis Insurance white paper.

f. Catastrophe Insurance (C) Working Group

Commissioner Chaney said the Catastrophe Insurance (C) Working Group met jointly with the NAIC/Federal Emergency Management Agency (FEMA) (C) Advisory Group Dec. 12 to hear from David Maurstad (FEMA) on the implementation of the new National Flood Insurance Program (NFIP) rating methodology known as Risk Rating 2.0, which is meant to more accurately match individual rates with risk. Commissioner Chaney said state insurance regulators appreciate their partnership with FEMA, and FEMA staff have been available with training and other assistance in helping consumers understand the rollout of these new rates. The Working Group and Advisory Group also heard from Edie Lohmann (FEMA), who reviewed the FEMA regions, regional flood insurance specialists, and how FEMA can engage with state insurance regulators on outreach, education, and training; technical assistance; NFIP claims, underwriting, and coverage; pre- and post-disaster support; and public awareness events and activities.

Commissioner Chaney said the Working Group and Advisory Group heard an update regarding the NAIC Catastrophe Resource Center. This website has information about NAIC and state resources, and it has recently been updated to include FEMA regional information and FEMA contact information. Louisiana provided a report on Hurricane Ida, including the department’s response to the hurricane in assisting consumers and collecting claims data. Commissioner Chaney said an update was provided on a state survey that will help the Working Group in updating the Catastrophe Modeling Handbook. He said any states not yet completing the survey should reach out to the NAIC. The drafting group plans to meet in January to further discuss the survey and the drafting process. Commissioner Chaney said upcoming events involving FEMA include an NAIC/FEMA workshop for FEMA Region 6 tentatively planned for early 2022; an earthquake event to be hosted by the Missouri Department of Insurance (DOI) in May 2022; and the Cascadia Rising 2022 National Level Exercise.
g. Pet Insurance (C) Working Group

Mr. Beatty said the Pet Insurance (C) Working Group met three times to finalize edits to the Pet Insurance Model Act, with the Working Group adopting the model on Oct. 21. Following the adoption of the model, the Working Group met Dec. 1 to discuss the issue of the collection of pet insurance data, which arose as a topic of discussion during the development of the model. Because the only 2021 charge for the Working Group was the development of the model, the Working Group voted to ask the Committee to make the proper referrals to the Blanks (E) Working Group for the collection of data on the financial annual statement, as well as forwarding drafted referrals to the Market Analysis Procedures (D) Working Group to collect Market Conduct Annual Statement (MCAS) data and the Market Information Systems Research and Development (D) Working Group to collect complaint data.

h. Terrorism Insurance Implementation (C) Working Group

Commissioner Schmidt said the Terrorism Insurance Implementation (C) Working Group has not met since the Summer National Meeting.

i. Transparency and Readability of Consumer Information (C) Working Group

Mr. Bradner said the Transparency and Readability of Consumer Information (C) Working Group met Nov. 17 and has been working on best practices documents regarding disclosures for premium increases. These best practices documents include a disclosure document to be sent from insurers to consumers regarding premium increases (both capped and uncapped) and reasons for the premium increase; a rate/rule filing checklist that can be used by DOIs to ensure appropriate information is provided to the DOI regarding rate filings; and consumer education regarding ratemaking, rating factors, and premium discounts for both homeowners and auto insurance.

Mr. Bradner said the disclosure document and the rate/rule filing checklist will be exposed for 30 days before the Working Group votes on adoption. He also said the Working Group has a proposed charge to study and evaluate ways to engage DOI communication to more diverse populations, such as rural communities. He said the Working Group plans to begin discussing this topic in January.

Commissioner Chaney made a motion, seconded by Commissioner Mais, to adopt the following task force and working group reports: Casualty Actuarial and Statistical (C) Task Force; Surplus Lines (C) Task Force; Title Insurance (C) Task Force; Workers’ Compensation (C) Task Force; Cannabis Insurance (C) Working Group (Attachment Two); Catastrophe Insurance (C) Working Group (Attachment Three); Pet Insurance (C) Working Group (Attachment Four); Terrorism Insurance Implementation (C) Working Group; and Transparency and Readability of Consumer Information (C) Working Group (Attachment Five). The motion passed unanimously.

3. Heard Presentations Related to Auto Insurance Premium Refunds Resulting from the Pandemic

Commissioner Schmidt said the Consumer Federation of America (CFA) requested to speak about auto insurance premium refunds resulting from reduced driving due to the pandemic.

Doug Heller (CFA) said the CFA believes there was a duty to get more refunds to drivers over the past year and a half, and it is still not too late to do so. He said commissioners went to great lengths when the pandemic started to make sure the insurance market could function effectively, including granting premium payment extensions and cancellation moratoria. He said insurers were granted new means by which they could comply with a variety of statutory and regulatory requirements, and DOIs figured out how to work from home.

Mr. Heller said the CFA urged insurance departments to act to create a mandate and mechanism for insurers to return the excess premium they would collect as a result of the pandemic. He said insurers finally did give back premium, but it was not enough. He said insurance departments need to do more to prevent the excessive rates that data now documents. He said commissioners should revisit the question of pandemic premium refunds for drivers in their states and develop a plan for a systematic response should a similar situation happen in the future.

Mr. Heller said premiums were about the same in 2020 as they were in 2019 even with the premium refunds. He noted that incurred losses for 2020 fell dramatically. He said insurers claimed that severity has increased, but the volume of claims has fallen dramatically. The drop in auto claims led to a historically low industry-wide loss ratio for 2020. The 2020 loss ratio was
more than 10 points lower than the average over the prior four years. Mr. Heller said rate decreases did not come close to offsetting the excessive prices consumers were being charged.

Mr. Heller noted that insurers have been telling investors their profits increased in 2020. He said AM Best identified that $12.9 billion was given back to policyholders. State Farm paid more than $44 million in bonuses to its top executives in 2020, dramatically higher than prior years, and spent $400 million to buy a nonstandard insurer. Geico increased its auto insurance underwriting income by 128% over 2019. Progressive paid investors $2.6 billion in January 2021 through its largest ever annual dividend to shareholders. Allstate paid its largest dividend ever and spent $4 billion to acquire another insurer.

Mr. Heller said insurers are currently requesting rate hikes by saying claim histories from the pandemic should not apply. He said his research shows there is $29 billion that should still be returned from insurers' windfall profits. He said DOIs should consider conducting their own investigation and data call.

Rich Gibson (Academy) said the Academy will not weigh in on whether additional refunds are appropriate. He said rates are set on a prospective basis, estimating future costs. He said the pandemic added to the usual uncertainty. He noted that when insurers underestimate the needed rate, there is no recourse to recoup the shortfalls. Actuaries have practice and procedures for making these future cost estimates that are embodied in Actuarial Standards of Practice (ASOPs). Mr. Gibson noted that the Academy has published a paper titled Considerations for Handling Auto Insurance Data in the Era of COVID-19.

Mr. Gibson said the loss and loss adjustment expense ratio for 2020 was the best year over the last 10 years. He said generally, the auto insurance industry has not made an underwriting profit for auto liability for the nine years before 2020. These figures do not consider the investment income earned by the industry.

Mr. Gibson also noted that industry aggregate data and averages may not be the best way to judge the appropriateness of refunds. State insurance regulators and others should look at company specific and state specific data. Mr. Gibson said insurers should continue to monitor their individual results and adjust rates as appropriate.

David F. Snyder (American Property Casualty Insurance Association—APCIA) said the APCIA is releasing a comprehensive report titled U.S. Auto Insurance Market Still Struggling. He said insurers and state insurance regulators quickly moved in-person operations to virtual to better serve consumers. He said state insurance regulators offered flexibility to insurers who in turn offered flexibility to customers in areas such as grace periods for late payments and waiving delivery exclusions.

Mr. Snyder said insurers provided more than $14 billion in premium relief and credits, reflecting the sudden and dramatic downturn in driving activity and losses. As the pandemic continued, the APCIA warned against mandating more premiums reductions as traffic speeds increased, as did serious accidents and eventually miles driven. Mr. Snyder said fatalities in 2020 increased by 7.2% over 2019, and 2020 fatalities were the highest in the last 10 years. He also said the first half of 2021 has seen an 18.4% increase in fatalities over 2020. He said rising insured losses are being driven by the intersection of more dangerous driving behavior, return of mileage, and rapid inflation affecting the cost of products and services covered by auto insurance. He said rising claims costs reflect the cost to repair and replace motor vehicles being seen in increased inflation.

Mr. Snyder said loss ratios dropped dramatically in 2020 but recovered in the last half of 2020, and they are rising throughout 2021, thus offsetting the short-term gains from 2020. He said state insurance regulators should maintain the long-term stability and solvency of the insurance markets. He asked whether premiums should be lowered in the short term and raised when losses rise, moving toward a rating system where consumers would get refunds or surcharges every month. He said such a system does not provide stability and solvency. He urged cooperation between state insurance regulators and industry to ramp up highway safety measures and a recognition of the dramatic inflation in the cost of products and services covered by auto insurance. He said state insurance regulators should avoid the temptation to grant short-term relief if the reality of that has been overtaken by losses that have occurred since. He said a short-term approach would lead to instability and potential solvency issues.

Commissioner Lara said the APCIA indicated that insurers should not be mandated to provide premium reductions based on short-term fluctuations in losses. He said 2020 was not just a fluctuation, as it resulted in consumers overpaying premiums by billions of dollars. Mr. Snyder said losses went down but then climbed back up, and the industry is advocating for a long-term strategy. He said insurers should not bill consumers midterm when losses increase. He said the long-term trends differ from short-term trends. Commissioner Lara said 2020 should not be ignored. He said the industry does not say wildfire losses over the past few years in California are just an anomaly. He said the industry raises rates when they see losses increase, but they do not give back premium when losses decrease dramatically. Mr. Snyder said if there is a demand of refunds based on short-
term development, then there should be midterm increases when inflation takes over, but the industry believes in a long-term approach.

Commissioner Kreidler said insurers are keeping short-term gains to keep insurers above water. He said Washington received testimony from small businesses indicating their insurance was not covering business interruption, and those businesses could use help. He said state insurance regulators should be asking how much the auto insurance industry actually refunded. Mr. Snyder said insurance companies operate in the long term, factoring in losses and working with state insurance regulators to ensure solvency is not at risk.

Tony Cotto (National Association of Mutual Insurance Companies—NAMIC) said rates are prospective, complex, and take time to develop. He said rates are designed to adjust to behavioral and experience patterns over years. He said in early 2020, vehicle miles traveled decreased dramatically at the onset of temporary closures due to the pandemic, but by summer 2020, miles driven were back within 10% of 2019. He said in acknowledgement of the overall reduction and driving during spring 2020, insurers returned more than $14 billion in premium to consumers.

Mr. Cotto said anyone advocating for additional rebates for 2020 should also advocate for additional premium charges to consumers for the years from 2010 to 2019. He said the important discussion should be on the fact that most costs involved in providing auto insurance are driven by external forces outside the control of auto insurance. He said highways are seeing more distracted and impaired driving; vehicles are becoming much more expensive to repair, as auto parts and labor costs are skyrocketing; and insurers are seeing more expensive medical care and more extreme weather events.

Mr. Cotto said NAMIC supports consumer choice, data privacy, and sound underwriting. He said the industry wants to join state insurance regulators to find effective ways to combat riskier roads and higher prices.

Commissioner Lara asked if 2020 was an extraordinarily profitable year for insurance companies. Mr. Cotto said the cost of providing auto coverage is increasing. He said $14 billion in premium refunds was returned to consumers in 2020, but death rates rose even though miles driven fell. Commissioner Lara said it was a record profitable year in 2020 for auto insurers.

Commissioner Kreidler said the industry is saying there were unanticipated gains but then also unanticipated losses, so the industry wants to keep the money. He said the industry is fighting state insurance regulators in providing data about these issues. He said if insurers make unanticipated gains, they have a responsibility to their policyholders. He asked why NAMIC is resisting providing data to state insurance regulators. Mr. Cotto said NAMIC would be happy to speak with individual state departments.

Birny Birnbaum (CEJ) said the pandemic led to such reduced driving that claim payments declined by 20% from expected levels, and rates became excessive by over $40 billion in 2020. He said traditional actuarial ratemaking methods and traditional regulatory rate filing approaches were not suited to the problem. He said rates in effect at the beginning of March 2020 anticipated $175 billion of claims out of the expected $260 billion in premium. The reported claims in 2020 were about $35 billion, 20% less than expected. Mr. Birnbaum said after insurer relief, there is about a $30 billion windfall profit for the industry, which is about $125 per insured vehicle or 10% of total premium.

Mr. Birnbaum said any increase in claims severity in 2020 was dwarfed by the reduction in claim frequency. He said loss ratios have returned to normal in 2021, but insurers are not losing money. He said Progressive reported $3 billion in profits year-to-date (YTD). He also said insurers are seeking rate increases. The 20% reduction in claims was not offset by losses in 2021. Mr. Birnbaum said windfall profits were given to investors or management. He noted that insurer rate filings are claiming 2020 was an anomaly and should be ignored. He noted that the 2020 loss ratio was over 10 points lower than historical results. He said state insurance regulators should learn that more timely data collection is needed to better monitor the market and move to a monthly premium relief program during an emergency.

Erica Eversman (Automotive Education & Policy Institute—AEPI) said if there is no state insurance regulator requirement, insurers do as they see fit. She said the National Highway Traffic Safety Administration (NHTSA) does not collect the appropriate universe of data to determine what causes vehicle fatalities. She said obtaining prior claims information from auto insurers about whether a vehicle had been previously damaged and repaired would be valuable information. She said the industry should not use fatalities as justification for not refunding premiums to consumers. She said part of the reason the number of vehicle fatalities is growing is because insurers have increasing control over vehicle repairs in terms of dictating repair procedures. She said insurers should voluntarily provide the NHTSA with auto claims data.
4. **Adopted its 2022 Proposed Charges**

Jennifer Garder (NAIC) said the Committee’s 2022 proposed charges were posted and distributed on Nov. 19. She said the Committee received comments from the CEJ on Dec. 9. Leadership of the Casualty Actuarial and Statistical (C) Task Force and the Title Insurance (C) Task Force discussed those comments, and they are recommending two additional charges. For the Statistical Data (C) Working Group, a proposed third charge would read, “[i]implement the expedited reporting and publication of average auto and average homeowners premium portions of the annual Auto Insurance Database and Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance.”

For the Title Insurance (C) Task Force, a proposed fifth charge would read, “[r]eview current rate regulation practices.”

The Committee had no additional discussion on the two recommended revisions. Commissioner Lara made a motion, seconded by Mr. Travis, to adopt the Committee’s 2022 proposed charges with the two additions (Attachment Six).

5. **Heard a Report on Federal Activities**

Brooke Stringer (NAIC) said the federal Infrastructure Investment and Jobs Act has been signed into law and includes such items as $5 billion for FEMA flood mitigation and pre-disaster hazard mitigation grants, as well as a provision requiring that auto manufacturers install impaired-driving technology in new vehicles. She said the U.S. House of Representatives (House) passed a $1.7 trillion reconciliation bill in November that includes policy priorities on climate, jobs, and health care into one massive bill. This bill has not yet passed the U.S. Senate (Senate). The proposed bill forgives the NFIP’s $20 billion debt, provides funding for flood mapping and a means-tested affordability program, provides $145 million to FEMA for updating and enforcing hazard resistant codes and standards and grants to state and local governments, and provides $121 million to the U.S. Department of Labor’s (DOL’s) Office of Workers’ Compensation Programs (OWCP) for activities of the OWCP; but it does not include a specific reference to oversight of state workers’ compensation programs that were included in previous versions and raised concerns from the industry.

Ms. Stringer said the NFIP was extended as part of a short-term funding bill through Feb. 18, 2022. The NAIC continues to reiterate its support for a long-term reauthorization and urgent prompt action before the program expires. Ms. Stringer noted that there is a bipartisan/bicameral five-year reauthorization bill (S. 3128/H.R. 5082) from U.S. Sen. Bob Menendez (D-NJ), U.S. Sen. Bill Cassidy (R-LA), U.S. Congressman Frank Pallone (D-NJ), and U.S. Congressman Clay Higgins (R-LA). The NAIC does not have a position on this bill, but it does support U.S. Sen. Rick Scott (R-FL) and U.S. Rep. Kathy Castor’s (D-FL) bill, the Flood Insurance Consumer Choice Act of 2021 (S. 2915/H.R. 4669), which would clarify that a flood insurance policy purchased in the private market can count as “continuous coverage” under the terms of the NFIP, and policyholders could return to the NFIP without losing any previous subsidy.

Ms. Stringer said FEMA began implementing its new NFIP pricing methodology, Risk Rating 2.0, in October. She said a bipartisan group of coastal senators tried unsuccessfully to urge FEMA to postpone Risk Rating 2.0, warning about the impact of premium hikes, and introduced legislation to try to delay it. Risk Rating 2.0 will remain a key issue for NFIP reauthorization, particularly with phase two rolling out in April 2022.

Ms. Stringer reported that U.S. Congresswoman Carolyn Maloney (D-NY) reintroduced the Pandemic Risk Insurance Act of 2021 (PRIA) (H.R. 5823), which would establish a federal backstop for pandemic risk. PRIA would require that insurers make available in all their P/C insurance policies coverage for insured losses due to covered public health emergencies. The NAIC is monitoring this legislation.

Ms. Stringer said the U.S. Congress (Congress) has also focused on legislation regarding access to financial services for legitimate cannabis businesses, which has garnered bipartisan support. The House has passed the Secure and Fair Enforcement (SAFE) Banking Act (H.R. 1996/S. 910) several times, which would provide a safe harbor from violations of federal law for those engaged in the business of insurance participating in cannabis industry activity that is permissible under state law. There were recent efforts to add the bill to the annual defense authorization bill, but ultimately, they were not successful, as some Democrats wanted to include broader cannabis policy reforms. The NAIC supports the SAFE Banking Act, as well as the Clarifying Law Around Insurance of Marijuana (CLAIM) Act (S. 862), which ensures that legal marijuana and related businesses have access to comprehensive insurance coverage.

Ms. Stringer said NAIC staff received a Congressional inquiry regarding a problem one of their constituents had with renters insurance/military housing. NAIC staff previously circulated a news article to Committee members. There was a military family with a renters insurance policy that had a claim denied because the rented house was through a public-private venture and not “government controlled” as the policy specified. A Congressional office is exploring federal legislative solutions to prevent
this from happening in the future. Ms. Stringer said NAIC staff plan to reach out to industry to understand if it is common practice that a renters policy differentiates between government housing and private housing in terms of coverages on military bases.

Having no further business, the Property and Casualty Insurance (C) Committee adjourned.
The Property and Casualty Insurance (C) Committee met Nov. 10, 2021. The following Committee members participated: Vicki Schmidt, Chair (KS); Mike Chaney, Vice Chair (MS); Jim L. Ridling and Mark Fowler (AL); Ricardo Lara represented by Ken Allen (CA); Andrew N. Mais (CT); Colin M. Hayashida (HI); James J. Donelon represented by Warren Byrd (LA); Grace Arnold represented by Julia Dreier (MN); Larry D. Deiter (SD); and Mike Kreidler (WA). Also participating were: Matt Gendron (RI); and Don Beatty (VA).

1. **Adopted its Summer National Meeting Minutes**

Director Deiter made a motion, seconded by Commissioner Kreidler, to adopt the Committee’s Aug. 16 minutes (see *NAIC Proceedings – Summer 2021, Property and Casualty Insurance (C) Committee*). The motion passed unanimously.

2. **Adopted the Pet Insurance Model Act**

Mr. Beatty said after the Pet Insurance (C) Working Group released *A Regulator’s Guide to Pet Insurance*, it adopted a Request for NAIC Model Law Development on June 27, 2019, which was adopted by the Executive (EX) Committee and Plenary on Aug. 6, 2019. He said the Working Group held 24 open meetings to draft the model, with active participation from industry, consumer representatives, producers, and veterinarian groups. Mr. Beatty noted the model covers required definitions and disclosures, as well as regulations for policy conditions, sales practices for wellness programs, and producer training. He said the Working Group had extensive discussions on the following major issues: preexisting conditions, waiting periods, free-look periods, policy renewals, wellness programs, and licensing. While the Working Group did decide that this model was not the appropriate place to decide the type of license required to sell pet insurance, state insurance regulators wanted to make sure producers are trained on the specific features of pet insurance products before selling those products.

Mr. Beatty noted that the Working Group is aware that industry does have issues with the waiting periods and wellness programs language in the adopted version, but state insurance regulators thought this language was necessary to include in this model. He also said during the course of discussing the model, the Working Group has considered the need for specific data collection on the pet insurance line of business and would like to continue those discussions in order to craft referrals to the proper NAIC working groups.

Mr. Beatty said the Pet Insurance Model Act was initially adopted by the Pet Insurance (C) Working Group on Aug. 4, but after a review by the NAIC Legal Division, members of the Working Group suggested edits, and the Working Group requested the Committee allow further meetings of the Pet Insurance (C) Working Group to address these suggestions. The Working Group met Oct. 21, Oct. 7, and Sept.8. During these meetings, the Working Group considered the suggested changes from the NAIC Legal Division, as well as new suggested changes to the “Sales Practices for Wellness Programs” section and a new section titled “Insurance Producer Training.” Mr. Beatty said the NAIC Legal Division has further reviewed the model and made some small, non-substantive changes to the formatting of the model. These changes include moving the “Violations” section to the end of the model and reordering two subsections in Section 4 – Disclosures.

Cari Lee (North American Pet Health Insurance Association—NAPHIA) said NAPHIA appreciates the work of the Working Group but has two objections to the model. She said NAPHIA believes waiting periods should be allowed in order to prevent adverse selection. She said disclosures and an option to waive waiting periods should be sufficient, and without waiting periods, insurers may have to increase premiums. She also said NAPHIA objects to the language in the model related to wellness products. She said the Working Group earlier included language regarding the marketing and sales of wellness products, but later it adopted language that prohibits the marketing of non-insurance wellness products sold during the sale, solicitation, or negotiation of pet insurance. She said consumers want to purchase wellness plans at the same time as insurance.

Birny Birnbaum (Center for Economic Justice—CEJ) said he supports the Committee’s adoption of the model but would offer two additional comments. He supports a prohibition on waiting period provisions as industry has offered no credible rationale or evidence for issuing policies with both a preexisting condition clause and waiting periods that delay coverage. He said the broad and extensive waiting periods advocated for by industry will lead to consumer confusion and harm. Purchasers who buy...
pet insurance will expect to receive insurance coverage that begins when they pay the insurer and sign the policy contract. However, under NAPHIA’s proposal, consumers could actually purchase policies that provide no coverage until a future date, even though the insurer has already taken their premium dollars. He said the potential harm far outweighs any anti-fraud benefit that would be gained from instituting these broad waiting periods, particularly when the preexisting condition exclusion already offers the exact same protection. He noted that while the Working Group ultimately decided to permit a waiting period provision, that provision in the model law is more limited and far less open-ended than the industry proposal and includes some key consumer protections. He said the Working Group’s proposal strikes a reasonable balance between consumer and insurer concerns.

Mr. Birnbaum said that regarding wellness, the model appropriately eliminates the ability of insurers to arbitrage insurance versus non-insurance products. He also noted that significantly different approaches were taken in the recently adopted travel insurance model and the pet insurance model. He said both travel and pet insurance are hybrid insurance products with a combination of coverages from health insurance to property/casualty (P/C) insurance. Both are typically sold either online or through retailers, and both are often sold in connection with non-insurance services. He said the model laws for travel and pet insurance take significantly divergent approaches, such as the travel insurance model specifically addressing producer licensing and retailers and the pet insurance model prohibiting the marketing of non-insurance services at the same time as the sale of pet insurance. Mr. Birnbaum urged state insurance regulators to closely monitor insurer and producer behavior and consumer outcomes in these two markets to determine which approach better produces the outcomes sought by state insurance regulators, insurers, and consumers.

Commissioner Chaney asked whether there was separate continuing education training required for producers in the model. Mr. Gendron said a compromise was reached where the model does not have specific requirements of major line producers beyond their standard continuing education, but for limited lines producers, in states where that is allowed, the model requires 10 hours of continuing education.

Mr. Byrd made a motion, seconded by Mr. Allen, to adopt the Pet Insurance Model Act (Attachment One-A). The motion passed unanimously.

3. Discussed Other Matters

Commissioner Schmidt said the Committee’s 2022 proposed charges would be posted within the next week. She also noted that the Committee’s meeting at the Fall National Meeting will consist of presentations from various parties related to auto insurance refunds that were granted in response to reduced driving during the pandemic.

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

https://naiconline.sharepoint.com/w/r/sites/NAICSupportStaffHub/Member%20Meetings/Fall%202021/Cmte/C/11-10%20CCmte_min.docx?d=wb5db09da87e347d988c295d63352f7b6&csf=1&web=1&e=0hUYGbh
PET INSURANCE MODEL ACT

New Model
Adopted by the Pet Insurance (C) Working Group - 10/21/21
Adopted by the Property and Casualty Insurance (C) Committee - 11/10/21

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Section 1.  Short Title

This Act shall be known as the “Pet Insurance Act.”

Section 2.  Scope and Purpose

A. The purpose of this Act is to promote the public welfare by creating a comprehensive legal framework within which Pet Insurance may be sold in this state.

B. The requirements of this Act shall apply to Pet Insurance policies that are issued to any resident of this state, and are sold, solicited, negotiated, or offered in this state, and policies or certificates that are delivered or issued for delivery in this state.

C. All other applicable provisions of this state’s insurance laws shall continue to apply to Pet Insurance except that the specific provisions of this Act shall supersede any general provisions of law that would otherwise be applicable to Pet Insurance.

Section 3.  Definitions

If a pet insurer uses any of the terms in this Act in a policy of pet insurance, the pet insurer shall use the definition of each of those terms as set forth herein and include the definition of the term(s) in the policy. The pet insurer shall also make the definition available through a clear and conspicuous link on the main page of the pet insurer or pet insurer’s program administrator’s website.

Nothing in this Act shall in any way prohibit or limit the types of exclusions pet insurers may use in their policies or require pet insurers to have any of the limitations or exclusions defined below.

As used in this Act:

A. “Chronic condition” means a condition that can be treated or managed, but not cured.

B. “Congenital anomaly or disorder” means a condition that is present from birth, whether inherited or caused by the environment, which may cause or contribute to illness or disease.

C. “Hereditary disorder” means an abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.

D. “Pet insurance” means a property insurance policy that provides coverage for accidents and illnesses of pets.
E. “Preexisting condition” means any condition for which any of the following are true prior to the effective date of a pet insurance policy or during any waiting period:

(1) A veterinarian provided medical advice;
(2) The pet received previous treatment; or
(3) Based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for which a claim is being made.

A condition for which coverage is afforded on a policy cannot be considered a preexisting condition on any renewal of the policy.

F. “Veterinarian” means an individual who holds a valid license to practice veterinary medicine from the appropriate licensing entity in the jurisdiction in which he or she practices.

G. “Veterinary expenses” means the costs associated with medical advice, diagnosis, care, or treatment provided by a veterinarian, including, but not limited to, the cost of drugs prescribed by a veterinarian.

H. “Waiting period” means the period of time specified in a pet insurance policy that is required to transpire before some or all of the coverage in the policy can begin. Waiting periods may not be applied to renewals of existing coverage.

I. “Renewal” means to issue and deliver at the end of an insurance policy period a policy which supersedes a policy previously issued and delivered by the same pet insurer or affiliated pet insurer and which provides types and limits of coverage substantially similar to those contained in the policy being superseded.

J. “Orthopedic” refers to conditions affecting the bones, skeletal muscle, cartilage, tendons, ligaments, and joints. It includes, but is not limited to, elbow dysplasia, hip dysplasia, intervertebral disc degeneration, patellar luxation, and ruptured cranial cruciate ligaments. It does not include cancers or metabolic, hemopoietic, or autoimmune diseases.

K. “Wellness program” means a subscription or reimbursement-based program that is separate from an insurance policy that provides goods and services to promote the general health, safety, or wellbeing of the pet. If any wellness program [insert language from state statute or regulation that defines the trigger for insurance contracts, which might include language such as: [undertakes to indemnify another], or [pays a specified amount upon determinable contingencies] or [provides coverage for a fortuitous event]], it is transacting in the business of insurance and is subject to the insurance code. This definition is not intended to classify a contract directly between a service provider and a pet owner that only involves the two parties as being “the business of insurance,” unless other indications of insurance also exist.

Section 4. Disclosures

A. A pet insurer transacting pet insurance shall disclose the following to consumers:

(1) If the policy excludes coverage due to any of the following:
   (a) A preexisting condition;
   (b) A hereditary disorder;
   (c) A congenital anomaly or disorder; or
   (d) A chronic condition.

(2) If the policy includes any other exclusions, the following statement: “Other exclusions may apply. Please refer to the exclusions section of the policy for more information.”

(3) Any policy provision that limits coverage through a waiting or affiliation period, a deductible, coinsurance, or an annual or lifetime policy limit.
Whether the pet insurer reduces coverage or increases premiums based on the insured’s claim history, the age of the covered pet or a change in the geographic location of the insured.

If the underwriting company differs from the brand name used to market and sell the product.

B. Right to Examine and Return the Policy.

(1) Unless the insured has filed a claim under the pet insurance policy, pet insurance applicants shall have the right to examine and return the policy, certificate or rider to the company or an agent/insurance producer of the company within fifteen (15) days of its receipt and to have the premium refunded if, after examination of the policy, certificate or rider, the applicant is not satisfied for any reason,

(2) Pet insurance policies, certificates and riders shall have a notice prominently printed on the first page or attached thereto including specific instructions to accomplish a return. The following free look statement or language substantially similar shall be included:

“You have 15 days from the day you receive this policy, certificate or rider to review it and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide not to keep it, simply return it to the company at its administrative office or you may return it to the agent/insurance producer that you bought it from as long as you have not filed a claim. You must return it within 15 days of the day you first received it. The company will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate, or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate or rider will be void as if it had never been issued.”

C. A pet insurer shall clearly disclose a summary description of the basis or formula on which the pet insurer determines claim payments under a pet insurance policy within the policy, prior to policy issuance and through a clear and conspicuous link on the main page of the pet insurer or pet insurer’s program administrator’s website.

D. A pet insurer that uses a benefit schedule to determine claim payment under a pet insurance policy shall do both of the following:

(1) Clearly disclose the applicable benefit schedule in the policy.

(2) Disclose all benefit schedules used by the pet insurer under its pet insurance policies through a clear and conspicuous link on the main page of the pet insurer or pet insurer’s program administrator’s website.

E. A pet insurer that determines claim payments under a pet insurance policy based on usual and customary fees, or any other reimbursement limitation based on prevailing veterinary service provider charges, shall do both of the following:

(1) Include a usual and customary fee limitation provision in the policy that clearly describes the pet insurer’s basis for determining usual and customary fees and how that basis is applied in calculating claim payments.

(2) Disclose the pet insurer’s basis for determining usual and customary fees through a clear and conspicuous link on the main page of the pet insurer or pet insurer’s program administrator’s website.

F. If any medical examination by a licensed veterinarian is required to effectuate coverage, the pet insurer shall clearly and conspicuously disclose the required aspects of the examination prior to purchase and disclose that examination documentation may result in a preexisting condition exclusion.

G. Waiting periods and the requirements applicable to them, must be clearly and prominently disclosed to consumers prior to the policy purchase.
H. The pet insurer shall include a summary of all policy provisions required in subsections (A) through (G), inclusive, in a separate document titled “Insurer Disclosure of Important Policy Provisions.”

I. The pet insurer shall post the “Insurer Disclosure of Important Policy Provisions” document required in subsection (H) through a clear and conspicuous link on the main page of the pet insurer or pet insurer’s program administrator’s website.

J. In connection with the issuance of a new pet insurance policy, the pet insurer shall provide the consumer with a copy of the “Insurer Disclosure of Important Policy Provisions” document required pursuant to subsection (H) in at least 12-point type when it delivers the policy.

K. At the time a pet insurance policy is issued or delivered to a policyholder, the pet insurer shall include a written disclosure with the following information, printed in 12-point boldface type:

   (1) The [insert state insurance department]’s mailing address, toll-free telephone number and website address.

   (2) The address and customer service telephone number of the pet insurer or the agent or broker of record.

   (3) If the policy was issued or delivered by an agent or broker, a statement advising the policyholder to contact the broker or agent for assistance.

L. The disclosures required in this section shall be in addition to any other disclosure requirements required by law or regulation.

Section 5. Policy Conditions

A. A pet insurer may issue policies that exclude coverage on the basis of one or more preexisting conditions with appropriate disclosure to the consumer. The pet insurer has the burden of proving that the preexisting condition exclusion applies to the condition for which a claim is being made.

B. A pet insurer may issue policies that impose waiting periods upon effectuation of the policy that do not exceed 30 days for illnesses or orthopedic conditions not resulting from an accident. Waiting periods for accidents are prohibited.

   (1) A pet insurer utilizing a waiting period permitted in Subsection 6B shall include a provision in its contract that allows the waiting periods to be waived upon completion of a medical examination. Pet insurers may require the examination to be conducted by a licensed veterinarian after the purchase of the policy.

      (a) A medical examination under Subsection 6B(1) shall be paid for by the policyholder, unless the policy specifies that the pet insurer will pay for the examination.

      (b) A pet insurer can specify elements to be included as part of the examination and require documentation thereof, provided the specifications do not unreasonably restrict a consumer’s ability to waive the waiting periods in section Subsection 6B.

   (2) Waiting periods and the requirements applicable to them, must be clearly and prominently disclosed to consumers prior to the policy purchase.

C. A pet insurer must not require a veterinary examination of the covered pet for the insured to have their policy renewed.

D. If a pet insurer includes any prescriptive, wellness, or non-insurance benefits in the policy form, then it is made part of the policy contract and must follow all applicable laws and regulations in the insurance code.

E. An insured’s eligibility to purchase a pet insurance policy must not be based on participation, or lack of participation, in a separate wellness program.
Section 6. Sales Practices for Wellness Programs

A. A pet insurer and/or producer shall not do the following:

(1) Market a wellness program as pet insurance;

(2) Market a wellness program during the sale, solicitation, or negotiation of pet insurance.

B. If a wellness program is sold by a pet insurer and/or producer:

(3) The purchase of the wellness program shall not be a requirement to the purchase of pet insurance.

(4) The costs of the wellness program shall be separate and identifiable from any pet insurance policy sold by a pet insurer and/or producer.

(5) The terms and conditions for the wellness program shall be separate from any pet insurance policy sold by a pet insurer and/or producer.

(6) The products or coverages available through the wellness program shall not duplicate products or coverages available through the pet insurance policy; and

(7) The advertising of the wellness program shall not be misleading and shall be in accordance with Subsection 7B of this Model.

(8) A pet insurer and/or producer shall clearly disclose the following to consumers, printed in 12-point boldface type:

(a) That wellness programs are not insurance.

(b) The address and customer service telephone number of the pet insurer or producer or broker of record.

(c) The [insert state insurance department]’s mailing address, toll-free telephone number, and website address.

C. Coverages included in the pet insurance policy contract described as “wellness” benefits are insurance.

Section 7. Insurance Producer Training

A. An insurance producer shall not sell, solicit, or negotiate a pet insurance product until after the producer is appropriately licensed and has completed the required training identified in subsection B of this Section.

B. Producer Training Requirements

(1) Training for Insurance Producers with a Major Lines License. Both the producer and the insurer shall ensure that its producers have been appropriately trained on the features of its products.

Drafting Note: The major line license referenced here is a reference to the Producer Licensing NAIC Model Act (#218). See Section 8E for the term “major line,” and Section 7A(1) through (6) for a listing of those major lines, or see the NAIC State Licensing Handbook, Chapter 9, Lines of Insurance, The Major Lines.

(2) Training for Limited Lines Producers

(a) A limited lines insurance producer shall not sell, solicit, or negotiate a pet insurance product until after the producer completes training courses approved by the department of insurance and provided by the department of insurance-approved education provider.

(b) The minimum length of the initial training required under this subsection shall be sufficient to qualify for at least ten (10) pre-licensing education or continuing education credit hours.
In addition to the training required in Paragraphs (a) and (b) of this subsection, a limited lines insurance producer who sells, solicits, or negotiates pet insurance shall complete ongoing training as set forth in paragraph (d).

The ongoing training required by this subsection shall be no less than four (4) continuing education credit hours prior to every license renewal.

The training required under this subsection may also qualify for a state’s pre-licensing education or continuing education credit hours in accordance with [insert reference to state law or regulations governing producer continuing education course approval].

Providers of pet insurance training that qualifies for pre-licensing or continuing education shall comply with the reporting requirements and shall issue certificates of completion in accordance with [insert reference to state law or regulations governing producer continuing education course approval].

The satisfaction of the training requirements of another state that are substantially similar to the provisions of this section shall be deemed to satisfy the training requirements of this subsection in this state.

The satisfaction of the components of the training requirements of any course or courses with components substantially similar to the provisions of this section shall be deemed to satisfy the training requirements of this subsection in this state.

An insurer shall verify that a producer has completed the pet insurance training courses required under this section before allowing the limited lines producer to sell, solicit or negotiate pet insurance for that insurer. An insurer may satisfy its responsibility under this paragraph by obtaining certificates of completion of the training course or obtaining reports provided by commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

Drafting Note: A state department of insurance may separately authorize a limited line producer to sell, solicit, or negotiate pet insurance, not based on authority in this statute. See Uniform Licensing Standards section 37 (Non-Core Limited Lines) and Chapter 9 of the Producer Licensing Handbook.

C. The training required under this section shall include information on the following topics:

1. Preexisting conditions and waiting periods;
2. The differences between pet insurance and non-insurance wellness programs;
3. Hereditary disorders, congenital anomalies or disorders, and chronic conditions and how pet insurance policies interact with those conditions; and
4. Rating, underwriting, renewal, and other related administrative topics.

Section 8. Regulations

The commissioner may adopt reasonable rules and regulations, as are necessary to administer this part.

Section 9. Violations

Violations of this Act shall be subject to penalties pursuant to [insert state administrative code].
Cannabis Insurance (C) Working Group
Virtual Meeting (in lieu of meeting at the 2021 Fall National Meeting)
December 1, 2021

The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met Dec. 1, 2021. The following Working Group members participated: Ricardo Lara, Chair, represented by Melerie Michael and Camilo Pizarro (CA); Michael Conway, Vice Chair, represented by Peg Brown (CO); Austin Childs (AK); Jimmy Harris (AR); Angela King (DC); Christina Miller (DE); C.J. Metcalf (IL); Robert Barron (MD); Marlene Caride represented by Randall Currier (NJ); Gennady Stolyarov (NV); Ashley Scott (OK); Brian Fordham (OR); Elizabeth Kelleher Dwyer (RI); Karla Nuissl (VT); and Michael Walker (WA). Also participating was: Larry D. Deiter (SD).

1. **Adopted its Oct. 21 Minutes**

The Working Group met Oct. 21 and took the following action: 1) adopted its Summer National Meeting minutes; and 2) discussed the outline for the appendix to the *Understanding the Market for Cannabis Insurance* white paper; and 3) discussed its 2022 proposed charges.

Ms. Brown made a motion, seconded by Mr. Barron, to adopt the Working Group’s Oct. 21 (Attachment Two-A) minutes. The motion passed unanimously.

2. **Heard an Update on the Drafting of the *Understanding the Market for Cannabis Insurance* White Paper Appendix**

Ms. Michael said the Working Group reviewed the appendix outline during its last meeting on Oct. 16. The appendix will provide an update on the regulatory issues related to insurance in the cannabis industry that have occurred since the white paper’s adoption in July 2019. The appendix draws from information gained during the Working Group’s two-day hearing and the presentations received today. The drafting group met Nov. 10 to review the outline and assign the drafting of sections of the appendix to drafting participants. A draft of Section II c. *Cannabis Insurance Market Segments and Insurance Players* has been submitted for review from the drafting group. This section covers the impact from the lack of admitted insurers, seed to sale needs for each segment, and vertically integrated and niche players. The drafting group will meet again on Dec. 8 to review progress made on assigned sections.

Mr. Walker asked if drafts should be provided ahead of the Dec. 8 drafting meeting. Ms. Michael stated it would be preferred that drafts be sent to NAIC staff ahead of the meeting so they can be compiled and shared.

3. **Discussed the Potential to Collaborate with the Producer Licensing (D) Task Force**

Ms. Michael said she and Ms. Brown reached out on Nov. 18 to the co-chairs of the Producer Licensing (D) Task Force to gain their thoughts on potentially collaborating with the Working Group to study, in states where cannabis is legalized for medical and/or recreational use, whether cannabis-related convictions are preventing individuals from being licensed as an agent or broker. Superintendent Dwyer and Director Deiter stated they would review their database to see if they have information that they can share with the Working Group. Information and next steps will be shared with the Working Group once the data is received.

4. **Heard a Presentation from the University of Colorado on Emerging Scientific Issues in the Cannabis Space**

Cinnamon Bidwell (University of Colorado Boulder) stated the landscape of legality and products is constantly changing in the cannabis space, with minor tetrahydrocannabinol (THC)-like cannabinoids able to be synthesized from legal hemp. Despite that all but two states have adopted some form of legalized cannabis, federal prohibitions limit the scientific research that can contribute to these policy changes. Nearly all human work involving canvas administration has had to rely on government grown research grade cannabis, which bears little resemblance to products in the real world. Participants say it is dry and tasteless and, until very recently, came as rolled marijuana cigarettes. Testing was done with a controlled puffing procedure of the participants consuming the entire cannabis cigarette in 12 puffs over five minutes to regulate dose and timing. This is not consistent with the way people consume in cannabis in today’s world. It is difficult to draw conclusions from prior work because of these differences in product type and potency, as well as these administration procedures that happen in the lab.

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there are a couple of clear takeaways from the literature at this point. First, a wealth of lab research supports the fact that acute exposure to cannabis disrupts cognitive processing, resulting in cognitive impairment immediately after use. There may also be impacted mood and psychiatric functions for either short or long periods of time. Early and persistent use, especially prior to age, 16, worsens these cognitive and psychiatric effects. However, there is still almost no data on the impact of legal market cannabis on these same outcomes. There is a huge range of products available on the legal market that have never touched a research lab. The current body of evidence is the oversimplifications of cannabis. There is a huge diversity of reported effects from euphoria to paranoia and extreme anxiety. In addition, cannabis consists of a few primary cannabinoids and hundreds of minor cannabinoids and terpenes, many still being discovered. However, research studies primarily focus on the Delta component. There is also a huge variation in potency across strains. Different products have different levels of the major and minor cannabinoids, and each looks distinct. For these reasons, the study of cannabis is unlike the study of other drugs where one is pretty much focused on a dose dependent effect of a single pharmacological agent.

Delta-9, THC and cannabidiol (CBD) are present at the highest levels across most forms of cannabis. Each interacts differently with the human body. Delta-9 interacts with certain receptors in the brain and body to produce a drug reward and intoxication effect. They may also increase anxiety, have an inflammatory effect, and reduce pain. CBD has the opposite pharmacology, which means it may reduce anxiety and has stronger anti-inflammatory properties, but it is not intoxicating. Delta-8 is a minor cannabinoid that can be chemically characterized as a Delta-9 sibling. This chemical similarity means it may cause intoxication like Delta-9. As such, it is often referred to as a “light high.” Delta-8 exists in a legal gray area because it can be easily synthesized from hemp-derived CBD. Hemp-derived CBD became legal with the federal Agriculture Improvement Act of 2018. There are other minor cannabinoids that exist in the same legal limbo, such as Delta-10. Thus, the landscape of legal cannabis and the resulting market is constantly shifting. In particular, highly potent products are gaining market share. Federal prohibitions and discrepancy between federal and state law continue to create barriers to rigorous research on many of these new and emerging products.

There are three primary forms of cannabis: 1) flower; 2) edibles; and 3) concentrates. Sales of concentrates, which are highly potent, have risen substantially in Colorado and other states. Market names for concentrates include bubble, hash, and hash oil wax, and they typically come in a range of potencies. The low end for a concentrate is 65%, and the high-end is 95%. Concentrates are often consumed by “dabbing” or inhaling a small, but very potent, quantity of the drug. Correlational data suggests that these higher potency forms are likely to come with additional risks, such as a use disorder, mood problems, or psychiatric problems. Although research results are mixed, they suggest that concentrates and high potency products may increase risk over and above just very frequent use of cannabis. Although these products are widely available and used on state markets, there is no empirical or preclinical data on the impact of these highly potent forms due to federal illegality. As other states look to legalize recreational cannabis and federal policy changes are being considered, it is imperative that consumers and policymakers are well-informed about the health effects of these products.

Ms. Bidwell stated she created a regular rigorous, federally compliant research program that provides relevant research on the potential harms and benefits of commercially available cannabis products. Academic researchers who must be compliant with federal law are unable to bring these legal market forms into their laboratories. So instead, researchers at the University of Colorado Boulder worked closely with its administration to bring the lab to the people. This mobile pharmacology lab allows researchers to conduct observational cannabis research in a mobile environment. Participants self-administer legal market cannabis in their homes, and researcher then test them in the mobile lab before and after they use. The mobile lab is outfitted with the full range of assessments found in a typical laboratory setting. The goal of the project was to assess the acute effects of “dabbing” high potency forms of cannabis. Prior to this study, little was known about the acute effects of consuming concentrates. The study included 75 regular cannabis users who completed a comprehensive health assessment in the mobile lab. They were then randomly assigned to either a 70% or 90% concentrated oil that they would personally purchase from a partner dispensary with their own funds. Participants use their product as they naturally would in their home and then come to the mobile lab to collect data on intoxication and impairment.

Published research results show that THC levels peak immediately after use and then go down about an hour later. There were no blood level differences between the 70% and 90% concentrate groups. This suggests that individuals are maybe titrating up to a particular level of high regardless of potency or that participants are hitting an upper limit with very high potency products. The blood levels after a concentrated user are about three times higher than after a typical flower or bud use. Even the regular cannabis users before they use that day are not falling under the legal definition of intoxication. To establish impairment, the researchers took measures of subjective ratings of intoxication and objective measures of cognitive and psycho motor impairment after very high exposure. Despite the large differences in blood levels between the flower and concentrated users, the subjective impairment ratings were similar. This suggests that concentrated users develop a strong tolerance.
Objective tests of delayed memory recall also showed that concentrate users are more tolerant to the acutely, cognitively impaired effects of cannabis. It is complicated to establish if people are getting more intoxicated with higher potency concentrates. The subjective high and cognitive measures do not track with one another, potentially due to self-titrating or greater tolerance in regular users of concentrates. However, balance is the only function that gets worse immediately after use, but then it recovers quickly within the hour. This suggests that balance measures may not show the same tolerance effects and that measures of balance and motor control may be good candidates for acute use, even in very heavy users. This has huge relevance to public safety initiatives. There currently is not a valid biological or behavioral measure or breathalyzer that can allow officers to accurately detect recent cannabis use in drivers. Follow-up is needed on the possible long-term, clinical, and neurological consequences of chronically high THC exposure.

Mr. Currier asked for examples and citations of jurisdictions that use intoxication standards. Ms. Bidwell stated Colorado is among the states that uses them. The citation for this information is as follows:


Ms. Michael asked if CBD used for anti-inflammatory benefits has the same negative health risks as NSAIDS and if access to CBD is age restricted. Ms. Bidwell stated the risks with CBD are dose-dependent, and it could have similar risks in very high doses. CBD has been found to be helpful for treating childhood epilepsy and anxiety at certain doses. Age restrictions vary widely across states, mostly 18, 21 or no restrictions. However, they are likely not strongly enforced as states did not receive additional funding for enforcement around hemp legalization. Some states, such as Oregon, Michigan, and Nevada, are tightening their hemp policies to place the novel cannabinoids under cannabis regulations. However, it will likely take federal engagement to address online sales to minors. The FDA recently released a plan to collect data on hemp-derived products but has not taken regulatory action.

5. Heard a Presentation from CANNRA on Cannabis Policy and Regulation Trends

Gillian Schauer (Cannabis Regulators Association—CANNRA) said there is now a broader focus on how policy is made with increased parity in regulations across the use of cannabis. Social equity, restorative justice, and public health and safety are priorities. The patchwork in policy can present challenges to harmonization, particularly given how and when policy was made. There is a lag time of 12–24 months between when cannabis became legalized and when the marketplace was opened. Arizona holds the record for the quickest market opening at 12 months. There is currently a new wave of cannabis legalization coming across states. There is much more legislative policymaking than what occurred in 2018, when Vermont legalized adult-use without a marketplace. Illinois did the same in 2019. But in 2021, there have been four states legalized legislatively. This expansion allows for more discussion and more detailed statutes to evolve. Washington’s statute was 16 pages when it legalized cannabis in 2012. Now legislation around cannabis legalization is in the hundreds of pages with much detail. Although there is a benefit to having this detail in the front-end, it can also present challenges to harmonize down the road. In addition to seeing this change in how policies are made, there is also a broader policy focus than what occurred in the Cole Memorandum era shortly after Colorado and Washington legalized cannabis. The Cole Memorandum effectively said the U.S. Department of Justice (DOJ) would not challenge state authority as long as it followed certain public safety measures. It was rescinded under former President Donald Trump.

Currently, states have less fear of having federal agencies shutting everything down because of how many states have legalized cannabis. This has given states and policymakers the space to focus on the potential for federal engagement, social equity, public health, and consumer safety. There is also an increased desire to focus on getting more parity across cannabis regulations. So, states may have three entities regulated for cannabis—one for the operations, one for medical use, and one for adult use. There is a trend for a similar regulatory framework to be used because it is all from the same plant, and there have been some regulatory lines established.

In regard to the increased emphasis on equity and restorative justice, past criminalization of cannabis has not happened equally and has affected some communities much more than others. In the past, the focus has been on getting equity in the marketplace by ensuring diversity in licenses. Attention now is shifting to include automatic and easily obtainable expungements (having criminal records involving now legalized cannabis to be cleaned) and community reinvestment. Illinois and California have
been leaders in the community reinvestment areas, but some of the states that recently passed legislation have also focused on this. New York and New Jersey will be reinvesting in communities that have been disproportionately affected by the war on drugs in the past criminalization of cannabis. This focus includes job retraining, mental health, and substance abuse treatments in some states.

Youth prevention and consumer safety are two of the biggest areas being focused on with this increased emphasis on public health and safety. The amount of cannabis that can be held legally has increased in some states, which is of potential concern for public health and safety. Generally, states are legalizing 1 ounce of cannabis. Maine and Michigan have legalized 2.5 ounces, and New York just legalized 3 ounces. There has not been a shift in the types of products that are legal. However, there have been a few states (California, Michigan, and Washington) that have had restrictions that only allow shelf stable edibles. The primary reason for this is due to food inspection because cannabis is still a Schedule 1 substance federally. These restrictions lessen the complications in getting a federally funded food inspection program set up. The policy solution for the potential health impacts from concentrates that has been advocated for across a number of states in the last legislative session is to cap them. For example, in Vermont, a vape cartridge cannot have more than 60% in it. Connecticut will also have a cap. Vape cartridges will be potentially exempt from that cap. Homegrown cannabis is legal in many states with the exception of a few states. Illinois, New Jersey, and Washington do not allow homegrown cannabis for adult use. There is much concern about homegrown cannabis resulting in diversion. Additionally, homegrown products are not subjected to any regulatory oversight and, thus, are not tested for contaminants.

Packaging and labeling are also variables of concern for youth prevention, public health, and consumer safety. There has been increased focus, especially in medical-use states, on using plain, uniform, and opaque packaging like Canada. Studies of tobacco packaging demonstrate the package can have inherent appeal to youth and that plain packaging can greatly reduce this appeal. There is also discussion among standards organizations about implementing a universal symbol. There is some federal engagement around the challenges to making those changes in states. The inclusion of a poison center phone number, drug information, pertinent websites, and amount of THC are also beginning to be used in labeling. The level of THC is important for communicating with consumers about what the potential impairing properties are of the product they will consume. However, despite every adult-use state having a stature or regulation stating packaging should not appeal to children, they still exist. To help rectify this, these statutes and regulations should also state what packaging cannot include, such as cartoons and bright colors, to reduce the opportunity for interpretation. States that only allow plain or uniform packaging are not seeing packaging that appeal to children. On small packages, the challenge is getting the print large enough to be seen by consumers. Additionally, warning labels on cannabis products read similar to a legal disclaimer, which is not effective in communicating with consumers about the risks.

Advertising is another variable that has a lot of importance for educating consumers and for preventing youth consumption. States have increased their focus on audience restrictions by leveraging a provision that the alcohol industry developed to monitor its own advertising content and, thus, avoid federal engagement. However, under the alcohol industry’s interpretation, almost 30% of the viewership for an advertisement could be underage. Recently, there has been movement to close this age gap. Connecticut’s statute states that 90% or more of the audience has to be 21 years old or older. New Jersey uses a sliding scale of 80%-90% based on the type of advertising.

One of the challenges is in establishing what the legal age is for consumers of adult-use cannabis. An increasing number of states are banning advertising in or around transit, such as bus advertisements, and restricting advertisement content to what is included on packaging. For example, in some states, advertisements should not contain a pot leaf or a person consuming the product. States are also beginning to add warnings on advertisements. However, there still tends to be a lot of information in very small print. Social media advertisements on sites accessible to underage individuals are a challenge. It is important for states to focus on policy around social media for youth prevention.

In the wake of the lung injury from vaping outbreak, regulators took a much more careful look at product ingredients, devices used to vape, and processes in place for recalling products. This resulted in more regulatory authority over additives and ingredients to prevent future safety issues. A number of states have banned potentially harmful additives and focused on establishing a safety bar for other additives. Many states require the additive to be pharmaceutical grade or Federal Drug Administration (FDA) approved for the intended method of use. There has been more regulatory authority over vaping devices, especially in medical-use states. For example, there are provisions that deivses have temperature controls and heating elements made of certain materials. Ohio has a provision that liquids should not touch the coil to address findings that some devices can overheat, causing a change in structure and potential health risks. The batteries and coils can also leak heavy metals, causing a risk to consumer safety. Regulating vaping devices can be challenging because the devices are not just used for cannabis.
Broader oversight that includes other substances is needed so that there is a coordinated approach to tracking and tracing ingredients and quickly recalling if a safety risk arises. The lack of safety profiles on additives makes policymaking difficult.

Emerging policies on cannabis concentrates that place caps on concentrates (such as 60%) are likely creating unintended consequences. The safest products are the purest in terms of cannabinoids. Adding additives, such as to aerosolize a cannabis product, introduces substances not well-studied and, thus, raises potential consumer safety concerns.

Cannabis testing is done in third-party labs licensed by the state. There have been documented occurrences of lab shopping. To improve quality assurance, there has been an increase in states working towards setting up reference labs. This requires novel approaches because cannabis is still illegal at the federal level. Colorado was the first state to do this successfully. The approach to testing varies by state. Several groups, including CANNRA, are working on a method to increase standardization in this area. The removal of federal illegality would be helpful to getting better consistency across lab testing.

Where cannabis can be consumed is another important safety consideration. There is a trend towards states allowing on-site consumption or allowing cannabis consumption establishments. California and Illinois defer to local authorities, and Alaska, Colorado, Michigan, and Nevada have statewide licensing in this area. Studies show second-hand tobacco smoke is harmful. Although second-hand cannabis smoke in animals has been found to have some of the same effects, there is no human-level data to document the extent of it. Enforcement in this area can be challenging since it is hard to know if someone is smoking tobacco or cannabis. The policies that currently allow for more widespread public consumption of cannabis, particularly inside, may regress the gains from limiting second-hand tobacco smoke exposure. Future policy design protecting consumer safety from second-hand smoke is an important consideration.

Regulators are facing challenges related to novel cannabinoids from hemp. This includes not just Delta-8 and Delta-10, but acetate, which is derived in a lab environment. There is no human data on acetate, so humans are effectively the test subjects. In most states, hemp is not subject to the same packaging, labeling, testing, and other regulations as cannabis because it is regulated by a different entity. There are reports that the Delta-8 labeled products actually have high levels of Delta-9. The manufacturing process for these cannabinoids can also potentially leave unknown and untested byproducts. Additionally, many of these products are impairing, and they are widely available anywhere hemp products are sold and online where youth can easily order a product. Consumers may be purchasing these products thinking they are not impairing, like CBD. The Centers for Disease Control and Prevention (CDC) and Federal Drug Administration (FDA) have issued warnings on this based on reports from poison control, many requiring hospitalization.

CANNRA has posted a document on its website summarizing concerns and recommendations it proposes be considered with federal legalization. It recommends that a floor, rather than a ceiling, should be set. Additionally, states should be able to continue responding nimbly to issues without waiting for federal action. Protecting consumer safety and promoting equity should be priorities. Minimum standards are needed for lab testing for ingredients and additives. Federal engagement for packaging, labeling, and research would be helpful. Revenue generation from cannabis taxes at the federal level should focus on investment and research and data monitoring. Incentives to promote equity and revenue generation should be reserved for states. Finally, more coordination is needed between hemp and cannabis regulations.

Ms. Michael asked if states that legalized cannabis by legislation have had fewer challenges than others that did so by ballot measures with regards to labeling that is not attractive to minors. Ms. Schauer stated it remains to be seen what the markets will look like in many of the states that legalized legislatively because they just did so in the last session. There have been two different approaches. For instance, New York gave authority to their new Office of Cannabis Management but did not prescribe anything. Thus, the details of how the market will be regulated will come from rule-making versus statute. Conversely, Connecticut prescribed extensively in statute and will have rules overlay these to an extent. Consumer safety protections should be in statute. But other issues must be a balancing act because changes to legislation is cumbersome. The eastern states that just legalized cannabis have used new approaches.

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

https://naiconline.sharepoint.com/w:/r/sites/NAICSupportStaffHub/Member%20Meetings/Fall%202021/Cmte/C/CannabisWG/Dec%201-Fall%20NM/11- CannabisWG.docx?d=wa1e044d0825346edb0482af04c096d59&csf=1&web=1&e=6cc3fG
The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met Oct. 21, 2021. The following Working Group members participated: Ricardo Lara, Chair, represented by Melerie Michael and Camilo Pizarro (CA); Michael Conway, Vice Chair, represented by Peg Brown and Bobbie Baca (CO); Jimmy Harris (AR); Christina Miller (DE); C.J. Metcalf and July Mottar (IL); Marlene Caride represented by Randall Currier (NJ); Gennady Stolyarov (NV); Cuc Nguyen (OK); Elizabeth Kelleher Dwyer (RI); Karla Nuissl (VT); and Michael Walker (WA).

1. **Adopted its May 27 and Summer National Meeting Minutes**

The Working Group met May 27 as well as July 19 and July 27 in lieu of the Summer National Meeting. During its May 27 meeting, the Working Group took the following action: 1) adopted its April 27 Minutes; 2) discussed sending a memo to the Government Relations (EX) Leadership Council recommending that it consider supporting the Secure and Fair Enforcement (SAFE) Banking Act of 2019 (H.R. 1996/S. 910) and the Clarifying Law Around Insurance of Marijuana (CLAIM) Act (H.R. 2068/S. 862); 3) discussed the draft agenda for its hearing on market barriers for cannabis insurance; and 4) discussed objectives for the appendix to the *Understanding the Market for Cannabis Insurance* white paper. During its July 19 and July 27 meetings, the Working Group held its hearing on market barriers for cannabis insurance.

Ms. Brown made a motion, seconded by Mr. Harris, to adopt the Working Group’s May 27 (Attachment Two-A1) and July 19 and July 27 (see NAIC Proceedings – Summer 2021, Property and Casualty Insurance (C) Committee, Attachment Two) minutes. The motion passed unanimously.

2. **Discussed the Draft Outline for the *Understanding the Market for Cannabis Insurance* White Paper Appendix**

Ms. Michael said the appendix to the *Understanding the Market for Cannabis Insurance* white paper will provide an update on the regulatory issues related to insurance in the cannabis industry that have occurred since the white paper’s adoption in July 2019. The working outline discussed on the drafting group’s first call on Sept. 22 parallels the agenda from the Working Group’s two-day hearing. It begins by summarizing the hearing and its findings. The outline then moves to providing an overview of the geographical expansion of states legalizing cannabis and the current federal bills. The cannabis business regulatory and licensing framework, market segments and players, insurance product availability, actual and perceived risks, policy forms, and product availability and affordability are discussed next. The barriers to coverage availability and affordability section will cover coverage obstacles, challenges, gaps, coverage risks, and alternative arrangements. The next steps section will discuss the role of the state insurance regulator in helping the admitted market evolve and emerging issues. The drafting group proposes adding additional research into public versus private sector implications, jurisdictional differences, and cannabidiol (CBD) issues to the appendix content. The current drafting members include California, Colorado, Oregon, and Washington.

Ms. Nuissl and Mr. Metcalf offered to join the drafting group to provide feedback and insights on the content.

Ms. Michael asked that feedback on the working outline or additional offers to join the drafting group be sent to NAIC staff.

3. **Discussed the Drafting Timeline for the *Understanding the Market for Cannabis Insurance* White Paper Appendix**

Ms. Michael said given the length of the appendix outline, the drafting should be completed by or before the 2022 Summer National Meeting. However, the target timeline is to complete the first draft in December, complete the final draft in January 2022, and adopt the appendix at the 2022 Spring National Meeting.

4. **Discussed its 2022 Proposed Charges**

Ms. Michael said the Working Group should request that the Property and Casualty Insurance (C) Committee remove the charge to “[c]ollect aggregated insurance availability and coverage gap information…to then publicly share in a released report by the end of 2021.” The Working Group decided at the beginning of 2021 that reliable data for this charge was not available.
Ms. Michael also recommended that the Working Group propose charges to develop an appendix by the 2022 Summer National Meeting and collaborate with the Producer Licensing (D) Task Force on equity concerns, which includes drafting a memo requesting that the Task Force look into potential related issues. Both of these are work products that the Working Group initiated in 2021 but will be continued into 2022.

Mr. Metcalf said he is comfortable with the 2022 proposed charges. Mr. Walker said he supports the additional charges and the timeline of drafting the appendix by the 2022 Summer National Meeting.

Ms. Brown made a motion, seconded by Mr. Metcalf, for a vote of consensus on requesting the Property and Casualty Insurance (C) Committee revision to the Working Group’s 2022 proposed charges. The motion passed unanimously.

5. **Discussed Other Matters**

Ms. Michael said the Working Group will be meeting on Dec. 13 at the Fall National Meeting in San Diego, CA.

Ms. Brown said she would send NAIC staff the agenda for the Business Insurance Cannabis Conference on Oct. 13–14, 2021, to share with the Working Group as it considers additional presenters to invite to the Fall National Meeting. The National Cannabis Industry Association (NCIA) and Cannabis Regulators Association (CANNRA) have had leadership changes that the Working Group may want to apprise itself of.

Having no further business, the Cannabis Insurance (C) Working Group adjourned.
Draft: 6/1/21

Cannabis Insurance (C) Working Group
Virtual Meeting
May 27, 2021

The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met May 27, 2021. The following Working Group members participated: Ricardo Lara, Chair, represented by Melerie Michael (CA); Michael Conway, Vice Chair, represented by Peg Brown (CO); Lori K. Wing-Heier represented by Austin Childs (AK); Jimmy Harris (AR); C.J. Metcalf (IL); Marlene Caride represented by Randall Currier (NJ); Gennady Stolyarov (NV); Andrew R. Stolfi represented by Jan Vitus (OR); John Lacek (PA); Elizabeth Kelleher Dwyer and Beth Vollucci (RI); Christina Rouleau (VT); and Michael Walker (WA). Also participating was: Sandra Darby (ME).

1. Adopted its April 27 Minutes

The Working Group met April 27 and took the following actions: 1) adopted its March 11 minutes; and 2) held a panel discussion on cannabis insurance-related legislation.

Ms. Brown made a motion, seconded by Mr. Lacek, to adopt the Working Group’s April 27 minutes (Attachment Two-A1a). The motion passed unanimously.

2. Discussed a Draft Memo to the Government Relations (EX) Leadership Council

Ms. Michael stated that the memo satisfies the Working Group’s first and second work plan items for 2021. It is important to note that this is a draft memo from the Working Group to the Government Relations (EX) Leadership Council, and it does not represent the NAIC’s position. All NAIC policy positions go through and are determined by the Leadership Council.

The Working Group is aiming to send the recommendations expeditiously to the Leadership Council. The memo is from the Working Group to the Leadership Council recommending that the Leadership Council consider supporting the Secure and Fair Enforcement (SAFE) Banking Act of 2019 (H.R. 1996/S. 910) and the Clarifying Law Around Insurance of Marijuana (CLAIM) Act (H.R. 2068/S. 862). These bills would help remove federal barriers for insurers to conduct business with any state legalized cannabis-related businesses, thereby helping to provide insurance coverage options for these commercial policyholders that will mitigate their business risks. These protections can improve insurance availability by supporting the growth of the cannabis business-related admitted market. Additionally, given that the Cole Memo randum was rescinded in 2018, the Working Group recommends to the Leadership Council that the NAIC support and advocate for the U.S. Department of Justice (DOJ) to release an updated memo or similar policy of discretionary enforcement. If legislation is not enacted this year, a newly issued memo or policy could provide some minimal level of assurance to insurers, leading to an increase in coverage provided in the admitted insurance market for cannabis businesses.

Mr. Walker asked whether this is an internal memo and if it is common to ask for interested parties to comment. Brooke Stringer (NAIC) stated that it is an internal memo, and although interested parties are being invited to comment on this memo, they are usually not invited to comment.

Lisa Brown (American Property Casualty Insurance Association—APCIA) recommended placing the SAFE Banking Act and the CLAIM Act paragraphs before the Cole Memorandum paragraph to indicate that those are a higher priority. Ms. Brown replied that reorganizing the paragraphs is not necessary since it is an internal memo, and the recommendations are clear.

Ms. Brown made a motion, seconded by Mr. Childs, to send the memo to the Leadership Council (Attachment Two-A1b). The motion passed unanimously.

3. Discussed a Draft Agenda for a Hearing on Market Barriers for Cannabis Insurance

Ms. Michael stated that the hearing is anticipated to be four to five hours in total, and it will be held virtually over multiple days in August. The hearing addresses the Working Group’s third work plan item for 2021. The Working Group felt that the hearing is important because the need and demand for cannabis insurance will only continue to increase as more states legalize cannabis. The hearing is aimed at providing the Working Group with feedback from insurers on what state insurance regulators can do to help remove the barriers insurers are experiencing in offering coverage.
The draft agenda includes four parts. The first section is to provide a foundation of understanding and an overview. It begins by having a legal expert, such as Ian Stewart (Wilson Elser) who presented at the Working Group’s panel discussion, review what states have legalized cannabis, the impact of increasing legalization by states, and federal regulations. It then progresses to having an organization like CANN-RA discuss the regulatory landscape. It concludes with a discussion on underwriting and risk. Potential speakers for this include someone from the Insurance Services Office (ISO) and an academic from East Carolina University. The second section focuses on insurance product availability, including identifying insurance needs, current offerings and gaps. Potential speakers include Summer Jenkins from the National Cannabis Industry Association (NCIA) and Cannasure, Keri Kish from the Wholesale & Specialty Insurance Association (WSIA), and possibly another speaker from an organization similar to the NCIA. The third section addresses barriers to offering coverage. It includes federal versus state legalization differences and interstate considerations, potentially presented by a legal expert like Mr. Stewart. It also includes discussion on crop insurance and reinsurance considerations. Potential presenter suggestions are needed on these. The fourth section includes a panel question and answer (Q&A) style discussion on what is on the horizon and how state insurance regulators can help. Potential panelists include Mr. Stewart, Ms. Jenkins, the Golden Bear General Counsel, and another admitted insurer. It also includes a discussion by the Working Group on how to collaborate better.

Ms. Brown stated that CANN-RA is a new organization that is somewhat similar to the NAIC. Its members are the state regulatory agencies overseeing cannabis in states that have legalized cannabis for medical and/or recreational use. The NCIA is a trade group of organizations involved in the cannabis industry.

David Kodama (Surplus Lines Association of California) asked if the hearing would be virtual, in-person or hybrid. Ms. Michael stated that the hearing would be virtual.

Ms. Darby asked when the hearing would be held. Ms. Michael stated that the hearing would be held in segments over multiple days in August, likely in connection with the NAIC Summer National Meeting.

Ms. Brown made a motion, seconded by Mr. Childs, to proceed with implementing the hearing agenda. The motion passed unanimously.

4. Discussed Objectives on an Appendix to the NAIC Understanding the Market for Cannabis Insurance White Paper

Ms. Michael stated that the Working Group adopted the NAIC Understanding the Market for Cannabis Insurance white paper in July 2019. The white paper explored regulatory issues related to insurance in the cannabis industry, including how insurance rates are set; legal and regulatory authority at the federal, state and local levels; cannabis operations; and best practices. Much has happened in this space since the white paper’s adoption in 2019. As such, the Working Group determined during its work plan discussion that it should consider updating the white paper through the addition of an appendix. Drafting sessions on the appendix will begin shortly after the hearing. Ms. Michael invited Working Group members to notify Anne Obersteadt (NAIC) at aobersteadt@naic.org by June 10 if they want to participate in the drafting group. The appendix objectives include providing an update on the legalization of cannabis and how the industry is being insured. They also include taking a closer look at hemp and crop insurance, directors’ and officers’ coverage, reinsurance requirements, and interstate transportation issues. Discussion on innovations and emerging products, barriers to the admitted market, and how state insurance regulators can assist in this area are also proposed topics.

Mr. Stolyarov asked for clarification on what the objectives represent. Ms. Michael stated that they represent the goals of what the appendix should include.

Having no further business, the Cannabis Insurance (C) Working Group adjourned.
Cannabis Insurance (C) Working Group
Virtual Meeting
April 27, 2021

The Cannabis Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met April 27, 2021. The following Working Group members participated: Ricardo Lara, Chair, represented by Melerie Michael (CA); Michael Conway, Vice Chair, represented by Peg Brown (CO); Lori K. Wing-Heier represented by Austin Childs (AK); Angel King (DC); Michael Gould (DE); C.J. Metcalf (IL); Marlene Caride represented by Randall Currier (NJ); Gennady Stolyarov and Mark Garratt (NV); Cuc Nguyen (OK); Andrew R. Stolfi represented by TK Keen (OR); Mike McKenney (PA); Elizabeth Kelleher Dwyer and Beth Vollucci (RI); Christina Rouleau (VT); and Michael Walker (WA).

1. Adopted its March 11 Minutes

The Working Group met March 11 and discussed its 2021 work plan.

Ms. Brown made a motion, seconded by Mr. McKenney, to adopt the Working Group’s March 11 minutes (see NAIC Proceedings – Spring 2021, Property and Casualty Insurance (C) Committee, Attachment One) with the correction to remove the extra “Brown” typo throughout the document. The motion passed unanimously.

2. Held a Panel Discussion on Cannabis Insurance-Related Legislation

Ian Stewart (Wilson Elser) stated that there is public support for broad legalization. Almost seven in 10 adults surveyed by Quinnipiac University in April said marijuana use should be legal, regardless of political party affiliation. A September Gallup poll found that 68% of people favored the legalization of marijuana, including majorities of most demographic subgroups. However, there is considerable variation in the level of support within each group, as men, younger adults, college graduates and wealthier households are more likely to favor legalization. An April Pew Research Center survey found support for legal marijuana for medical and recreational use at 60% and for medical use only at 31%. An April CBS poll found that most adults support legalizing the recreational use of marijuana in their states. 59% of respondents supported expunging the criminal records of those with past marijuana convictions. 54% of respondents felt that legalized marijuana has no effect on crime. However, 53% disagree that consuming openly is socially acceptable.

Thirty-five states have medical marijuana programs, and 15 states and Washington, DC permit adult use of cannabis. Every state except Idaho (legislation is currently pending) permits hemp cultivation under either the Agricultural Act of 2014 or the 2018 Farm Bill. For the 2021 growing season, five states (Arizona, New Jersey, Mississippi, Montana and South Dakota) will operate under the 2018 Farm Bill; 20 states will continue to operate under the Agricultural Act of 2014; and 23 states will operate under the ballot initiatives to legalize adult-use and medical marijuana. New York and New Mexico passed adult-use legislation in early April. Virginia will allow personal possession of small amounts of cannabis on July 1, with adult-use retail sales set to begin Jan 1, 2024. Adult-use legislation is currently being considered in Connecticut, Minnesota, Pennsylvania, Rhode Island and Wisconsin. Adult-use ballot initiatives in 2022 are expected in Arkansas, Florida, Missouri, Ohio and Oklahoma.

Under federal law, marijuana is still a Schedule I illegal substance. U.S. Senate Majority Leader Chuck Schumer (D-NY) has made marijuana reform a top priority. In April, the U.S. House of Representatives (House) passed the Secure and Fair Enforcement (SAFE) Banking Act of 2021. The SAFE Banking Act creates a “safe harbor” to protect federal depository institutions and credit unions from federal prosecution if they work with marijuana-related businesses and ancillary companies in legal states. The Clarifying Law Around Insurance of Marijuana (CLAIM) Act was reintroduced in mid-March to coincide with the reintroduction of the SAFE Banking Act. It will “create a safe harbor for insurers engaging in the business of insurance in connection with a cannabis-related legitimate business, and for other purposes.”

The Marijuana Opportunity Reinvestment and Expungement (MORE) Act of 2019 would decriminalize cannabis by descheduling cannabis from the Controlled Substances Act (CSA) and enacting various criminal and social justice reforms related to cannabis, including the expungement of prior marijuana-related convictions. U.S. Sen. Cory Booker (D-NJ), U.S. Sen. Ron Wyden (D-OR), and U.S. Senate Majority Leader Schumer (D-NY) will introduce new legislation (MORE 2.0) to legalize cannabis. The bill will propose some combination of decriminalizing cannabis, giving states more authority to independently regulate cannabis, and allowing states to import and export cannabis to or from neighboring states. However, passage is
There is political maneuvering right now at the federal level around the use of the terms “decriminalization” and “legalization.” Decriminalizing marijuana means that individuals possessing or using marijuana will be subject to lesser punishment, such as a criminal record and possible jail time. Legalization would mean that one may possess or use the drug according to the guidelines and limitations governing marijuana use. President Biden’s administration has communicated that it is in favor of re-scheduling, rather than de-scheduling, marijuana. This is the prescription drug model, and it is not consistent with either the additional or adult-use markets.

Unresolved issues include determining what federal agencies will regulate legalized marijuana if the U.S. Food and Drug Administration (FDA) will regulate some but not all cannabinoids and how state regulations and interstate commerce will be handled. Additionally, accurately measuring intoxication remains an issue affecting road and workplace safety. Hemp-derived cannabinoids, such as Delta-8 THC, are another concern. Delta-8 THC is an analogue of THC that contains neuroprotective properties that can increase appetite and reduce nausea, anxiety and pain. It produces some psychotropic effects that are less potent than Delta-9, the primary form of THC found in cannabis. Industry stakeholders disagree over if it is federally legal and whether it presents a market opportunity for hemp and cannabis businesses. There is also potential for toxic tort and environment exposures. It is currently an uninsured risk, and insurers are pivoting in a similar way as they did after the vape crises. There has not been much bodily injury product litigation yet because the long-term exposures are not yet fully known. However, the American College of Cardiology put out a warning to its members last year about the risks of vascular incidents, even in young people, who are exposed to high levels. Studies are showing epigenetic issues and other issues involving gender differences and age differences with marijuana. State insurance regulators should be aware of the possibility for large, potentially uninsured risk and exposure five or 10 years from now.

Mona Dooley (American Property Casualty Insurance Association—APCIA) and Jon Bergner (National Association of Mutual Insurance Companies—NAMIC) stated that despite state legalization and court decisions mandating medical marijuana reimbursement, cannabis is illegal at the federal level. Participating in any way opens insurers to federal criminal and civil liability (aiding and abetting under the CSA and the Racketeer Influenced and Corrupt Organizations Act [RICO]). For example, under RICO statute, a private citizen can bring a civil case against an illegal operation and all those involved, including the insurer. The 2018 Farm Bill legalized industrial hemp, defined as containing no more than 0.3% THC. The Final Rule published Jan. 19 raised the acceptable hemp THC level threshold from 0.5% to 1%. The challenge for insurers is differentiating between cannabis and hemp in underwriting. None of the past federal actions have resolved the conflict between state and federal law. Further, Executive Action by the president is not enough; legislation is needed.

The SAFE Banking Act provides legal safe harbor for banks providing services to cannabis-related legitimate businesses, but it does not apply to other financial services like insurance. The last U.S. Congress (Congress) worked to include insurance into the SAFE Banking Act, but the Committee’s success in doing so was not done well. The insurance industry helped to craft the CLAIM Act to provide standalone legislation to create a safe harbor for insurers engaging in business with cannabis-related businesses. The strategy was to add CLAIM Act language to the SAFE Banking Act when it was brought to the House floor. The SAFE Banking Act passed the House with CLAIM Act-based language. However, it was combined with “criminal justice reform” and collapsed under its own weight. The SAFE Banking Act was reintroduced in the House and Senate in March with insurance language and passed by the House on April 19. Conventional wisdom would indicate that the current political environment is favorable to passing cannabis-related legislation. However, this is tempered with the likely push for other provisions in Congress, which could lead to it again collapsing under its own weight.

The data is starting to come in showing that increased marijuana use affects public safety. A recent American Auto Association (AAA) Foundation for Traffic Safety survey found that an estimated 14.8 million drivers reported driving within one hour of using marijuana in the past 30 days, and nearly 70% of Americans in the same survey believe it is unlikely that a driver will be caught by the police while high on marijuana. Additionally, a 2018 Insurance Institute for Highway Safety (IIHS)/Highway Loss Data Institute (HLDI) study found that roadway crashes increased by approximately 6% in four states that legalized marijuana, as compared to neighboring states that have not legalized marijuana for recreational use. Driving under the influence of any drug, including marijuana, remains illegal in all 50 states and Washington, DC. However, there is no standard or reliable methodology to determine marijuana impairment. Regardless of whether one supports or opposes legalizing marijuana, most believe it is critical to prevent marijuana-impaired driving. An APCIA online national survey conducted on Sept. 6, 2019, found strong public support for the development of an impairment standard.

Federal restrictions on scientific research into marijuana’s effects has resulted in a lack of effort into the development of a meaningful impairment standard and related testing technology. The National Highway Traffic Safety

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Administration’s (NHTSA’s) 2017 Marijuana-Impaired Driving Report to Congress recommended continued research to enable the development of an impairment standard for driving under the influence of cannabis. Given the number of federal agencies involved, easing the restrictions on marijuana research involves several different Congressional committees, and efforts to date have not been successful. However, legislation advanced much farther in the last Congress, and the momentum continues to grow. The Drug Enforcement Administration (DEA) issued a final rule in December 2020, “Controls to Enhance the Cultivation of Marihuana for Research in the United States.” Sec. 3014 of the America’s Transportation Infrastructure Act of 2019 (H.R. 2 from 116th Congress) directs the U.S. Depart of Transportation (DOT) to coordinate with the U.S. Department of Justice (DOJ) and the U.S. Department of Health and Human Services (HHS) to produce a report and recommendations on how to allow for expanded research into marijuana impaired driving. The Medical Marijuana Research Act (H.R. 3797 from 116th Congress) would allow scientists to access cannabis from state legal dispensaries so that they can study products that are available to consumers in commercial markets. The Cannabidiol and Marihuana Research Expansion Act (S. 2032 from the 116th Congress) requires further study of marijuana impairment and provides safe harbor for universities conducting marijuana research.

Michael Correia (National Cannabis Industry Association—NCIA) stated that Congress is lagging in public support of cannabis-related legislative reform by six to 10 years. There is an ongoing debate on whether reform should be done incrementally or comprehensively, especially considering the large number of states that have passed cannabis-related legislation. Unfortunately, there is currently not enough republican support to pass comprehensive legislation. The SAFE Banking Act has passed the House, and it has a chance of passing the Senate with enough republican and moderate democrat support. The SAFE Banking Act is not a cannabis bill; it is a safe banking bill, which helps avoid all the controversies that arise with a cannabis reform bill. However, the MORE 2.0 bill is not likely to garner enough bipartisan support. Delta-8 will be a major policy issue, and the NCIA will be discussing it in its meeting tomorrow.

Ms. Brown asked what the support is for addressing the issue in incremental pieces. Mr. Correia stated that there is support for incremental reform; however, it is being held back by some of the left-leaning democrats who fear incremental reform will diminish the energy for comprehensive reform. He believes it is a better course to take incremental reform now and then focus on comprehensive reform. Mr. Bergner stated that he agrees and noted that the prior Congress boxed themselves in when they stated that it was unfair to help banks and insurers and not the average person. Ms. Dooley also concurred and added that there is the potential for a medical marijuana research bill to pass both sides of Congress if every democrat were to be in favor of it.

Mr. Gould asked the panelists via email after the Working Group call for their impressions of whether and how issues surrounding compensation insurance, particularly with respect to increased costs for employers, are having an impact on the support for political reform. He also asked what the political views are on the impact of broader reforms on premiums or, alternatively, of marijuana therapy on driving down claims costs and absences as compared to opioid therapy. Mr. Bergner stated that he does not believe workers’ compensation insurance or the issues surrounding it are having any impact on the political debate (outside of the underlying justification for insurance being included in SAFE Banking Act because carriers are being compelled to participate in legalized cannabis regimes in various states). ‘However, workers compensation carriers are looking at studies very closely and trying to understand whether cannabis is indeed a preferable alternative to opioids. While there is hope that this bears out, it is tempered with the understanding that there is not a lot of understanding about long-term cannabis use. Mr. Stewart stated that he agrees and noted that workers’ compensation is based on state law that varies widely from state to state and is affected very little at the federal level. He believes federal reform should facilitate further research on medical cannabis and the endocannabinoid system more generally.

Having no further business, the Cannabis Insurance (C) Working Group adjourned.
To: Government Relations (EX) Leadership Council

From: Members of the Cannabis Insurance (C) Working Group

Date: May 21, 2021

Re: Position Recommendation for the Cole Memo, SAFE Banking Act, and CLAIM Act

STATEMENT OF ISSUE:

Legalization of cannabis has been debated for decades. Cannabis was once prohibited nationwide; however, some states have passed laws legalizing the use of cannabis for either medical and/or recreational use. This creates an issue as cannabis is still illegal federally because it is listed as a prohibited substance on the federal Controlled Substance Act (CSA) 1. Since cannabis is listed under the CSA, three main federal criminal laws are triggered when individuals are engaging in transactions involving cannabis or proceeds from cannabis. The three criminal laws are as follows.

1. The federal Bank Secrecy Act (BSA) 2 which requires “financial institutions” to report to the Treasury Department any transactions over $5,000 that the institution knows, or has reason to know, involve assets derived from illegal sources;
2. The federal money laundering statute 3 which makes it a felony for any person to engage in a financial transaction that the individual knows involves the proceeds of an unlawful activity; and,
3. The federal unlicensed money transmitter statute 4 which states that it is a felony to engage in an unlicensed money transmitting business.

“Financial institution” is defined broadly and includes banks, credit unions, broker-dealers, insurance companies, pawnbrokers, travel agencies, and a host of other institutions that may come into contact with assets derived from illegal sources. 5 The federal laws create an obstacle for admitted market insurers to participate in providing coverage to cannabis-related businesses.

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5 31 U.S.C. 5312(a)(2)

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Enforcement of the Federal Laws

Cole Memo: In August 2013, then U.S. Deputy Attorney General James Cole issued a memorandum that announced guidance to U.S. Department of Justice (DOJ) attorneys on the Obama administration’s priorities in the prosecution of cannabis-related federal crimes. The memo concluded that, with some exceptions, the federal government would exercise discretion in its enforcement determinations in jurisdictions that had implemented strong, effective regulatory and enforcement systems to control cultivation, distribution, sale, and possession of cannabis for industrial or recreational use. The memo indicated that the DOJ would not actively seek to prosecute cannabis transactions that are legal under state law. In February 2014, U.S. Deputy Attorney General James Cole issued another memo that further reinforced the 2013 enforcement priorities, specifically as they relate to the prosecution of marijuana-related financial crimes.

In January 2018, former Attorney General Jeff Sessions rescinded the Cole Memorandum by way of his own memorandum that emphasized the DOJ’s “well-established principles” with regard to the prosecution of cannabis crimes. This action left financial institutions that accept money from cannabis-related businesses potentially exposed to violations of federal law, including money laundering statutes. In 2019, Attorney General William Barr indicated he would not pursue cannabis businesses that are operating legally within their state jurisdiction. This declaration, however, does not provide insurers or other entities engaging with cannabis businesses any assurance that the forbearance extends to financial institutions.

Attorney General Merrick Garland was confirmed in March 2021. During his nomination hearing, Garland was asked about whether he would reinstate a Cole Memo and in response, Garland suggested a return to a Cole-like prioritization. Garland said he believes that with DOJ’s limited resources, it would not be a good use of limited resources to be pursuing prosecution in states that have legalized, and that are regulating the use of marijuana, either medically or otherwise. There has yet to be an official memo released. When the NAIC Cannabis Insurance (C) Working Group heard from a panel of experts from the insurance and cannabis industry on April 27, 2021, it was noted that it is likely an updated memo will come in 2021; however, experts from the panel also speculated that Attorney General Garland may be giving time to the Congress to pass legislation first. The experts also noted that while an updated memo would be appreciated, it will not provide the same protections as legislation since the memo will be subject to change in subsequent administrations.

Secure and Fair Enforcement (SAFE) Banking Act (H.R. 1996/S. 910): The SAFE Banking Act by Representative Perlmutter (D-CO) and Senator Merkley (D-OR) is one of two pending measures in Congress that would provide a “safe harbor” from violations of federal law for financial institutions, including insurers, that provide financial services to cannabis-related businesses that are permissible under state law. The House passed H.R. 1996 in April 2021 by a bipartisan vote of 321-101. The Senate companion bill, S. 910, has been introduced but has not yet been acted upon. In the last Congress, the


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SAFE Banking Act passed the House several times, but the Senate did not take it up. Some of the expert panelists that the Working Group heard from in April indicated that there was a desire to add other provisions to this bill essentially transforming it into a cannabis legalization bill, rather than a banking bill. The expert panel noted that if this bill remains a banking bill, there is a good chance that this bill could be taken up in the Senate and be signed into law. It is unclear, however, if the situation this year will be different. It has been stated that 2021 is a different climate given the change in the Administration and the Senate. It is important to note that Representative Perlmutter has actively sought the NAIC’s public support of his measure.

**Clarifying Law Around Insurance of Marijuana (CLAIM) Act (H.R. 2068/S. 862):** The CLAIM Act by Senator Menendez (D-NJ) and Representative Velazquez (D-NY) is broader than the SAFE Banking Act from an insurance perspective and would provide specific protections for those engaged in the business of insurance with policyholders that either directly or indirectly participate in cannabis industry activity that is permissible under state law. Members of the expert panel characterized the CLAIM Act as a bill largely introduced to use as leverage to include insurers within the SAFE Banking Act and to keep insurers as one of the included financial service industries. According to the experts on our panel, it is unlikely that this bill alone will move through the Congress.

**RECOMMENDATION FOR GRLC:**

Members of the Cannabis Insurance (C) Working Group recommend to the Government Relations (EX) Leadership Council (GRLC) that the GRLC membership issue letters in support and advocate for the passage of the SAFE Banking Act and CLAIM Act (Attachment A). The proposed bills will expand insurance coverage options for businesses and remove federal barriers for insurers to conduct business with cannabis-related businesses that are legal in their respective states. Since both bills may move through the legislative process, it is best to support both as they provide the protections to the insurance industry. With these protections, we can see an increase in the admitted market for insurance availability in relation to cannabis businesses.

Additionally, the members of the Cannabis Working Group recommend to GRLC that the NAIC support and advocate for the Department of Justice to release an updated memo or similar policy of discretionary enforcement. If legislation is not enacted this year, a newly-issued memo or policy could provide some minimal level of assurance to insurers, leading to an increase in coverage provided in the admitted insurance market for cannabis businesses.
The Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met Dec. 12, 2021, in joint session with the NAIC/FEMA (C) Advisory Group of the Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee. The following Working Group and Advisory Group members participated: Mike Chaney, Chair (MS); Katie Hegland (AK); Jimmy Harris (AR); Ken Allen (CA); George Bradner and Wanchin Chou (CT); Susanne Murphy (FL); Martha Im (HI); Doug Ommen (IA); Susan Berry (IL); Heather Droge (KS); Warren Byrd (LA); Joy Hatchette (MD); Jo LeDuc (MO); Tracy Biehn (NC); Tom Botsko (OH); TK Keen (OR); David Buono (PA); Megan Mihara (RI); Mark Worman (TX); Trey Hancock (TN); David Forte (WA); and Allan L. McVey (WV).

1. **Adopted the Catastrophe Insurance (C) Working Group’s Summer National Meeting Minutes**

Mr. Byrd made a motion, seconded by Mr. McVey to adopt the Catastrophe Insurance (C) Working Group’s July 22 minutes (see NAIC Proceedings – Summer 2021, Property and Casualty Insurance (C) Committee, Attachment Three). The motion passed unanimously.

2. **Adopted the NAIC/FEMA (C) Advisory Group’s Nov. 15 Minutes**

Ms. LeDuc made a motion, seconded by Commissioner Ommen, to adopt the NAIC/FEMA (C) Advisory Group’s Nov. 15 (Attachment Three-A) minutes. The motion passed unanimously.

3. **Heard a Report from FEMA on Risk Rating 2.0**

David Maurstad (FEMA) said more frequent and intense flooding events are occurring due to changing weather patterns. He said the Risk Rating 2.0 rating system is fair, equitable, and designed to adapt to the changing weather patterns.

The National Flood Insurance Program (NFIP) recognizes there are still concerns about Risk Rating 2.0. It is important to note that under the legacy NFIP pricing scheme, all policyholders have seen an average increase of 11% per year over the past number of years and would have continued to see increases year after year had Risk Rating 2.0 not been implemented. Risk Rating 2.0 takes an individual property’s unique flood risk into consideration.

With the use of advanced technological and mapping capabilities, Risk Rating 2.0 will provide a property’s true flood risk and equip property owners with the information they need to make informed decisions about mitigation actions. The new rating methodology has also exposed long-standing inequities in the pricing of flood insurance. Under the legacy rating system, people in lower value homes were paying more than they should have been paying, and people with higher value homes were paying less than they should have been paying. Risk Rating 2.0 will correct these inequities.

Two-thirds of the oldest Pre-Flood Insurance Rate Map (Pre-FIRM) homes have some of the highest flood insurance rates in the NFIP today. The implementation of Risk Rating 2.0 will correct this problem, and approximately one-fourth, or a little more than 1 million, of NFIP policyholders will see a decrease in their insurance costs. There will also be comparable premium increases for some policyholders. In the case of premium increases, a premium will not increase more than 18% per year.

The NFIP has taken a phased approach to the implementation of Risk Rating 2.0. Phase I began by allowing existing NFIP policyholders to take advantage of premium decreases on their renewal date, beginning Oct. 1. Additionally, new policies began being sold on Oct. 1. The premiums for new policies will no longer be subsidized by the NFIP, and the full-risk rate will be paid. Premiums will increase 18% per year until the full-risk rate has been achieved.

As of Dec. 5, the NFIP has sold more than 52,500 new policies under Risk Rating 2.0, and 4,800 NFIP policyholders have renewed their coverage. Under Risk Rating 2.0, 81% of renewals have seen a decrease in premium as compared to their prior NFIP premium, which reflects an average savings of $1,600 per year, or $139 per month. For those seeing a price increase, the increase is an average of $139 per year, or $13 per month, and the median cost for single-family homes with maximum coverage is $764.
Phase II of Risk Rating 2.0 will begin April 1, 2022. Under Phase II, all NFIP policies will be written under Risk Rating 2.0 on their renewal date. This phase will end on March 31, 2023, allowing policyholders extra time to prepare.

Risk Rating 2.0 includes the capability and tools to incorporate flood risk variables, such as multiple flood frequencies beyond the 1% annual chance events. These events include: 1) river overflow; 2) storm surge; 3) coastal erosion; and 4) heavy rainfall. Risk Rating 2.0 also takes a property’s characteristics into account, such as distance to a water source and the cost to rebuild.

Risk Rating 2.0 incorporates private sector data sets, catastrophe modeling, and evolving actuarial science. FEMA mapping in conjunction with NFIP policy and claims data is used in Risk Rating 2.0. Data obtained from the National Oceanic and Atmospheric Administration (NOAA), the United States Geological Survey (USGS), and the U.S. Army Corps of Engineers is also used, as well as additional third-party commercially available structural and replacement cost data.

The NFIP is upholding the statutory limits of 18% increases per year. Things that will not change with Risk Rating 2.0 include: 1) flood plain management; and 2) premium discounts for Pre-FIRM subsidized and newly mapped properties. Additionally, policyholders will still be able to transfer their rate discount to a new owner by assigning the flood insurance policy when the property ownership changes.

Discounts from 5% to 45% for policyholders in communities that participate in the Community Rating System (CRS) will continue. However, the discount will be applied uniformly to all policies throughout the participating community regardless of whether the structure is inside or outside the Special Flood Hazard Area (SFHA).

Mr. Maurstad said one misconception under the old rating system is that insurance rates are not subject to regular increases. He said rates increased every year for all policyholders prior to Risk Rating 2.0. Last year, the NFIP premiums increased by an average of 11.3%, which is approximately $8 per month.

Mr. Maurstad said under the new pricing structure, two-thirds of the policyholders will see a $0 to $10 per month increase in their flood insurance premiums. Seven percent of NFIP policyholders will see an increase of $10 to $20 per month. Four percent of the NFIP policyholders will see a $20 or more increase in their flood insurance premium per month. The $20 or more increases are for higher valued homes and homes in high-risk areas; this is also true under the NFIP legacy rating system.

Under the legacy rating system, 35,000 single-family policyholders have been seeing increases of more than $100 per month. The single-family homeowners in this group have an average replacement cost of $399,643. Under Risk Rating 2.0 only 3,246 single-family policyholders will see premium increases of more than $100 per month. However, the single-family homeowners in this group have a replacement cost value of more than $1 million. Currently, 3,000 single-family policyholders pay a premium between $12,000 and $45,000. Risk Rating 2.0 has an upper bound that limits cost on the highest end of the spectrum. Under Risk Rating 2.0, policyholders will pay no more than $12,125 for their policies.

Mr. Maurstad said stakeholders have weighed in on the impact that Risk Rating 2.0 will have on communities and policyholders. The National Association of Realtors (NAR), representing 1.4 million policyholders, backs the new pricing methodology and acknowledges that Risk Rating 2.0 will help ensure that NFIP policyholders pay premiums proportionate to their property’s risk.

Mr. Maurstad said affordability was an issue under the NFIP legacy rating system and will continue to be a concern under Risk Rating 2.0. He said the NFIP believes that the affordability framework released in 2018 will continue to be a valuable resource. President Joe Biden’s budget for fiscal year 2022 includes a legislative proposal, which, if approved, would establish a target means tested assistance program offering low- and moderate-income policyholders a graduated premium discount benefit. FEMA would implement the program so that the eligible low to moderate income policyholders see both the full-risk price and the means-tested assistance they receive so that they understand their full risk. The NFIP will continue to work with the administration’s team and the U.S. Congress on ways to reduce barriers to flood insurance and address mitigation options to achieve resiliencies for all communities.

Mr. Bradner asked how the gap can be fixed that many people fall into with not having the appropriate coverage, as it is important for consumers to know what their risk is. He said originally there was a scoring methodology to help people understand their risk and make an informed decision.
Mr. Maurstad said part of the unintended consequences originally associated with establishing the mandatory purchase area was that if a homeowner’s property was in that area, then they had flood risk and were required to buy flood insurance; if a homeowner’s property was outside that area, they had no risk and were not required to buy flood insurance. Risk Rating 2.0 recognizes a graduated risk throughout a community, and the pricing of the premium reflects this risk.

Mr. Maurstad reminded Working Group and Advisory Group members that the NFIP not only provided flood insurance, but also it was responsible for flood plain management, mitigation assistance grants, and flood risk mitigation. He said the NFIP is also making changes in the way it communicates flood risk. The NFIP is working with Congress through the reauthorization process on communication changes.

Mr. Maurstad said he believes Risk Rating 2.0 promotes mitigation in a different way than it has in the past. As people better understand their flood risk, especially those outside the high-risk area, homeowners will be encouraged to take mitigation actions to make their property safer and more resilient to flood events, to protect their property, and to protect their family from the devastating impacts of flood risk. Some areas will see less of an impact on premiums due to mitigation efforts.

Mr. Byrd said it was his understanding that an elevation certificate was no longer needed, but NFIP charts indicate first-floor elevation. He asked how this will be determined. Mr. Maurstad said the elevation certificate will no longer be required because the NFIP is getting first-floor data from a commercial vendor. He said if someone already has an elevation certificate, or if someone believes that an elevation certificate makes sense for them, the NFIP will use the information on their elevation certificate if it is to their benefit.

Mr. Byrd asked if there were any conditions on the transfer of flood insurance rate to a new homeowner if the property is sold. Mr. Maurstad said there were no conditions.

Mr. Chou asked about the catastrophe model evaluation process. Mr. Maurstad said the NFIP takes the catastrophe models and evaluates each individual model for its strengths and differences. Each model is evaluated against the known flood risk data. Mr. Maurstad said he will FEMA’s actuaries follow-up with more detailed information.

4. Heard a Report from FEMA on FEMA Structure and Regional Flood Insurance Specialists

Edith Lohmann (FEMA) said FEMA’s headquarters are in Washington, DC. However, there are 10 regional offices across the country broken down by state. There is at least one flood insurance specialist assigned to each FEMA region. Each of the regional offices acts as a liaison to FEMA headquarters and work in concert with the headquarters teams. The FEMA regional offices give FEMA the opportunity to have a local presence where they can customize and tailor their activities and outreach to their customers and partners in the various states.

Ms. Lohmann said regional flood insurance specialists work with consumers regarding questions and problems related to flood insurance. Flood insurance specialists also work with their partners, such as the NAIC and the departments of insurance (DOIs), as well as property owners, renters, real estate agents, lenders, appraisers, local insurance agents, surveyors, engineers, builders, or anyone else who is interested in flood insurance as a mitigation option to reduce disaster suffering.

Ms. Lohmann said flood insurance specialists are instrumental in assisting and facilitating the implementation of the NFIP’s program changes, such as Risk Rating 2.0, flood map changes, flood mitigation projects, or a new development that is being built in a particular community. Flood insurance specialists work closely with their federal, state, local, tribal partners, and DOIs.

Ms. Lohmann said flood insurance specialists do a lot of outreach and education and training. She said they also provide technical assistance to individuals or groups of consumers in public settings. Ms. Lohmann said flood insurance specialists can provide clarity on any types of claims, underwriting, or policy coverage questions or issues that arise. She said flood insurance specialists are available to provide support before, during, and after disasters. Ms. Lohmann said flood insurance specialists participate in public awareness events and all types of activities. She encouraged state insurance regulators to reach out to their regional flood insurance specialist.
5. **Received an Update on the NAIC Catastrophe Resource Center**

Jennifer Gardner (NAIC) showed the location of the Catastrophe Resource Center. She highlighted the catastrophe contact list and asked states that were not on this list to reach out to NAIC staff to provide this information. Ms. Gardner explained each of the tabs located on the page, as well as the information available.

6. **Heard an Update on Hurricane Ida**

Mr. Byrd said Hurricane Ida struck on the 16th anniversary of Hurricane Katrina. Hurricane Ida was close to being a Category 5 hurricane. He said AIR Worldwide’s original insured losses to onshore property were somewhere between $17 billion and $25 billion. These estimates include physical damage to residential, industrial, and commercial properties, as well as automobile losses. The estimates do not include flood damage and are based on the current higher material costs. AIR Worldwide estimates an additional cost to insurers of $2.5 billion to $5 billion for inland flood losses.

Karen Clark & Company (KCC) estimated insured losses to be nearly $18 billion, with only $40 million of these costs for losses in the Caribbean and the rest for losses in the U.S. These estimates include physical damage to residential, industrial, and commercial properties, as well as automobile losses.

Temporary adjusters were hired to help after the disaster, and Louisiana has issued or reinstated licenses to 14,625 adjusters to help in this effort. Four thousand three hundred and seventy-five of these licenses are for catastrophe adjuster registrations, which is not a full license, but an insurer can advise the state if it is bringing on additional catastrophe adjusters.

As of Nov. 15, Louisiana had a total of 116,112 actively licensed claims adjusters, which is an increase of approximately 12,000 adjusters in a two-and-a-half-month period. One thousand five hundred and eighty licenses per month are being issued.

Mr. Byrd said Commissioner James J. Donelon (LA) issued Emergency Rule 47 for the 25 parishes that were affected by Hurricane Ida. Emergency Rule 47 provided for the suspension of certain statutes related to all types of insurance and all types of insurers doing business in Louisiana. However, reinsurers were not included. The statutes suspended included: 1) inability to cancel; 2) inability to terminate; 3) non-renewal; and 4) non-reinstate. Emergency Rule 47 protected policyholders from cancellation for non-payment of premium until after the emergency rule expired on Oct. 24; insurance could also not be cancelled solely due to filing a claim because of Hurricane Ida.

Bulletin number 2021-07 was also issued to address the issue of the civil authority loss of use. This is typically in effect for a maximum of 14 days and allows for extra expenses. One insurer took the DOI to task on this and is awaiting a final judgement. Commissioner Donelon issued Directive 218, telling insurers to honor reasonable expenses incurred for evacuation.

Bulletin 2021-08 and Bulletin 2021-09 were also issued. These bulletins reminded insurers to be careful of how they adjusted claims with the policyholder, including to treat the policyholder with respect throughout the adjusting process. Louisiana has a policyholder Bill of Rights set forth in their insurance code, and the bulletins called attention to the bill of rights. The bill of rights requires an adjuster’s report to be given to the policyholder if the policyholder requests the report.

Louisiana has a provision in its law stating a claim is to be initiated in 14 days. However, if a catastrophe occurs that changes to 30 days, the commissioner can extend it an additional 30 more days. This was done in Emergency Rule 47 and was extended to 60 days. Hurricane Ida could not be used for cancellation and non-renewal and could not be used as a material change in a policyholder’s risk.

Mr. Byrd said Louisiana did allow insurers in first-party claims to deduct any unpaid premium when they adjusted the claim. He said they cautioned insurers that there are two statutes on the books in Louisiana that require insurers to pay any undisputed portion of a claim within 30 days from satisfactory proof of loss. The insurers were cautioned that they would be exposing themselves to time-and-a-half damages plus attorney fees if this time frame was not met.

Mr. Byrd said Louisiana issued a data call to insurers. This is referenced in Bulletin 2021-10. The first report is due in January 2022. As of Nov. 28, the total NFIP claims paid totaled $869 million. The highest number of claims were filed in Louisiana; Louisiana had 14,230 claims.
Mr. Byrd said complaints totaled 3,003. Most of the complaints encompassed: 1) adjusters not calling policyholders back; 2) changes in adjustment; and 3) not having any payment whatsoever for what the policyholder deemed to be undisputed portions of their claim.

7. Received a Report on the Update of the *Catastrophe Modeling Handbook*

Ms. Gardner said the Catastrophe Insurance (C) Working Group met virtually in November to discuss the directive it received from the Climate and Resiliency (EX) Task Force to update the *Catastrophe Modeling Handbook*. The Working Group directed NAIC staff to send a survey to all states to obtain information regarding how the current *Catastrophe Modeling Handbook* is being used and what needs to be updated. NAIC staff received responses from 20 states.

The survey results indicated the sections regarding “General Overview of Catastrophe Models,” “Model Input Provided by Company,” “Model Output,” and “Model Validation and Update” were all sections of the handbook that are helpful to state insurance regulators.

The survey additionally asked if a state used the questions included in the handbook regarding evaluation of models. These questions include items a state insurance regulator would ask of the catastrophe model vendor and of an insurer that was using the model. The responses showed that eight states use the questions currently. Eight states do not use the questions, and four states indicated they used some of the questions.

The survey also asked if it would be helpful to include questions specific to other perils and asked members to name the perils they would like to see included. The most common responses were for flood and wildfire followed by severe convective storm.

These results represent a small sample of the information received in the surveys. NAIC staff are analyzing the results and putting together a summary for the drafting group to consider as it works through the updates to the handbook.

Ms. Gardner said a few regulators offered to participate in a drafting group to review the survey responses and work on the handbook revisions. She said if anyone would like to join that drafting group, contact Aaron Brandenburg or Sara Robben. The first drafting group meeting will take place in January 2022.

8. Discussed Future Engagements with FEMA

The Advisory Group plans to work with FEMA on future events. These events include a FEMA meeting for FEMA Region 6. This event will be hosted by Oklahoma sometime in the first quarter of 2022. If any other regions would like to hold a similar event, please let Commissioner Glen Mulready (OK) know.

The Missouri DOI will be hosting an earthquake event May 23–May 25, 2022. This event will be held in St. Louis, MO.

The Advisory Group will hear an update regarding the Cascadia Rising 2022 national event during a future meeting.

Future topics for discussion and presentation include: 1) the NFIP CRS and how state insurance regulators can work with their communities in improving those CRS ratings; 2) the latest data on the private flood insurance market and the NFIP; and 3) a report from the National Insurance Crime Bureau (NICB) about the geospatial insurance consortium and how state insurance regulators might be able to use this technology during disasters.

Having no further business, the Catastrophe Insurance (C) Working Group and NAIC/FEMA (C) Advisory Group adjourned.
The NAIC/FEMA (C) Advisory Group of the Catastrophe Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met Nov. 15, 2021. The following Advisory Group members participated: Glen Mulready, Chair (OK); Carter Lawrence, Vice Chair (TN); Brian Powell (AL); Lucy Jabourian (CA); George Bradner (CT); Travis Grassel (IA); Sharil Sivertson (KS); Warren Byrd (LA); Joy Hatchette (MD); Jo LeDuc (MO); Beth Vollucci (RI); Maggie Dell (SD); and Matt Stoutenburg (WA).

1. **Heard an Update on Risk Rating 2.0 From FEMA**

David Maurstad (Federal Emergency Management Agency—FEMA) said FEMA began using the Risk Rating 2.0 rating system Oct. 1. Risk Rating 2.0 is equitable, easy to understand and designed to adapt to the increasing perils of the changing climate. Mr. Maurstad said equity in action was developed with the uniqueness of each state and locality in mind. The increasing of dramatic weather events calls for action.

Mr. Maurstad said FEMA has taken a phased approach to the implementation of Risk Rating 2.0. Phase I of Risk Rating 2.0 kicked off with existing National Flood Insurance Program (NFIP) policyholders being able to take advantage of decreases on their policy renewal date. The NFIP also began selling new flood insurance policies on Oct. 1. Risk Rating 2.0 requires new policyholders, for any structure type located across the community, to pay full risk rates. New policies are no longer subsidized or discounted under the NFIP.

Mr. Maurstad said some of the initial reactions the NFIP has seen regarding the Risk Rating 2.0 rollout include: 1) the NFIP sold more than 28,000 new flood policies as of Nov. 7; 2) more than 2,100 current policyholders have renewed their flood insurance policies; 3) 82% of the policyholders renewing their flood insurance policies have seen a decrease in their premium; 4) policyholders renewing their NFIP policy have seen an average savings of $1,500 per year; and 5) policyholders renewing their NFIP policies that are seeing an increase are seeing an average increase in premium of $125 per year. He said the NFIP believes Risk Rating 2.0 will help to close the insurance gap.

Mr. Maurstad said as of April 1, 2022, the NFIP will use Risk Rating 2.0 to rate existing NFIP policies. Risk Rating 2.0 uses a broader range of variables, such as multiple flood frequencies beyond the 1% annual chance event and including river overflow, coastal erosion, storm surge, and heavy rainfall. The Risk Rating 2.0 variables also include a property’s characteristics such as distance to a water source, elevation, and the cost to rebuild.

Mr. Maurstad said with improved technology, the NFIP can help people to understand a single property’s flood risk profile. He said the NFIP is using its years of investment in flood hazard information, incorporating private sector data sets, using catastrophe models, and evolving actuarial science. Data sets incorporated into the Risk Rating 2.0 methodology include: 1) NFIP mapping and claims data; 2) United States Geological Survey (USGS) data; 3) National Oceanic and Atmospheric Administration (NOAA) data; and 4) data from the U.S. Army Corps of Engineers. The NFIP also uses third-party commercial structural data and replacement cost data.

Mr. Maurstad said under FEMA’s legacy rating system, flood insurance rates were subject to regular annual increases. He said NFIP flood insurance policies saw an average increase of 11.3% last year; this is equivalent to approximately $8 per month. Mr. Maurstad said premiums will decrease for over 1 million or 23% of the NFIP policyholders under the Risk Rating 2.0 rating system. Some NFIP policyholders will see increases, which include: 1) 66% of the NFIP policyholders will see a $0 to $10 increase in their premiums; 2) 7% of the NFIP policyholders will see an increase of $10 to $20 in their premiums; and 3) 4% of the NFIP policyholders will see an increase of $20 or more in their monthly premiums.

Mr. Maurstad said three catastrophe models were licensed for use by the NFIP. These models include AIR, KatRisk, and CoreLogic. FEMA also developed two additional models based on government data.

Mr. Maurstad said the affordability of flood insurance was an issue under FEMA’s legacy rating model. He said the affordability framework FEMA delivered to the U.S. Congress in 2018 will continue to be a valuable resource as the discussion regarding affordability of flood insurance continues. There is currently a budget proposal which, if passed by Congress, would establish
a targeted means tested assistance program. The proposal would offer low to moderate income NFIP policyholders a graduated risk premium discount benefit.

Mr. Maurstad said there are things individuals and communities can do to lower flood insurance premiums. The NFIP offers incentives to policyholders who take actions to mitigate their flood threats. This includes premium discounts to people who elevate expensive items such as heating, ventilating, and air conditioning (HVAC) units, hot water heaters, etc. Communities can receive discounts for their policyholders by participating in the Community Rating System (CRS), as well as taking local actions that enhance flood protection.

Mr. Byrd said under the new infrastructure bill, there will be money available for levy improvements. He asked if FEMA would evaluate levy improvements under the Risk Rating 2.0 methodology if these improvements are made, so there would possibly be some decrease in flood insurance premiums. Mr. Maurstad said the NFIP is involving the analysis of levies in Risk Rating 2.0, more so than they were evaluated in the legacy rating methodology. Partial credits are allowed if a levy is providing partial protection, i.e., is not fully accredited but in the levy database. Levies that provide protection beyond the federal standard provide extra credit in the new pricing methodology. Mr. Maurstad said when there are changes in conditions, they will be reflected in the rates. He said FEMA will coordinate closely with the U.S. Army Corps of Engineers.

Mr. Bradner asked how Risk Rating 2.0 will reflect actuarially soundness. He said being actuarially sound may not be affordable and asked how rates are going to be reflective of the true risk of the exposure. Andy Neal (FEMA) said the NFIP’s legacy rating plan lacked the ability to reflect risk at a state level, much less a local or property-specific level. He said the glide path to full actuarial rates will help. Currently, the NFIP needs to collect 50% more premium for rates to be actuarially sound, and it will take more than 10 years for this to happen. Mr. Neal said most policyholders will be on an 18% glide path. He said policyholders getting decreases are getting them immediately. Therefore, the NFIP will be collecting less premium in year one than it has been collecting, so there is a slow trajectory. Mr. Neal said historical data is also used in conjunction with the models.

Commissioner Donelon asked if there are any plans in place for the residual market to provide for the people who do not have access to affordable flood insurance. Mr. Maurstad said under the legacy rating system, there were low-value homes that low-to-moderate income people lived in who were on a glide path that was beyond their full-risk. This is evident by the large reduction in premiums that many NFIP policyholders are seeing. The NFIP believes that Risk Rating 2.0 helps to relieve some of the affordability issue. Mr. Maurstad said the NFIP does not have a new program in the works for a residual market for their program. He believes one could already consider the NFIP a residual market.

Mr. Maurstad there are three things he believes can help close the insurance gap and make the NFIP sustainable. These items include product, price, and distribution. Currently, the NFIP has new policy forms that are going through the rulemaking process. Additionally, the Risk Rating 2.0 engine and application are easier for insurance agents to use, which should help with distribution.

Mr. Bradner said it was his understanding that Risk Rating 2.0 was going to weight the X zones according to a risk scale. He asked about the intent behind this weighting and asked if the NFIP was hoping that banks would begin looking at this factor and determining whether the property had a higher risk of loss based upon the weighting.

Mr. Neal said the NFIP elected not to use scores as part of the rating process. He said there is a more traditional plan with rating variables, territory factors, and various things that create a multiplicative rating model. Risk Rating 2.0 reflects a much fuller view of risk. The zones in the legacy rating system were based on a single scenario. Risk Rating 2.0 considers where a property sits outside the Special Flood Hazard Area (SFHA), as the resulting flooding can be very different based on the property’s location. The NFIP is hopeful that property owners will maintain their flood insurance policy by seeing their full risk.

Mr. Bradner said if property owners are in an X zone, most of the time they are told they are not required to purchase flood insurance and may never see their full-risk or what they would be required to pay for flood insurance. Mr. Maurstad said there is still the issue of how to get property owners to fully appreciate their flood risk, so there will be the need to continue looking for ways to get this message out. He said part of the process is getting agents and lenders to look at this differently from how flood risk has been looked at in the past.
2. **Heard About Risk Rating 2.0 Training Opportunities From FEMA**

Liana Kang (FEMA) said FEMA has a variety training programs in place for Risk Rating 2.0. FEMA offers a two-part “Key Fundamentals of Flood Insurance for Agents” training course for agents that is offered year-round. The course is not geared toward Risk Rating 2.0 but has been updated to reflect the new rating changes.

Ms. Kang said FEMA offers a “Risk Rating 2.0 – Equity in Action” webinar that is geared toward Risk Rating 2.0. This two-hour webinar provides the latest information on Risk Rating 2.0 and covers key topics including: 1) what is Risk Rating 2.0; 2) what led to the NFIP transformation; 3) what is changing and not changing in Risk Rating 2.0; and 4) the transition of current policies.

Ms. Kang said FEMA offers a “Webinar Wednesdays” training series that provides information on: 1) Risk Rating 2.0 fundamentals; 2) premium calculation; 3) mitigation credits; and 4) transition of policies and use cases. There are four sessions, each lasting approximately two hours. These sessions include a live question-and-answer (Q&A) forum.

Ms. Kang said FEMA additionally offers regionally led methodology workshops. This training is done as needed throughout the FEMA regions. The length of these trainings depends on the need of the stakeholders and can run from two hours to six hours. This training includes much of what is covered in “Webinar Wednesdays” but offers a more interactive experience with the instructor. Ms. Kang said Region 5 is providing some of these trainings in November and December.

3. **Heard About Joint Messaging Opportunities From FEMA**

Butch Kinerny (FEMA) said FEMA has done a lot of outreach in 2021. He said FEMA has worked with a lot of states on flood awareness weeks and is currently working on a digital engagement strategy. FEMA wants to ensure that when customers or stakeholders ask a question, they get a quick consistent and correct answer. Mr. Kinerny said FEMA is also improving its social media space and has kicked off a new LinkedIn space. Content is updated two or three times a week, and FEMA is open to sharing its information.

FEMA provides education through traditional earned media, which includes press releases, blogs, op-eds, and webinars. It also uses the following to educate consumers: its direct-to-consumer website (FloodSmart.gov); social media; paid search; paid digital marketing; out of home; broadcast; direct mail; digital radio; advocates, agents, and infomediaries; and updated publications and graphics.

FEMA conducts regional marketing campaigns, such as urban flooding, flood risks behind dams, hurricanes, agent outreach, flood after fire, and atmospheric rivers. Its marketing campaigns are pushed through ads for websites and apps if a particular event is occurring or likely to occur in an area, such as a hurricane, flooding, or storms. FEMA has also produced videos specific to various regions of the country.

Additionally, the *NFIP Desk Reference Guide for State Insurance Commissioners and Others* is going to be updated in the near future.

4. **Discussed Other Matters**

Commissioner Mulready said the Advisory Group members may want to facilitate training sessions in their regions. He said he would be interested in facilitating a training for FEMA Region 6 in Oklahoma. Commissioner Mulready asked any other members of the Advisory Group to let NAIC staff know if they are interested in facilitating a training session in their FEMA region.

Having no further business, the NAIC/FEMA (C) Advisory Group adjourned.
Pet Insurance (C) Working Group
E-Vote
December 8, 2021

The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee conducted an e-vote that concluded Dec. 8, 2021. The following Working Group members participated: Don Beatty, Chair (VA); Kendra Zoller, Vice Chair (CA); George Bradner (CT); Sheri Cullen (MA); Shirley Corbin (MD); Jo LeDuc (MO); Erin Summers (NV); Michael McKenney (PA); Matt Gendron (RI); and Kathy Stajduhar (UT).

1. **Adopted its Dec. 1 Minutes**

The Working Group considered adoption of its Dec. 1, 2021, meeting minutes. During its Dec. 1, 2021, meeting, the Working Group took the following action: 1) discussed data collection for pet insurance; 2) voted to move forward referrals to the Market Analysis Procedures (D) Working Group and the Market Information Systems Research and Development (D) Working Group; and 3) voted to ask the Property and Casualty Insurance (C) Committee to make the appropriate referrals to collect pet insurance data on the financial annual statement.

A majority of the Task Force members voted in favor of adopting the Task Force’s Dec. 1 minutes (Attachment Four-A). The motion passed unanimously.

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

PetInsminE-vote
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met Dec. 1, 2021. The following Working Group members participated: Don Beatty, Chair (VA); Kendra Zoller, Vice Chair (CA); Colin Corsetti (AK); Charles Hansberry (LA); Sheri Cullen (MA); Linas Glemza (MD); Jo LeDuc, Lockey Travis, and Marjorie Thompson (MO); Michael McKenney (PA); Matt Gendron and Beth Vollucci (RI); Kathy Stajduhar (UT); Jamie Gile and Anna Van Fleet (VT); and John Haworth (WA). Also participating were: Linda Grant (IN); Tate Flott and Brenda Johnson (KS); Brock Bubar (ME); Joseph Sullivan (MI); Chris Aufenthie (ND); Maggie Dell (SD); and Jody Ullman (WI).

1. **Adopted its Oct. 21 Minutes**

The Working Group met Oct. 21 and took the following action: 1) discussed language related to wellness plans and producer training in the draft Pet Insurance Model Act; and 2) adopted the Pet Insurance Model Act

Mr. Gendron made a motion, seconded by Ms. Zoller, to adopt the Working Group’s Oct. 21 minutes (Attachment Four-A1). The motion passed unanimously.

2. **Discussed Collection of Pet Insurance Data**

Mr. Beatty said the Working Group had previously discussed data collection for pet insurance in early 2020. He said the group had adopted a referral to the Market Conduct Annual Statement Blanks (D) Working Group, but it was determined that the referral should actually be sent to the Market Analysis Procedures (D) Working Group. He said this referral was to consider adding pet insurance as a line of business reported on the Market Conduct Annual Statement (MCAS). He said the Working Group also previously adopted a referral to the Market Information Systems Research and Development (D) Working Group to collect complaint data on pet insurance. Mr. Beatty said due to a large gap in meetings in 2020, the referrals were not sent at that time. He said if the Working Group still thinks it is necessary to collect this data, the referrals will be forwarded to the appropriate groups at this time.

Ms. Van Fleet said Vermont supports the referrals for data collection.

Birny Birnbaum (Center for Economic Justice—CEJ) said he is supportive of both referrals. He said the Market Analysis Procedures (D) Working Group has a specific set of procedures in order to consider a new line of business. Mr. Birnbaum said that while the Market Information Systems (MIS) data is public, the MCAS data that is collected is not public. He said he would like to see pet insurance data collected on the financial annual statement in order to have publicly available data. He said this will allow consumers to compare pet insurers.

Ms. LeDuc said the Market Information Systems Research and Development (D) Working Group had already considered adding a pet insurance complaint code. She said the Working Group should ensure that the complaint code has not already been added before sending the referral.

Mr. Gendron made a motion, seconded by Ms. Van Fleet, to move the proposals forward, with the understanding that the Market Information Systems Research and Development (D) Working Group referral should not move forward if the pet insurance complaint code already exists. The motion passed unanimously.

Mr. Beatty said the Working Group had previously discussed developing a supplement to the financial annual statement to collect pet insurance data. He said pet insurance data should be collected separately from the inland marine line of business because it is a growing line of business, and state insurance regulators should be able to see how much pet insurance business is being written.

Mr. Gendron said MCAS ratios are publicly available on dashboards. He asked if the MCAS data collection could also include premiums by state. Mr. Birnbaum said dashboards contain state aggregate information, not individual company information. He said the dashboards only include selected ratios and do not provide premium data, even if that data is collected. He said this MCAS data is also collected later in the year, whereas the financial annual statement data is collected in April.
Brendan Bridgeland (Center for Insurance Research—CIR) said data from the financial annual statement is vitally important for public users such as consumers and academics.

Ms. Van Fleet made a motion, seconded by Mr. Gendron, to ask the Property and Casualty Insurance (C) Committee to make the appropriate referrals to collect pet insurance data on the financial annual statement.

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

PetInsWG_1201min
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met Oct. 21, 2021. The following Working Group members participated: Don Beatty, Chair (VA); Kendra Zoller, Vice Chair, Tyler McKinney, and Charlene Ferguson (CA); Austin Childs (AK); Jimmy Harris (AR); George Bradner and Kristin Fabian (CT); Warren Byrd (LA); Sheri Cullen (MA); Shirley Corbin (MD); Jo LeDuc and Jeana Thomas (MO); Erin Summers (NV); David Forte, John Haworth, and Eric Slavich (WA). Also participating were: Linda Grant (IN); Brock Bubar and Sandra Darby (ME); Joseph Sullivan (MI); Christine Peters (MN); Cuc Nguyen (OK); Colette Hittner (OR); and Maggie Dell (SD).

1. **Adopted its Oct. 7 Minutes**

The Working Group met Oct. 7 to discuss language related to wellness plans and producer training in the draft Pet Insurance Model Act.

Mr. Byrd made a motion, seconded by Mr. Forte, to adopt the Working Group’s Oct. 7 minutes (Attachment Four-A1a). The motion passed unanimously.

2. **Discussed Comments on the Revised Draft Pet Insurance Model Act**

Mr. Beatty said during its Oct. 7 meeting, the Working Group discussed a proposal from California on revisions to the wellness programs language and a proposal from Rhode Island on adding language about producer training requirements. He said both proposals had been revised based on comments heard during that meeting.

Ms. Zoller said there were quite a few concerns about how to regulate not allowing the insurance policies and wellness programs to be advertised together. She said the language was changed to reflect that a “pet insurer shall not market a wellness program as pet insurance or during the transaction of pet insurance.” She said there was also issue with whether to use the term “coverage” or “product,” so language was changed to include both terms. Mr. Byrd asked if the language in Section 7A should be reworded to be clearer. He said he agrees with the purpose of the language but does not think it is reading the way the language is meant to be read. Mr. Gendron clarified that the goal of the language in Section 7A is to be read as two separate points.

Birny Birnbaum (Center for Economic Justice—CEJ) said insurance policies are sold with a wellness component built into the policy or added as an endorsement to the policy. He said the Working Group should consider adding language to clarify that the requirements in in Section 7A do not apply to insurance coverage, described as wellness benefits, that is included in the policy contract. Mr. McKenney agreed with the language that Mr. Birnbaum proposed.

Lisa Brown (American Property Casualty Insurance Association—APCIA) asked if the term “transaction” referred to the moment the policy was issued. She said the word could be interpreted as any time the insured used pet insurance after it is purchased. Ms. Zoller clarified that the marketing of the wellness products should be separate from the transaction of purchasing a pet insurance policy. Ms. Zoller said it may be best to instead use the term “sell, solicit, or negotiate.” Mr. Byrd agreed that it would be better to use “sell, solicit, or negotiate.”

Mr. Birnbaum asked if this language in Section 7A would prohibit an insurer from offering a wellness program for purchase until after an insurance policy has already been purchased. Ms. Zoller said that is the goal of the language.

Cari Lee (North American Pet Health Insurance Association—NAPHIA) asked if an insurer can sell a wellness program that is part of the insurance coverage. Ms. Birnbaum said this language would not apply to those policies and that the issue would be clarified by the additional language he submitted.

Ms. Zoller made a motion, seconded by Mr. Gendron, to adopt the changes to the wellness language in Section 3 and Section 7. The motion passed unanimously.
Mr. Gendron said the first provision in his proposed Section 9 – Insurance Producer Training says that a producer must be appropriately licensed and complete the required training before the sale, solicitation, or negotiation of pet insurance. He said the next provision applies to those producers with a major lines license and would require them to be appropriately trained on the features of the pet insurance product. He said this would be in-house training that would not require approval from the state insurance department but would be subject to market conduct examination. Mr. Gendron said the third provision deals with limited lines license holders. He said the original proposal required 10 credits at initial licensing and 10 credits of continuing education (CE) every two years. He said that after conversations with other states and producers, that requirement was changed to 10 credits at initial licensing and four credits of CE every two years. Mr. Gendron said the final part of his proposal outlines the required covered topics for in-house training and licensing education courses.

Mr. Byrd asked if the required credits are in addition to the requirements already in place. Mr. Gendron said this proposal does not add any credit requirements for major lines license holders. He said limited lines license holders do not currently have a required number of credits to obtain a license.

Ms. Zoller said she would like to add a provision to require a certificate of completion for the training for state insurance regulators to track the completed training. Mr. Gendron said he would expect the company to keep track of the course list and who was at the training, but he would not expect the producer to provide that information. Mr. Beatty said the insurer would keep track of this, and it would be checked during a market conduct exam.

Mr. Harris said he is concerned about placing CE requirements on a limited lines licensee, and he asked if there are other limited lines where there are continuous requirements. Mr. Gendron said there is a lot more to selling pet insurance than other limited lines products, and the CE requirements would make sense for this line of business.

Mr. Birnbaum said Section 9B(1)(i) should clarify that both the producer and the insurer shall ensure that the producer has been appropriately trained on the product. Mr. Gendron agreed that the subsection should read: “Both the producer and the insurer shall ensure that its producers have been appropriately trained on the features of its products.”

Isham Jones (American Veterinary Medical Association—AVMA) asked who would be providing the training on medical conditions. Mr. Gendron said for major lines license holders, the insurer would provide training on the specifics of pet insurance, and for limited lines license holders, the training would come from training providers that are required to register with the state department of insurance (DOI).

Wes Bissett (Independent Insurance Agents & Brokers of America—IIABA) said Section 8 – Regulations should be moved to the end of the model. He said in Section 9B(2)(iii), the term “limited lines” should be added before “insurance producer” for clarification.

Mr. Gendron made a motion, seconded by Mr. Byrd, to adopt Insurance Producer Training as Section 8 into the model, with the suggested edits in Section 8B(2)(iii) from Mr. Bissett and Section 8B(1)I from Mr. Birnbaum, and to move Regulations to Section 9. The motion passed unanimously.

3. Adopted the Pet Insurance Model Act

Mr. Gendron made a motion, seconded by Mr. McKenney, to adopt the Pet Insurance Model Act as drafted (see NAIC Proceedings – Fall 2021, Property and Casualty Insurance (C) Committee, Attachment One-A). The motion passed unanimously.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met Oct. 7, 2021. The following Working Group members participated: Don Beatty, Chair, and Jessica Baggarley (VA); Kendra Zoller, Vice Chair (CA); Katie Hegland and Colin Corsetti (AK); Jimmy Harris (AR); Kristin Fabian (CT); Angela King (DC); Warren Byrd (LA); Sheri Cullen (MA); Shirley Corbin (MD); Cynthia Amann and Jo LeDuc (MO); Michael McKenney and Dennis Sloand (PA); Elizabeth Kelleher Dwyer, Matt Gendron, and Beth Vollucci (RI); Kathy Stajduhar (UT); Chris Antoine, Jamie Gile, and Anna Van Fleet (VT); and David Forte and John Haworth (WA). Also participating were: Michele Mackenzie (ID); Linda Grant (IN); Heather Droge (KS); Brock Bubar and Sandra Darby (ME); Sandra Anderson and Christine Peters (MN); Chris Aufenthie and Janelle Middlestead (ND); Maggie Dell (SD); Jody Ullman (WI); and JoAnne DeBella (WY).

1. Adopted its Sept. 8 Minutes

The Working Group met Sept. 8 to discuss language related to wellness plans in the draft Pet Insurance Model Act.

Mr. Forte made a motion, seconded by Mr. Byrd, to adopt the Working Group’s Sept. 8 minutes (Attachment Four-A1a1). The motion passed unanimously.

2. Discussed Comments on the Revised Draft Pet Insurance Model Act

Mr. Beatty said the Working Group received new comments from both state insurance regulators and industry since the last meeting.

Ms. Zoller said she submitted comments that address some changes to the language in Section 3—Definition and Section 7—Sales Practices for Wellness Programs. She said the changes include using the terms “shall and shall not” instead of “may,” removing blood tests from the activities covered under wellness programs in the definition, and using clear language that wellness programs should not be marketed with insurance products. Mr. Byrd said he agrees that there should be separation between the wellness products and insurance products, including separate billing and contract forms. Mr. McKenney said the term “products” in Section 7(4) should be changed to “coverages.” Mr. Forte agreed with this change. Birny Birnbaum (Center for Economic Justice—CEJ) said the term “products” should be used when talking about wellness programs, and the term “coverage” should be used when talking about insurance. Ms. Zoller agreed with this change.

Cari Lee (North American Pet Health Insurance Association—NAPHIA) asked whether products would be exempt from premium tax if wellness products are separated from the insurance policy. Mr. Forte said if wellness benefits are made a part of the insurance policy, then they are considered insurance. Ms. Lee asked for clarification of what separate marketing would be if the products are combined. Ms. Zoller agreed with Mr. Forte that if it is part of the policy, it is considered insurance, but currently some wellness plans that are sold as add-ons to an insurance policy do not make it clear to the consumer that the wellness program is not insurance. Ms. Lee asked for clarification on the types of policies being addressed by this language. Mr. Gendron said he knows of four companies that sell a wellness product that they do not consider to be insurance, but the way these products are sold looks like how other companies sell endorsements to their pet insurance policies for wellness, which would be considered insurance. Mr. Birnbaum asked how something could be considered insurance because it is included in the policy, but the same services are not considered insurance if they are sold separately. Mr. Beatty said if a wellness program is included in the insurance policy and has been appropriately filed and approved in a state, then state insurance regulators have jurisdiction over that product. He said the Working Group is trying to separate out those products from the ones not sold as insurance, making it clear to the consumer that those products are not insurance and would not provide coverage that they may expect.

Ms. Lee said proposed Section 7(C)(1) reads “pet insurance and wellness programs should not be advertised together to avoid consumer confusion.” She asked if the intention is to not allow those products to be sold on the same website. Ms. Zoller said the language is not preventing the products from being on the same website, but the products need to be clearly distinct. She said right now added on wellness products only have fine print indicating that it is not insurance. She said the websites should not allow customers to purchase an insurance policy with the wellness product already added on if that wellness product is not considered insurance and not a part of the policy. Ms. Lee said NAPHIA proposed that this should be addressed with clear
disclosures to the consumer. Mr. Birnbaum said he thinks the purpose of the language is that the purchase of a wellness program cannot be tied to the purchase of an insurance policy, and vice versa.

Mr. Forte said the purpose of the proposal is to change the language from permissive to restrictive and further clarify that pet insurance and wellness programs need to be clearly delineated as unique products, and they should not be contingent.

Mr. Forte said the adopted definition of wellness program says it is a subscription or reimbursement-based program that is separate from an insurance policy and provides services to promote general health, safety, and well-being. He said pet insurance policies are property policies, and anything that is for general health, safety, and well-being is not considered insurance and an insurable item.

Mr. Byrd asked where the differences are in how wellness programs are handled in health insurance as opposed to how they are handled in pet insurance. Mr. Birnbaum said consumers have come to understand that wellness programs are a part of health insurance policies. He said he does not see how consumers are supposed to know that wellness programs for pets would not be a part of the pet insurance policy. He said there has been a push in property/casualty (P/C) policies to include loss mitigation and resilience activities into the policies, and those activities are analogous to wellness programs in health insurance.

Mr. Beatty suggested that the proposal should be re-drafted after considering the comments made during the meeting and re-submitting them for viewing before the Working Group votes on adopting the new language.

Mr. Gendron said the Working Group previously discussed the issue of producer licensing and determined that the decision on what type of license was needed to sell pet insurance should not be made in this group. He said based on discussions in the Producer Licensing (D) Task Force, this Working Group would be the appropriate place to address what is required to obtain the license to sell pet insurance and what kind of training should be required to maintain that license. He said both the Long-Term Care Insurance Model Act (#640) and the Suitability in Annuity Transactions Model Regulation (#275) require initial training, and Model #640 requires ongoing training. He said because of the innovations in the industry that have been discussed in the Working Group’s meetings, it is a good idea to have ongoing training requirements in addition to the initial training requirements. He proposed requiring four credits of pet insurance specific training for those that hold a major lines license before they can market and sell pet insurance, plus four credits of training at license renewal. He proposed 10 credits of pet insurance specific training for those that hold a limited lines license, plus 10 credits of training at license renewal.

Mr. McKenney asked how the proposed training requirements compare to other lines of insurance. Mr. Gendron said he is not aware of specific training in other lines of business, but pet insurance is a unique coverage type because it is more like health insurance than other property lines of business. Mr. McKenney said he does not want to create requirements for producers that would cause pet insurance to only be sold direct.

Jack Chaskey (Westmont Associates) asked if the education requirements are additive or if they are intended to be part of the qualifying education requirements. Mr. Gendron said the intent of the proposal is that these requirements would not be additive. Mr. Byrd asked if these training requirements should be addressed in state code provisions or in the draft Pet Insurance Model Act. Mr. Gendron said the Producer Licensing Model Act (#218) sets standard training, but this provision would require four of those credits to be specifically focused on pet insurance education for anyone that is selling pet insurance. He said because this is a unique line of business and there is a lot of innovation in the pet insurance industry, it is important to require specific training. Superintendent Dwyer said continuing education (CE) is not currently tracked by subject matter. She said this is a good way to confirm that P/C producers that are selling pet insurance are staying informed on that subject. Mr. Birnbaum said he would support the proposal to address producers training in the draft Pet Insurance Model Act.

Mr. Beatty asked if NAPHIA would still recommend their proposed drafting note that addresses producer licensing requirements and compliance with the Uniform Licensing Standards.

Having no further business, the Pet Insurance (C) Working Group adjourned.
The Pet Insurance (C) Working Group of the Property and Casualty Insurance (C) Committee met Sept. 8, 2021. The following Working Group members participated: Don Beatty, Chair (VA); Kendra Zoller, Vice Chair (CA); Katie Hegland (AK); Jimmy Harris (AR); Angela King (DC); Warren Byrd (LA); Shirley Corbin (MD); LeeAnn Cox and Jo LeDuc (MO); Dennis Sloand (PA); Matt Gendron and Beth Vollucci (RI); Kathy Stajduhar (UT); Mary Block and Jamie Gile (VT); and David Forte, John Haworth, and Eric Slavich (WA). Also participating were: Lucretia Prince (DE); Linda Grant (IN); Heather Droge, Brenda Johnson, and Tate Flott (KS); Brock Bubar (ME); Joseph Sullivan (MI); Christine Peters (MN); Chris Aufenthie (ND); Maggie Dell (SD); and Jody Ullman (WI).

1. **Discussed the Definition of “Wellness Plans” in the Draft Pet Insurance Model Act**

Mr. Beatty said during its Aug. 4 meeting, the Working Group adopted the Pet Insurance Model Act. He said following that meeting, there were suggested edits to some elements of the model.

Mr. Beatty said the first suggested change was to remove the word “internet” and make “website” one word throughout the model. Mr. Gendron made a motion, seconded by Mr. Forte, to make this change throughout the model. The motion passed unanimously.

Mr. Beatty said the next suggested change was to make “preexisting” consistent throughout the model. He said the Working Group should decide whether to use “pre-existing” or “preexisting.” Mr. Gendron made a motion, seconded by Mr. Forte, to use “preexisting” throughout the model. The motion passed unanimously.

Mr. Beatty said the next suggested change was to insert language in Section 4–Disclosures, titled Right of Return, that addresses the free look period. Mr. Sloand said in the adopted version of the model, there was a statement indicating that a claim must have been paid in order to negate the free look period. Brendan Bridgegland (Center for Insurance Research—CIR) said he agrees with Mr. Sloand’s point. He said the substantive sections of the model should stay intact and these issues should not all be addressed in the disclosure section. Cari Lee (North American Pet Health Association—NAPHIA) said NAPHIA’s submitted comments suggest adding language to the Right of Return section that clarifies that a policy cannot be returned if the insured has filed a claim. Mr. Byrd said whether or not a claim has been paid, when an insured makes a claim, he or she is making a demand of the policy. Mr. Beatty said it is unlikely that an insured would make a claim under the policy and then try to return it. He said the paid language is not necessary. Mr. Gendron said it is unlikely that a claim would even be paid or denied within the first 15 days of the policy.

Mr. Gendron made a motion, seconded by Mr. Byrd, to add Section 4D–Right to Examine and Return the Policy, with the following language:

(1) Unless the insured has filed a claim under the pet insurance policy, pet insurance applicants shall have the right to examine and return the policy, certificate or rider to the company or an agent/insurance producer of the company within fifteen (15) days of its receipt and to have the premium refunded, after examination of the policy, certificate or rider, the applicant is not satisfied for any reason,

(2) Pet insurance policies, certificates and riders shall have a notice prominently printed on the first page or attached thereto including specific instructions to accomplish a return. The following free look statement or language substantially similar shall be included:

You have 15 days from the day you receive this policy, certificate or rider to review it and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide not to keep it, simply return it to the company at its administrative office or you may return it to the agent/insurance producer that you bought it from as long as you have not filed a claim. You must return it within 15 days of the day you first received it. The company will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate or rider will be void as if it had never been issued.
The motion passed, with Pennsylvania voting against.

Mr. Beatty said the next suggested change is to remove repetitious language in Section 6(B)(4) and instead address this language in Section 4–Disclosures. Mr. Forte said this language should be moved to Section 4 because it does relate to a disclosure to the insured. Mr. Forte made a motion, seconded by Mr. Byrd to move the language in Section 6(B)(4) to Section 4. The motion passed unanimously.

Mr. Byrd said any mention of “insurer” in the model should be changes to “pet insurer” for clarification. Mr. Byrd made a motion, seconded by Mr. Forte, to change “insurer” to “pet insurer” throughout the model. The motion passed unanimously.

Mr. Beatty said the next suggested change was removing the reference to the Unfair Trade Practices Act (#880) and replacing it with a reference that each state can change to include its own unfair trade practice law. Mr. Byrd made a motion, seconded by Mr. Gendron, to adopt this change. The motion passed unanimously.

Mr. Beatty said the next suggested change was to change Section 4(E) to read: “An insurer shall clearly disclose a summary description of the basis or formula on which the insurer determines claim payments under a pet insurance policy within the policy itself, prior to policy issuance and through a clear and conspicuous link on the main page of the insurer or insurer’s program administrator’s website.” Mr. Gendron said he had never seen the word “itself” inserted after referring to a policy and said the change was not necessary.

Mr. Beatty said the next suggested change was to move the definition of “preexisting condition” from Section 3 to Section 4. Mr. Forte said the definitions guide the policy, and they should not only be a part of the disclosures. There was no motion to make this change.

Mr. Beatty said there were a few more suggestions of moving language from Section 6 to Section 4. There was no motion to make those changes.

Mr. Forte said the Working Group had previously voted that there should not be waiting periods for accidents. He said the current language in Section 6 is ambiguous if waiting periods for accidents are prohibited. Ms. Lee said that prohibiting waiting periods for accidents could allow for insurance fraud since a consumer could purchase and immediately use the insurance to cover his or her pet after an accident has already occurred. Mr. Forte said state insurance regulators do not want insurance fraud to occur. Mr. Bridgeland said that if the accident occurred before coverage, that would be considered a preexisting condition. Ms. Lee said the insurer would not know it is a preexisting condition if the consumer does not disclose the accident. Mr. Byrd said a waiting period of three days for accidents should mean that the policy is not effective until that waiting period is over. Ms. Lee said these policies have different waiting periods for different coverages, so only the accident coverage would not be effective during that period. Mr. Bridgeland said it is problematic to charge a consumer for a 365-day policy with only 362 days of coverage.

Mr. Forte made a motion, seconded by Mr. Gendron, to change the language in Section 6B to: “A pet insurer may issue policies that impose waiting periods upon effectuation of the policy that do not exceed 30 days for illnesses or orthopedic conditions not resulting from an accident. Waiting periods for accidents are prohibited.”

Ms. Zoller said state insurance regulators do not have authority over non-insurance products, and she said Section 7 and language relating to wellness programs should not be included in the model. Mr. Forte said the language says “by a licensed insurance entity” to refer to products sold by licensed pet insurers.

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

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The Transparency and Readability of Consumer Information (C) Working Group of the Property and Casualty Insurance (C) Committee met Nov. 17, 2021. The following Working Group members participated: Joy Hatchette, Chair (MD); Willard Smith (AL); Ken Allen (CA); Bobbie Baca (CO); Angela King (DC); Patrice Dziire, Julie Rachford, and Robert Rapp (IL); Heather Droge and Brenda Johnson (KS); Cynthia Amann, Jo LeDuc, and Jeana Thomas (MO); Kathy Shortt (NC); Chris Aufenthie (ND); Dave Buono and Shannen Logue (PA); Elizabeth Kelleher-Dwyer and Brett Bache (RI); Jennifer Ramcharan (TN); and Marianne Baker and Cassandra Enoch Brown (TX). Also participating were: Kate Kixmiller (IN); Renee Campbell (MI); Denise Lamy (NH); Tynesia Dorsey and Jana Jarrett (OH); Tricia Goldsmith and Glenda Villamar (OR); Marcia Violette (VT); Josh Martinsen and Manabu Mizushima (WA); Diane Dambach and Darcy Paskey (WI); and Kristi Alma Jose and Bill Cole (WY).

1. Adopted its Summer National Meeting Minutes

Ms. Droge made a motion, seconded by Mr. Aufenthie, to adopt the Working Group’s July 20 minutes (see NAIC Proceedings – Summer 2021, Property and Casualty Insurance (C) Committee, Attachment Five). The motion passed unanimously.

2. Adopted the Report of the Consumer Education Drafting Group

Ms. Hatchette said the work on the rate and rule filing checklist and the disclosures for premium increases for both capped and uncapped premium has been completed by their perspective drafting groups. She said Brenda J. Cude (University of Georgia) will do a readability review on the consumer language in the document. Ms. Hatchette said several states have indicated that they would like to start using these documents. She said once Ms. Cude has reviewed the documents, they will be sent out to the Working Group to vote on exposing the document. Once the document has been exposed for 30 days, the Working Group will consider adoption of the documents and will then send them to the Property and Casualty Insurance (C) Committee for consideration of adoption. The Working Group was in agreement.

Ms. Shortt said the consumer education drafting group was divided into three areas: 1) ratemaking; 2) rating factors; and 3) premium discounts. The ratemaking and premium discounts drafting for auto insurance has been completed. The rating factors drafting is nearing completion. Drafting groups will begin working on ratemaking and rating factors for homeowners’ insurance once the rating factors for auto insurance is complete. The drafting group working on homeowners’ discounts has started drafting this document. The drafting groups have been meeting every couple of weeks to complete the work.

Ms. Rachford made a motion, seconded by Mr. Buono, to adopt the report of the Consumer Education Drafting Group. The motion passed unanimously.

3. Heard a Presentation Regarding Disparities in Insurance Access

Ms. Hatchette said some of the Working Group members may have seen the report Disparities in Insurance Access: A Report Detailing Findings From a Survey of Grassroots Consumer Organizations. She said some states have begun to hold discussions regarding the information in this report to address this issue. Ms. Hatchette said Maryland has been discussing ways in which they can address the concerns and issues included in this report.

Ms. Cude said the information presented in the report is based on a survey the consumer representatives conducted earlier this year. She said the information she is presenting today is based on new data that has not yet been reported to anyone at the NAIC. Ms. Cude said the primary goal of the survey was to look at disparities and inequities in the insurance system; this was done in the lens of community organizations.

Ms. Cude said the survey respondents included 72 unique individuals who were leaders or senior employees of consumer organizations. Approximately half of the respondents of this survey worked in organizations that they defined as working statewide. Fifteen of the respondents worked nationally, and seven of the respondents said their primary work was in a specific city. The survey was intended to reach across a number of product lines, and although the majority of the respondents worked in health, they worked in other product lines too. The three areas most relevant to the Working Group include auto; property;
and flood, earthquake, or wind. Forty-four percent of the respondents’ constituents included all ethnic groups. However, there was a focus on Black or African American and Hispanic or Latino populations. The majority of respondents said their primary constituency served included racial and ethnic groups. However, there was representation in other groups as well, such as senior citizens, rural residents, veterans, etc.

Ms. Cude said the challenges of the constituents that the respondents’ organizations worked with include: 1) the belief that insurance products are unaffordable; 2) difficulty understanding coverage; 3) difficulty understanding costs; 4) the belief that available insurance products do not provide sufficient coverage; 5) the belief that insurance claims are not paid; 6) the belief that filing insurance claims is difficult; 7) difficulty in applying for insurance; 8) language barriers; 9) the belief that consumer education/information is not written or available for constituents; and 10) the belief that the state insurance department is not helpful. She said this Working Group might want to consider drafting consumer education pieces addressing understanding coverage and costs, reasons insurance claims are not paid, and education regarding the filing of insurance claims. Ms. Cude said about 20% of the respondents said that consumer education is not available and written for their constituents. While consumer education information is available, it is important to understand why the educational pieces are not making their way to the community organizations.

Ms. Cude said respondents were asked questions about state insurance department contact with the respondents’ constituents. The questions asked included asking if state insurance departments: 1) provide education about insurance; 2) increase awareness about insurance; 3) ask about opportunities to learn about respondents’ organizations; 4) discuss the department of insurance’s (DOI’s) services; and 5) ask about ways to hear about respondents’ constituents’ insurance issues. She said barely one-fourth of the respondents answered “yes” regarding education and increasing awareness about insurance. Ms. Cude said the consumer representatives believe the community organizations are saying it is a one-way conversation. She said less than 20% of the respondents said that the DOIs contacted or discussed the services offered by the DOI with their organizations. Only 17% of the respondents said that they had been asked about ways to learn about the constituents’ insurance issues.

Ms. Cude said recommendations relevant to the DOIs include: 1) developing more expansive partnership networks with community organizations, especially those serving low-income communities and communities of color; and 2) embracing active, ongoing engagement with community partners and developing relationships that go beyond passive information sharing. She said recommendations for the NAIC to consider include: 1) identifying, promoting, and replicating best practices across states; and 2) creating minimum community engagement standards.

Ms. Cude said there are large sections of states where there are not the types of community-based organizations that the Working Group has been discussing. She said smaller communities do have community-based organizations. However, these organizations are not always the typical traditional community-based organizations. Ms. Cude said community-based organizations in small, rural communities might be churches, a cooperative extension service, a public library, civic organizations, a Chamber of Commerce, or elected county officials.

Ms. Hatchette said when the report was released, they decided to reach out to the grassroots organizations in Maryland to see what they could do better. She said they reached out in a variety of ways, such as sending emails and making phone calls. Ms. Hatchette said they received responses from only 10% of those they contacted. She asked Ms. Cude for a good way to get these conversations started. Ms. Cude said many community organizations are understaffed and under-resourced, so they may not have time to respond without knowing why they are being contacted. She said this is where the standards about what it means to have and build community engagement come into play. Ms. Cude said it is important to think about and discuss ways to work with some of the community-based organizations. She said creating a best practices document that provides items that have worked for the various states would be valuable.

Ms. Ramcharan said the DOI sent employees to the rural areas that flooded in Tennessee following the flood event. She said they have found senior centers to be an excellent resource in rural communities. Ms. Ramcharan said the senior centers are usually open to the DOI visiting to talk with them and to provide materials and brochures.

Mr. Allen said the California DOI has a community relations and outreach branch. He said this group holds forums, roundtables, or outreach events virtually or in person in every county in California. Mr. Allen said they use community centers, businesses, chambers of commerce, and other nontraditional areas to try to get information out to consumers. He said he was going to share the report and information presented today with the community relations and outreach branch. Ms. Cude said this is helpful, as one of the first steps is to collect best practices.
Ms. Baker said Texas has a program for their coastal wind pool that does outreach to consumers. She said this program was created by statute. The program has one dedicated employee who spends a great deal of time attending meetings on the coast, attending city council meetings, and attending meetings at the libraries. Ms. Baker said this person also provides outreach when there is a storm, as well as fielding complaints. She said she would share this information with the Working Group.

Karrol Kitt (University of Texas at Austin) said that while communicating information following disasters is important, consumers also need information to help them with protecting their assets. Ms. Cude said once contact is made with the community-based organizations, it would be helpful to ask the organization what it needs to know to better serve its constituents. She said it might be a train-the-trainer model that works.

Bonnie Burns (California Health Advocates) said most people do not understand their insurance policy until they have to use it. She suggested that DOIs could teach people how to read policies of various types.

Having no further business, the Transparency and Readability of Consumer Information (C) Working Group adjourned.

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

Ongoing Support of NAIC Programs, Products or Services

1. The Property and Casualty Insurance (C) Committee will:
   A. Discuss issues arising and make recommendations with respect to advisory organization and insurer filings for personal and commercial lines, as needed. Report yearly.
   B. Monitor the activities of the Casualty Actuarial and Statistical (C) Task Force.
   C. Monitor the activities of the Surplus Lines (C) Task Force.
   D. Monitor the activities of the Title Insurance (C) Task Force.
   E. Monitor the activities of the Workers’ Compensation (C) Task Force.
   F. Provide an impartial forum for considering appeals of adverse decisions involving alien insurers delisted or rejected for listing to the Quarterly Listing of Alien Insurers. Appeal procedures are described in the International Insurers Department (IID) Plan of Operation.
   G. Monitor and review developments in case law and rehabilitation proceedings related to risk retention groups (RRGs). If warranted, make appropriate changes to the Risk Retention and Purchasing Group Handbook.
   H. Monitor the activities of the Federal Crop Insurance Corporation (FCIC) that affect state insurance regulators:
      1. Serve as a forum for discussing issues related to the interaction of federal crop insurance programs with state insurance regulation.
      3. Monitor the regulatory information exchanges between the FCIC and state insurance regulators, as well as the FCIC and the NAIC, and make recommendations for improvements or revisions, as needed.
   I. Report on the cyber insurance market, including data reported within the Cybersecurity Insurance and Identity Theft Coverage Supplement.
   J. Monitor regulatory issues that arise with the development of autonomous vehicles. Study and, if necessary, develop recommendations for changes needed to the state-based insurance regulatory framework.
   K. Provide a forum for discussing issues related to parametric insurance and consider the development of a white paper or regulatory guidance.

2. The Cannabis Insurance (C) Working Group will:
   A. Assess and periodically report on the status of federal legislation that would protect financial institutions from liability associated with providing services to cannabis businesses operating legally under state law.
   B. Encourage admitted insurers to ensure coverage adequacy in states where cannabis, including hemp, is legal.
   C. Provide insurance resources to stakeholders and keep up with new products and innovative ideas that may shape insurance in this space.
   D. Develop an appendix to the Understanding the Market for Cannabis Insurance white paper, providing updated information on cannabis-related insurance issues for adoption by the 2022 Summer National Meeting.
   E. Collaborate with the Producer Licensing (D) Task Force to study whether cannabis-related convictions in states where cannabis is legalized for medical and/or recreational use are preventing individuals from being licensed as an agent or broker.

3. The Catastrophe Insurance (C) Working Group will:
   A. Monitor and recommend measures to improve the availability and affordability of insurance and reinsurance related to catastrophe perils for personal and commercial lines.
B. Evaluate potential state, regional, and national programs to increase capacity for insurance and reinsurance related to catastrophe perils.

C. Monitor and assess proposals that address disaster insurance issues at the federal and state levels. Assess concentration-of-risk issues and whether a regulatory solution is needed.

D. Provide a forum for discussing issues and recommending solutions related to insuring for catastrophe risk, including terrorism, war, and natural disasters.

E. Consider revisions to the *Catastrophe Computer Modeling Handbook*.

F. Investigate and recommend ways the NAIC can assist states in responding to disasters by continuing to build the NAIC’s Catastrophe Resource Center for state insurance regulators to better prepare for disasters.

G. Continue to monitor the growth of the private flood insurance market and assess the actions taken by individual states to facilitate growth. Update the Considerations for Private Flood Insurance appendix to include new ways states are growing the private flood insurance market.

H. Study, in coordination with other NAIC task forces and working groups, earthquake matters of concern to state insurance regulators. Consider various innovative earthquake insurance coverage options aimed at improving take-up rates.

4. The **NAIC/Federal Emergency Management Agency (FEMA) (C) Working Group** will:
   A. Assist state insurance regulators in engaging and collaborating with FEMA on an ongoing basis by establishing a process for the oversight, prioritization, and reporting of disaster-related regional workshops and other exercises to improve disaster preparation and resilience.

5. The **Terrorism Insurance Implementation (C) Working Group** will:
   A. Coordinate the NAIC’s efforts to address insurance coverage for acts of terrorism. Work with the U.S. Department of the Treasury’s (Treasury Department’s) Terrorism Risk Insurance Program (TRIP) Office on matters of mutual concern. Discuss long-term solutions to address the risk of loss from acts of terrorism.
   B. Review and report on data collection related to insurance coverage for acts of terrorism.

6. The **Transparency and Readability of Consumer Information (C) Working Group** will:
   A. Facilitate consumers’ capacity to understand the content of insurance policies and assess differences in insurers’ policy forms.
   B. Assist other groups with drafting language included within consumer-facing documents.
   C. Complete the drafting of regulatory best practices that serve to inform consumers of the reasons for significant premium increases related to P/C insurance products.
   D. Update and develop web page and mobile content for *A Shopping Tool for Homeowners Insurance* and *A Shopping Tool for Automobile Insurance*.
   E. Study and evaluate ways to engage department of insurance (DOI) communication to more diverse populations, such as rural communities.

NAIC Support Staff: Aaron Brandenburg/Jennifer Gardner
Ongoing Support of NAIC Programs, Products or Services

1. The **Casualty Actuarial and Statistical (C) Task Force** will:
   A. Provide reserving, pricing, ratemaking, statistical, and other actuarial support to NAIC committees, task forces, and/or working groups. Propose changes to the appropriate work products (with the most common work products noted below) and present comments on proposals submitted by others relating to casualty actuarial and statistical matters. Monitor the activities, including the development of financial services regulations and statistical (including disaster) reporting, regarding casualty actuarial issues.
   1. Property and Casualty Insurance (C) Committee – ratemaking, reserving, or data issues.
   2. Blanks (E) Working Group – P/C annual financial statement, including Schedule P; P/C quarterly financial statement; P/C quarterly and annual financial statement instructions, including Statement of Actuarial Opinion (SAO) and Actuarial Opinion Summary Supplement.
   B. Monitor national casualty actuarial developments and consider regulatory implications.
   1. Casualty Actuarial Society (CAS) – Statements of Principles and *Syllabus of Basic Education*.
   3. Society of Actuaries (SOA) – general insurance track’s basic education.
   C. Facilitate discussion among state insurance regulators regarding rate filing issues of common interest across the states through the scheduling of regulator-only conference calls.
   D. Conduct the following predictive analytics work:
   1. Facilitate training and the sharing of expertise through predictive analytics webinars (Book Club).
   2. Review the completed work on artificial intelligence (AI) from other committee groups. Coordinate with the Innovation, Cybersecurity, and Technology (H) Committee on the tracking of new uses of AI, auditing algorithms, product development, and other emerging regulatory issues in as far as these issues contain a Task Force component.
   3. With NAIC staff assistance, discuss guidance for the regulatory review of tree-based models and generalized additive models (GAM) used in rate filings.
2. The **Actuarial Opinion (C) Working Group** will:
   
   A. Propose revisions to the following, as needed, especially to improve actuarial opinions, actuarial opinion summaries, and actuarial reports, as well as the regulatory analysis of these actuarial documents and loss and premium reserves:
      3. *Annual Statement Instructions—Property/Casualty.*
      4. Regulatory guidance to appointed actuaries and companies.
      5. Other financial blanks and instructions, as needed.

3. The **Statistical Data (C) Working Group** will:
   
   A. Consider updates and changes to the *Statistical Handbook of Data Available to Insurance Regulators.*
   
   B. Consider updates and developments, provide technical assistance, and oversee the production of the following reports and databases. Periodically evaluate the demand and utility versus the costs of production of each product.
      1. *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance.*
      2. *Auto Insurance Database.*
   
   C. Implement the expedited reporting and publication of average auto and average homeowners premium portions of the annual *Auto Insurance Database and Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance.*

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

https://naiconline.sharepoint.com/w:/r/sites/NAICSupportStaffHub/Member%20Meetings/Fall%202021/TF/CasAct/2022%20CASTF%20Charges_110921.docx?d=wa6d88b54e90094dfee1ce6417a215b016&csf=1&web=1&e=ucfssR
2022 Proposed Charges

SURPLUS LINES (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

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

NAIC Support Staff: Andy Daleo

https://naiconline.sharepoint.com/w:/r/sites/NAICSupportStaffHub/Member%20Meetings/Fall%202021/Cmte/C/Surplus%20Lines%20TF/2022%20Charges.docx?d=wa4353f06f876491992ba3354bbf6d4f7&csf=1&web=1&e=vBuun0
2022 Proposed Charges

TITLE INSURANCE (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Anne Obersteadt

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2022 Proposed Charges

WORKERS’ COMPENSATION (C) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

2. The NAIC/IAIABC Joint (C) Working Group will:
   A. Study issues of mutual concern to state insurance regulators and the IAIABC. Review relevant IAIABC model laws and white papers and consider possible charges in light of the Working Group’s recommendations.

NAIC Support Staff: Sara Robben/Aaron Brandenburg

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The Casualty Actuarial and Statistical (C) Task Force met Dec. 7, 2021. The following Task Force members participated: Grace Arnold, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Nichole Torblaa (LA); Jim L. Ridling represented by Daniel Davis (AL) Evan G. Daniels represented by Tom Zuppan (AZ); Ricardo Lara represented by Lynne Wehmueller (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); David Altsnaier represented by Greg Jaynes (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Anthony Bredel and Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. B rimane represented by Robert Baron and Walter Dabrowski (MD); Eric A. Cioppa represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers and Cynthia Amann and Julie Lederer (MO); Mike Causey represented by Kevin Conley and Arthur Schwartz (NC); Chris Nicolopoulous represented by Christian Citarella (NH); Russell Toal and Anna Krylova (NM); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by David Dahl (OR); Jessica K. Altman represented by Michael McKenney (PA); Cassie Brown represented by J’ne Byckovski and Miriam Fisk (TX); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler represented by Eric Slavich (VA); and Allan L. McVey represented by Juanita Wimmer (WV).

1. Adopted its Nov. 17, Nov. 9, Oct. 19, Oct. 12, Aug. 20, and Summer National Meeting Minutes

The Task Force met Nov. 9, Oct. 19, and Oct. 12 and held e-votes ending on Nov. 17 and Aug. 20. During its e-vote ending on Nov. 17, the Task Force adopted the Report on Profitability by Line by State (Profitability Report). During its Nov. 9 meeting, the Task Force took the following action: 1) adopted a decision to discontinue requiring continuing education (CE) categorization by Appointed Actuaries in 2023; and 2) adopted its 2022 proposed charges. During its Oct. 19 and Oct. 12 meetings, the Task Force took the following action: 1) adopted its Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2021 (Regulatory Guidance); 2) adopted a response to the Blanks (E) Working Group regarding proposal 2021-11BWG; and 3) heard a report on the NAIC Rate Model Technical Reviews. During its e-vote ending on Oct. 24, the Task Force adopted a comment letter on the second exposure draft of the U.S. Qualification Standards to send to the American Academy of Actuaries (Academy).

The Task Force also met Oct. 19, Sept. 21, and Aug. 17 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to discuss rate filing issues.


Mr. Chen made a motion, seconded by Mr. Botsko, to adopt the Task Force’s Nov. 17 (Attachment One), Nov. 9 (Attachment Two), Oct. 19 and Oct. 12 (Attachment Three), Aug. 20 (Attachment Four), and Aug. 10 (see NAIC Proceedings – Summer 2021, Casualty Actuarial and Statistical (C) Task Force) minutes. The motion passed unanimously.

2. Adopted the Report of the Actuarial Opinion (C) Working Group

Ms. Krylova said the Actuarial Opinion (C) Working Group met Sept. 23, Sept. 8, and Sept. 2 and adopted its Regulatory Guidance. Ms. Krylova said one of the key changes was to mention that the state insurance regulators expect to establish a deadline for the Appointed Actuary’s qualification documentation submission to the insurer’s Board of Directors in the 2022 Statement of Actuarial Opinion (SAO) Instructions.

Ms. Krylova made a motion, seconded by Mr. Botsko, to adopt the report of the Actuarial Opinion (C) Working Group, including its Sept. 23 (Attachment Five) and Sept. 8 and Sept. 2 (Attachment Six) minutes. The motion passed unanimously.

3. Adopted the Report of the Statistical Data (C) Working Group

Ms. Darby said the Statistical Data (EX) Working Group met in regulator-to-regulator sessions and took the following action: 1) researched the ability to collect and publish auto and home premium and exposures under an accelerated timeline; 2) adopted...
the Profitability Report; 3) adopted the *Competition Database Report* (Competition Report); and 4) adopted the *Auto Insurance Database Report* (Auto Report) to be considered by the Task Force before the end of December. Ms. Darby said the Working Group is continuing to work on the *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report* (Homeowners Report).

Ms. Darby made a motion, seconded by Mr. Chou, to adopt the report of the Statistical Data (C) Working Group. The motion passed unanimously.

4. **Exposed the Project #2019-49 Proposal**

Mr. Hay presented a proposal regarding the referred Project #2019-49: Retroactive Reinsurance Exception. His presentation included background information about Schedule P reporting and *Statement of Statutory Accounting Principles (SSAP) No. 62R—Property and Casualty Reinsurance*, discussion topics, a proposal, and alternative actions not proposed (Attachment Seven).

Ms. Darby made a motion, seconded by Mr. Chou, to expose a proposed answer to the referral Project #2019-49, as presented by a drafting group, for a 45-day public comment period ending Jan. 20, 2022.

5. **Exposed Random Forest Information Items and Glossary**

Sam Kloese (NAIC) presented background about random forest models (Attachment Eight) and requested feedback on the regulatory review of random forest models. He presented an exhibit of random forest information items, modeled from the appendix of generalized linear models (GLMs) information items in the *Regulatory Review of Predictive Models* white paper and a proposed glossary of random forest model terminology.

Mr. Dahl made a motion, seconded by Ms. Darby, to expose the NAIC staff’s proposed random forest information items and glossary (Attachment Nine) for a 60-day public comment period ending Jan. 20, 2022.

6. **Heard Presentations from Professional Actuarial Associations**

Dee Dee Mays (Academy) presented the activities of the Academy’s Casualty Practice Council, and Derek Freihaut (Academy) described the activities of the Committee on Property and Liability Financial Reporting (COPLFR) (Attachment Ten).

Brian Fannin (Casualty Actuarial Society—CAS) presented about CAS research activity (Attachment Eleven).

7. **Discussed Other Matters**

Mr. Vigliaturo said proposal 2021-11BWG was not adopted by the Blanks (E) Working Group. Given that result, he said he expects the Property and Casualty Insurance (C) Committee to charge the Statistical Data (C) Working Group with expediting the collection and publication of auto and home premium and exposure data from statistical agents.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Nov. 17, 2021. The following Task Force members participated: James J. Donelon, Vice Chair, represented by Nichole Torblaa (LA); Lori K. Wing-Heier represented by Tom Zuppan (AZ); Ricardo Lara represented by Lynne Wehmueller (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); David Altmaier represented by Christina Huff (FL); Colin M. Hayashida represented by Kathleen Nakasone (HI); Doug Oommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd (KS); Eric A. Cioppa represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers and Cynthia Amann (MO); Troy Downing represented by Mari Kindberg (MT); Chris Nicolopoulos represented by Christian Citarella (NH); Marlene Caride represented by Carl Sornson (NJ); Russell Toal and Anna Krylova (NM); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by David Dahl (OR); Raymond G. Farmer represented by Will Davis (SC); Cassie Brown represented by J’ne Byckovski (TX); Michael S. Pieciak represented by Rosemary Raszka (VT); Mike Kreidler represented by Eric Slavich (WA); and Allan L. McVey and Juanita Wimmer (WV).

1. **Adopted the Profitability Report**

The Task Force conducted an e-vote to consider adoption of the *Report on Profitability by Line by State* (Profitability Report). The motion passed unanimously.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
The Casualty Actuarial and Statistical (C) Task Force met Nov. 9, 2021. The following Task Force members participated: Grace Arnold, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Nichole Torblaa (LA); Lori K. Wing-Heier represented by David Heppen (AK); Jim L. Ridling represented by Daniel J. Davis (AL); Ricardo Lara represented by Lynne Wehmuehler (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); David Altmairer represented by Greg Jaynes (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severinghaus represented by Reid McClintock (IL); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Bierman represented by Ron Coleman and Walter Dabrowski (MD); Eric A. Cioppa represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by Julie Lederer (MO); Troy Downing represented by Mari Kindberg (MT); Mike Causey represented by Arthur Schwartz (NC); Chris Nicolopoulou represented by Christian Citarella (NH); Barbara D. Richardson represented by Gennady Stolyarov (NV); Judith L. French represented by Tom Botsko (OH); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by David Dahl (OR); Jessica K. Altman represented by Kevin Clark (PA); Raymond G. Farmer represented by Ryan Bailey (SC); Cassie Brown represented by J’ne Byckovski (TX); Michael S. Pieciak represented by Mary Richter (VT); and Mike Kreidler represented by Eric Slavich (WA).

1. **Received a Report from the Statistical Data (C) Working Group**

Ms. Darby said the Statistical Data (C) Working Group will be reviewing the *Competition Database Report*; the *Dwelling Fire, Homeowners Owner-Occupied*, and the *Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report* (Homeowners Report); and the *Auto Insurance Database Report* soon and will consider them for adoption prior to the Fall National Meeting.

Ms. Darby made a motion, seconded by Mr. Chou, to adopt the Statistical Data (C) Working Group’s report. The motion passed unanimously.

2. **Adopted a Decision Based on the CAS Study on Appointed Actuary CE**

Mr. Vigliaturo said the continuing education (CE) charge is to “work with the Casualty Actuarial Society (CAS) and the Society of Actuaries (SOA) to identify: 1) what types of learning property/casualty (P/C) Appointed Actuaries are using to meet CE requirements for specific qualification standards today; and 2) whether more specificity should be added to the P/C Appointed Actuaries’ CE requirements to ensure that CE is aligned with the educational needs for a P/C Appointed Actuary. He said this charge resulted from the Executive (EX) Committee’s Appointed Actuary Job Analysis project, was a recommendation from the NAIC’s consultant, and was adopted by the Property and Casualty Insurance (C) Committee as a charge for the Task Force. The Task Force started work on this charge by asking the CAS and SOA to collect data on Appointed Actuaries’ CE and requiring Appointed Actuaries to categorize their CE using specified categories. Mr. Vigliaturo said the first part of the charge was completed with the CAS’ report on Oct. 12. He said what remains of the charge is to determine if there is any reason to believe that Appointed Actuaries are not remaining competent and taking appropriate CE. No one expressed concerns with Appointed Actuaries’ CE selections.

Ms. Stolyarov made a motion, seconded by Mr. Schwartz, to discontinue requiring CE categorization and the reporting of CE to the CAS and SOA in the 2022 Statement of Actuarial Opinion instructions. The motion passed unanimously.

3. **Adopted its 2022 Proposed Charges**

Mr. Vigliaturo said the CE charge is eliminated for 2022 because of the action taken to discontinue CE categorization and reporting. Mr. Vigliaturo presented some proposed additions to the charges regarding predictive analytics work. The Task Force agreed to add two proposed predictive analytics charges with revised wording.

Ms. Lederer made a motion, seconded by Mr. Dyke, to adopt the Task Force’s 2022 proposed charges as amended (Attachment Two-A). The motion passed unanimously.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
The mission of the Casualty Actuarial and Statistical (C) Task Force is to identify, investigate, and develop solutions to actuarial problems and statistical issues in the property/casualty (P/C) insurance industry. The Task Force’s goals are to assist state insurance regulators with maintaining the financial health of P/C insurers; ensuring that P/C insurance rates are not excessive, inadequate or unfairly discriminatory; and ensuring that appropriate data regarding P/C insurance markets are available.

Ongoing Support of NAIC Programs, Products, or Services

1. The Casualty Actuarial and Statistical (C) Task Force will:
   A. Provide reserving, pricing, ratemaking, statistical, and other actuarial support to NAIC committees, task forces and/or working groups. Propose changes to the appropriate work products (with the most common work products noted below) and present comments on proposals submitted by others relating to casualty actuarial and statistical matters. Monitor the activities, including the development of financial services regulations and statistical (including disaster) reporting, regarding casualty actuarial issues.
      1. Property and Casualty Insurance (C) Committee – ratemaking, reserving or data issues.
      2. Blanks (E) Working Group – P/C annual financial statement, including Schedule P; P/C quarterly financial statement; P/C quarterly and annual financial statement instructions, including Statement of Actuarial Opinion (SAO) and Actuarial Opinion Summary Supplement.
   B. Monitor national casualty actuarial developments and consider regulatory implications.
      1. Casualty Actuarial Society (CAS) – Statements of Principles and Syllabus of Basic Education.
      3. Society of Actuaries (SOA) – general insurance track’s basic education.
   C. Facilitate discussion among state insurance regulators regarding rate filing issues of common interest across the states through the scheduling of regulator-only conference calls.
   D. Conduct the following predictive analytics work:
      1. Facilitate training and the sharing of expertise through predictive analytics webinars (Book Club).
      2. Review the completed work on artificial intelligence (AI) from other Committee groups. Coordinate with the Innovation, Cybersecurity, and Technology (H) Committee on the tracking of new uses of AI, auditing algorithms, product development, and other emerging regulatory issues, in as far as these issues contain a Task Force component.
      3. With NAIC staff assistance, discuss guidance for regulatory review of tree-based models and generalized additive models (GAMs) used in rate filings.
2. The **Actuarial Opinion (C) Working Group** will:
   A. Propose revisions to the following, as needed, especially to improve actuarial opinions, actuarial opinion summaries, and actuarial reports, as well as the regulatory analysis of these actuarial documents and loss and premium reserves:
      3. *Annual Statement Instructions—Property/Casualty.*
      4. Regulatory guidance to appointed actuaries and companies.
      5. Other financial blanks and instructions, as needed.

3. The **Statistical Data (C) Working Group** will:
   A. Consider updates and changes to the *Statistical Handbook of Data Available to Insurance Regulators.*
   B. Consider updates and developments, provide technical assistance, and oversee the production of the following reports and databases. Periodically evaluate the demand and utility versus the costs of production of each product.
      1. *Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance.*
      2. *Auto Insurance Database.*

NAIC Support Staff: Kris DeFrain/Jennifer Gardner/Libby Crews
The Casualty Actuarial and Statistical (C) Task Force met Oct. 12 and Oct. 19, 2021. The following Task Force members participated: Grace Arnold, Chair, represented by Phil Vigliaturo (MN); James J. Donelon, Vice Chair, represented by Nichole Torblaa (LA); Lori K. Wing-Heier represented by David Heppen (AK); Evan G. Daniels represented by Tom Zuppan (AZ); Ricardo Lara represented by Mitra Sanandajifar and Lynne Wehmuller (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N.Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); David Altmayer represented by Sandra Severinghaus and Judy Mottar (IL); Amy L. Beard represented by Stephen Chambee (IN); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Brrane represented by Ron Coleman and Walter Dabrowski (MD); Eric A. Cioppa represented by Sandra Darby (ME); Anita G. Fox represented by Kevin Dyke (MI); Chlora Lindley-Myers represented by Julie Lederer (MO); Troy Downing represented by Mari Kindberg (MT); Mike Causey represented by Arthur Schwartz (NC); Chris Nicolopouls represented by Christian Citarella (NH); Russell Toal represented by Anna Krylova (NM); Barbara D. Richardson represented by Gennady Stolyarov (NV); Judith L. French represented by Maureen Motter (OH); Andrew R. Stolfi represented by David Dahl (OR); Jessica K. Altman represented by James DiSanto (PA); Raymond G. Farmer represented by Will Davis (SC); Cassie Brown represented by J’ne Byckowski and Miriam Fisk (TX); Michael S. Pieciak represented by Rosemary Raszk (VT); and Mike Kreidler represented by Eric Slavich (WA). Also participating was: Gordon Hay (NE).

1. **Adopted Regulatory Guidance and Received a Report from the Actuarial Opinion (C) Working Group**

Ms. Krylova said the Actuarial Opinion (C) Working Group met Sept. 2 and Sept. 8 to finalize the *Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2021* (Regulatory Guidance). Substantive changes include Schedule P reconciliation and notification about a future expected change to create a deadline of submission of qualification documentation to the Board of Directors. The Working Group adopted the Regulatory Guidance via an e-vote on Sept. 23.

Ms. Krylova made a motion, seconded by Ms. Darby, to adopt the Actuarial Opinion (C) Working Group’s report, including the 2021 Regulatory Guidance *(see NAIC Proceedings – Fall 2021, Casualty Actuarial and Statistical (C) Task Force, Attachment Five-A)*. The motion passed unanimously.

2. **Received a Report from the Statistical Data (C) Working Group**

Ms. Darby said the Statistical Data (C) Working Group updated its *Report on Profitability by Line by State* (Profitability Report) and will consider it for adoption on Oct. 20. Data for auto and homeowners have been received.

The Working Group met Oct. 7 to: 1) adopt its Sept. 23 minutes; and 2) discuss the timeline for the data collection of NAIC reports.

Ms. Darby made a motion, seconded by Mr. Chou, to adopt the Statistical Data (C) Working Group’s report, including its Oct. 7 minutes (Attachment Three-A). The motion passed unanimously.

3. **Adopted a Response to the Blanks (E) Working Group Regarding Proposal 2021-11BWG**

Mr. Vigliaturo said proposal 2021-11BWG (Attachment Three-B) was submitted by Birny Birnbaum (Center for Economic Justice—CEJ), one of the NAIC consumer representatives, to the Blanks (E) Working Group earlier this year. The Task Force was asked for comments on the original proposal and responded, “CASTF is ready to provide guidance regarding the implementation of the Blanks proposal 2021-11BWG if that proposal moves forward. Furthermore, CASTF requests that Birny Birnbaum submit the most current up-to-date version of the proposal for further consideration and suggestions from CASTF.”

On July 22, the Working Group met and discussed a modified proposal. As noted in the July 22 letter from the Working Group, the Task Force is asked to review the modified proposal and comment. Mr. Vigliaturo said the question of whether the data would be useful for solvency reporting is a question being handled under the Financial Condition (E) Committee, so he...
suggested that the Task Force focus on three things: 1) whether the Task Force can get some data from statistical agents under similar timing as the annual statement reporting; 2) whether the data elements in the blanks proposal are defined appropriately; and 3) whether the Task Force wishes to support the proposal.

Ms. Darby reported that the Statistical Data (C) Working Group met Sept. 23 and Oct. 7 to discuss the charge from the Task Force to gather information on whether the timeline can be sped up on receipt of premium and exposure information from outside parties. NAIC staff asked submitting statistical agents and residual markets if their current timeline for submitting data could be sped up. NAIC staff also gathered data on what percentage of the total data each party was submitting.

The Working Group received varied responses from the submitting parties. Because statistical agents are not collecting data in the same way, they cannot provide the data to the NAIC on the same timeline. Additionally, statistical agents indicated that not only do they need to wait for company submissions, but they also need time for data quality checks and communication with companies for any data issues.

For the Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report (Homeowners Report), in the year following the data year, the Working Group would be able to collect 32% of premium data by the end of May, 60% of premium data by the end of August, and 99% of premium data by the end of November. The Working Group initially believed California would still only be able to provide its data every other year, but it has since indicated that it would be able to use another data set to send in average premium data in June of the year following the data year. All data would still need to be aggregated by NAIC staff, making any output report available in December following the data year, at the earliest.

For the Auto Insurance Database Report (Auto Report), in the year following the data year, the Working Group would be able to collect 32% of premium data by the end of May, 49% of premium data by the end of August, and 91% of premium data by the end of November. Texas data, which makes up the remaining 9% of data, would not be provided until January of the next year. Again, all data would have to be aggregated and reviewed by NAIC staff before a report could be produced. The responses for the Auto Report are based only on the collection of premium and exposure data. Loss data cannot be provided on this same timeline.

Ms. Darby said the Working Group has fulfilled its charge as requested by the Task Force. The Working Group is open to continuing the discussion of data collection, including discussion on the data collection and submission process outlined in the Statistical Handbook, that may address the need for more timely data.

The Task Force discussion included the following: 1) statistical premium and exposure data would be increased by about 12 months; 2) both the statistical report speed increase and the annual statement proposal could be implemented; 3) an option would be to implement the financial statement proposal in the short term and speed up the statistical data in the longer term; 4) data would be useful to assess the impacts of sudden changes, such as COVID-19; 5) the quarterly part of the proposal would not be broken out by state and would not be useful; 6) a cost benefit analysis should be conducted; 7) 100-year events may be better handled using a data call rather than through annual reporting; 8) average premium could be misleading because the same data could support multiple explanations (e.g., moving policies between legal entities in a group); 9) companies may consider exposures by state to be competitive information and not want it to be in a public filing; 10) the data is company-by-company, whereas the statistical data is aggregated; 11) the exposure data would be useful for rate filings so data can be reconciled; 12) exposure data is an element not currently collected anywhere in the annual statement; 13) the proposal can be expanded to other lines of business over time; and 14) exposure basis by line of business has not been discussed by the Task Force.

Mr. Birnbaum said the Working Group should take a more holistic review of modernizing and re-engineering statistical reporting and not make changes one piece at a time. He said the financial statement approach is a less expensive plan and would be beneficial to consumer representatives, financial analysts, and academics. He added that the quarterly reports do not contain by state by line information; thus, this proposal did not include that by quarter. He said the blanks proposal is consistent with the NAIC State Ahead initiative to modernize regulatory processes. He reiterated that this data is financial data and completely consistent with the financial statement aim. He said the data would be available in four to five months; statistical data will not be available for at least 12 months.

Continuing the discussion on the Oct. 19 meeting, interested parties Ralph Blanchard (Travelers), Jonathan Rodgers (National Association of Mutual Insurance Companies—NAMIC), Rachel Underwood (Cincinnati Insurance Companies), and Angela Gleason (American Property Casualty Insurance Association—APCIA), voiced opposition to the blanks proposal. Mr.
Blanchard said the data is statistical; the three main financial reports are cash flow statements, income statements, and balance sheets. He said financial data has a dollar sign in front of it; calling it statistical data borders on dishonest. The cost of this proposal has not been calculated; it is usually cheaper to speed up an existing process than to create a new one. The financial systems are not set up to collect exposure data. Mr. Blanchard said there is a big difference between financial systems and statistical systems. He said it is not a trivial exercise for the companies to report this requested information on these financial statements. He added that there has been no specificity with how the data would be used. Mr. Rodgers said the chief concern is that the request is to add statistical-level data to the blanks. There will be several unintended consequences. NAMIC would like a clear explanation of how the data will be used. Mr. Rodgers said the statistical data can be collected a full year earlier through statistical agents, and that should be the way forward. The purpose of the blanks is to communicate financial information in a uniform format; this data is not financial. Mr. Rodgers said this proposal could lead to requesting more statistical data in the financial statements. He said companies share the concern of data reporting errors and the resulting amended financial statements; statistical agents do data quality checks. Audit issues would be material. Currently, reports are aggregated and produced annually; the data is being proposed to be by company and produced quarterly. State insurance regulators can request the information. Ms. Underwood said the proposal is to get industry-level, aggregate premium per exposure by state. The sponsor previously responded that if the data could be available sooner, this proposal would not be needed. The time to publish statistical data can be cut in half, and preliminary results could be published even earlier. She said this data does not change significantly, especially quarter-by-quarter. Statistical agents need two months to perform data quality checks, but this proposal is asking companies to have final reports in less than two months. Ms. Gleason agreed with previous comments, and she looks forward to understanding the reasons for the reporting and desired use. She said everyone likes data, but there are valid data security concerns. She said the Working Group proposed a method that is in line with State Ahead because it tried to modernize and propose a way forward.

Mr. Vigliaturo said preliminary state views were gathered by NAIC staff about how Task Force members proposed to respond to the Blanks (E) Working Group, asking whether to voice support, voice opposition, or remain neutral as a Task Force and the reasons each state would use to support their position. His plan was to see if there is a strong majority for any view and then propose a fitting motion. Unfortunately, the strawman vote with 20 Task Force states responding, does not give much direction because the votes are about evenly split between supporting and opposing the proposal. Mr. Vigliaturo suggested that the Task Force submit a state-by-state Task Force member survey response, but with final votes from states that may differ what was submitted on the survey. He asked the states to report to NAIC staff by Oct. 22.

Mr. Vigliaturo said states would be identified, and any comments made in the survey will be forwarded. Mr. Birnbaum said the statistical report is not a direct comparison to the blanks proposal because it is not company-by-company.

Mr. Chou made a motion, seconded by Ms. Darby, to respond to the Blanks (E) Working Group on Oct. 22 with the results of individual states’ survey responses and the Statistical Data (C) Working Group report about the potential to speed up premium and exposure statistical data collection and reporting. The motion passed unanimously.

4. Received a Report from the CAS on Appointed Actuary CE

Mr. Vigliaturo said the Executive (EX) Committee hired a consultant a few years ago to conduct a job analysis on the property/casualty (P/C) Appointed Actuary. One of the recommendations in the consultant’s report was to evaluate the continued competence of Appointed Actuaries after obtainment of credentials. With that charge given to the Task Force, the Task Force asked the Casualty Actuarial Society (CAS) and the Society of Actuaries (SOA) to collect data on Appointed Actuaries’ continuing education (CE) and required Appointed Actuaries to categorize their CE using the Task Force’s adopted categories. With those actions taken, what remains of the continued competence charge is to work with the CAS and the SOA to identify: 1) what types of learning P/C Appointed Actuaries are using to meet CE requirements for “Specific Qualification Standards” today; and 2) whether more specificity should be added to the P/C Appointed Actuaries’ CE requirements to ensure that CE is aligned with the educational needs for a P/C Appointed Actuary.

Ken Williams (CAS) described the written report submitted by the CAS (Attachment Three-C) in fulfillment of the Task Force’s first charge. He said the CAS reviewed over 100 members to evaluate CE compliance. A higher percentage of appointed actuaries participate in the process. There were 41 Appointed Actuaries and 37 used the required categorization. Mr. Williams said reserves and requirements were the highest number of hours, and reinsurance was the lowest; there were a lot of “other,” which is mostly COVID-19-related. He said the report shows the number of Appointed Actuaries who reported learning in a category and provided the average number of hours.
Mr. Vigliaturo said the aim is for the Task Force to: 1) discuss any concerns with the types of CE being taken by Appointed Actuaries; 2) decide whether there is a need to take any action to require that specific CE be taken by Appointed Actuaries; and 3) decide whether to continue to require the CE categorization or end this reporting requirement in the SAO instructions.

On its Oct. 19 call, the Task Force began discussion of the second part of the Task Force’s charge. Mr. Vigliaturo asked: 1) whether anyone has any concerns with the types of CE being taken by Appointed Actuaries; 2) whether it appears that Appointed Actuaries are taking relevant CE to continue to update skills; and 3) whether the Task Force has concerns that there is a need to take any further action, such as creating requirements for certain types of CE. He said if the Task Force has no concerns, then the question becomes whether to continue to require the CE categorization or end this reporting requirement in the 2022 SAO instructions. Mr. Schwartz said the categories originally adopted by the Task Force are excessive. He said he would want to make the categories fewer, the reporting simpler, and the process streamlined.

Ms. Lederer said before implementation of the CE categorization, she submitted a comment letter on this proposal and stated that she did not know what she would do with the resulting information. She said the reserving category is well represented, so perhaps actuaries find this topic to be important, or perhaps Appointed Actuaries are spending too much time on this category. She said it might be worth discussing not requiring the categorization in the future. Alternatively, she said state insurance regulators should discuss the findings and metrics that could lead to the decision to remove categorization requirements. Mr. Vigliaturo said he agrees that it was difficult to classify presentations because one presentation could contain multiple categories.

The Task Force will continue this discussion on its Nov. 9 call.

5. Received a Report on Project #2019-49

Mr. Hay said he drafted a response to the referral of Project #2019-49—Retroactive Reinsurance Exception, and he will have a final proposal for the Task Force for the meeting in December. His draft response includes two proposals regarding Statement of Statutory Accounting Principles (SSAP) No. 62R—Property and Casualty Reinsurance paragraph 36. First, add intercompany pooling agreements to the exceptions in SSAP No. 62R; second, modify the Schedule P instructions to require explanation for each of the steps in SSAP No. 62R paragraph 36 exceptions. Mr. Hay said the issues involve structured settlements, reinsurance commutations, innovations, runoff agreements, and affiliated reinsurance that qualify for prospective reinsurance accounting treatment.

Mr. Hay said he does not have proposed resolutions for at least two issues raised in the Statutory Accounting Principles (E) Working Group. Except for intercompany reporting, he does not see anything confusing in SSAP No. 62R for Schedule P presentations for members of the same group versus not in the same group. Also, the American Academy of Actuaries’ (Academy’s) Committee on Property and Liability Financial Reporting (COPLFR) observed variations in presentation to ambiguity in SSAP No. 62R. He said case studies did not validate this. Also, COPLFR thought better instructions and clarity would prevent distortions in the industry risk-based capital (RBC), but Mr. Hay also saw affiliated deals that on Schedule P would produce material sessions to entities outside the NAIC system. Therefore, improving instructions and adding clarity alone will not solve the problems.

Mr. Hay said he will seek input from Nebraska and the Catastrophe Risk (E) Subgroup, and he will collaborate with the Statutory Accounting Principles (E) Working Group.

6. Heard a Report on the NAIC Rate Model Reviews

Kris DeFrain (NAIC) presented three issues concerning rate model reviews by states and the NAIC. First, is a request for Task Force assistance about the regulatory review of tree-based models. The second issue is a professional and ethical question about how states should handle rate filings submitted by non-actuaries who are not subject to any professional standards. The third issue is to explain the NAIC tools available if states sign the NAIC Rate Review Support Services Agreement yet do not plan to ask the NAIC for a model review.

Most of the model reviews contain Generalized Linear Models (GLMs), and they are aligned with the Task Force’s Regulatory Review of Predictive Models white paper. Sam Kloese (NAIC) is taking the GLM information items and rankings of importance from the white paper’s appendix and modifying them via tracked changes for differences when reviewing a tree-based model. The Task Force will have to decide whether it wants to take the product forward for adoption or only use it as a reference for
discussion with the NAIC to ensure the NAIC is conducting reviews the way state insurance regulators need. Mr. Kloese will present the product on the Task Force’s Nov. 12 call.

Next is a professionalism issue. Some rate filings are being submitted by non-actuaries; thus, while still subject to law and regulation, the filings are most likely not subject to professional or ethical standards. Most states do not have any type of requirement for an actuary to prepare the filing or provide an expert opinion about the model. Ms. DeFrain said state insurance regulators are used to working with actuarial standards in place, and some requirements may need to be put in place to ensure the models are built in accordance with documentation, communication, ethical, and other requirements.

Last on the list is to discuss the Agreement, which 31 states have signed, and one more state is in the pipeline. While not all states need the NAIC rate review service, the Agreement also allows states access to the NAIC’s Shared Model Database and case studies. If one state finds that a company’s rate model has been reviewed by another state, the NAIC will conduct what is called a Comparison Report. NAIC staff will compare the filings between the two states, document any differences, track the objections made by the first state and answers received, and document the conclusions reached. If desired, the NAIC can also review any new issues. Ms. DeFrain added that the Agreement will place no burdens on the state, but if put in place now, it might be useful if state insurance regulators want to use the other NAIC services or have a short-term need to use the NAIC for model reviews after the loss of a key employee.

Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
The Statistical Data (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Oct. 7, 2021. The following Working Group members participated: Sandra Darby, Chair (ME); Wanchin Chou, Vice Chair, and Qing He (CT); Daniel Davis (AL); David Christhilf (DC); John Sobhianian, Nichole Torbla, and Tom Travis (LA); Christian Citarella (NH); Tom Botsko (OH); Andrew Schallhorn and Landon Hubbart (OK); David Dahl (OR); and Brian Ryder and J’ne Byckovski (TX). Also participating were: Giovanni Muzzarelli (CA); Anthony Bredel (IL); Cynthia Amman (MO); Chris Aufenthie (ND); and Eric Lowe (VA).

1. **Adopted its Sept. 23 Minutes**

The Working Group met Sept. 23 to discuss the timeline for the data collection of NAIC reports.

Mr. Botsko made a motion, seconded by Mr. Citarella, to adopt the Working Group’s Sept. 23 minutes (Attachment Three-A1). The motion passed unanimously.

2. **Discussed the Timeline for the Data Collection of NAIC Reports**

Ms. Darby said during its last meeting, the Working Group discussed responses received from statistical agents and residual markets about their ability to submit the data for the Homeowners and Auto reports on a faster timeline. She said the responses were varied, and there was no consensus during the last meeting on how to respond to the request for information from the Casualty Actuarial and Statistical (C) Task Force. She said NAIC staff asked statistical agents if they would be able to provide only premium and exposure data on a faster timeline, and NAIC staff calculated the percentage of data that was being reported by each statistical agent or residual market.

Birny Birnbaum (Center for Economic Justice—CEJ) said the varied responses make it clear that the data cannot be collected on a faster timeline.

Ms. Darby said the California and Texas data, which would not be able to be reported early, makes up about 20% of the data for both the Homeowners and Auto reports. Laura Panesso (Insurance Services Office—ISO) said the ISO’s data could be provided in May, following the end of the data year.

Ralph Blanchard (Travelers) said if companies can send one statistical agent data by a certain date, they should be able to send another statistical agent by that same date. Mr. Birnbaum said it is not possible with the current statistical reporting framework. He said the ISO can produce summaries of data quickly because it receives transaction data on a quarterly basis that can be processed quickly. He said the Independent Statistical Service (ISS) and the National Independent Statistical Service (NISS) get annual reports that include not just premium data, but also claims data, and those reports are timed with a long enough lead time that the claims data are meaningful in relation to the premiums. He said even all the reporting entities were able to provide the data at the same time, there is still time needed for NAIC staff to combine all the data to produce a report.

Rachel Underwood (Cincinnati Financial) said in the Working Group’s response to the Task Force, it should include all the information gathered, instead of a simple yes or no response. She said the Task Force can then decide, based on all the information, if they can proceed with only a certain percentage of the data since not all the data can be provided in a sped up timeline. Mr. Birnbaum said while the Working Group should provide all the information collected, it should be able to give a yes or no answer to the question of whether the reporting timeline can be sped up given the current statistical methods of reporting. He said that answer, based on the information collected, would be no. Ms. Darby said all the information would be summarized and reported to the Task Force.

Mr. Citarella asked for clarification of the charge from the Task Force. Libby Crews (NAIC) said the motion made and adopted during the Aug. 10 meeting was to “gather information about whether the timeline can be sped up on receipt of premium and exposure information from outside parties.” Mr. Citarella said the Working Group has completed that investigation, and the response to the Task Force should be more detailed than a simple yes or no answer. Mr. Chou agreed that the information gathered by the Working Group should be summarized in the report to the Task Force.
Mr. Citarella made a motion, seconded by Mr. Chou, to provide the Task Force with a summary of the responses received from submitting statistical agents. The motion passed unanimously.

Having no further business, the Statistical Data (C) Working Group adjourned.

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The Statistical Data (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Sept. 23, 2021. The following Working Group members participated: Sandra Darby, Chair (ME); Wanchin Chou, Vice Chair, George Bradner, and Qing He (CT); John Sobhanian (LA); Arthur Schwartz (NC); Christian Citarella (NH); Alexandra Vajda (NY); Andrew Schallhorn and Landon Hubbart (OK); Ying Liu (OR); and Ken Burton and J’ne Byckovski (TX). Also participating were: Luciano Gobbo (CA); Randy Jacobson (HI); Anthony Bredel (IL); and Eric Lowe (VA).

1. **Discussed the Timeline for the Data Collection of NAIC Reports**

Ms. Darby said that during the Aug. 10 meeting of the Casualty Actuarial and Statistical (C) Task Force, there was a request to the Statistical Data (C) Working Group to gather information on whether the timeline for data collection for the Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance (Homeowners Report) and Auto Insurance Database Report (Auto Report) reports can be sped up. She said NAIC staff requested that information from submitting statistical agents and residual markets. She said some of the responses indicated that certain statistical agents could provide data in late fall in the year following the data year. She said two big exceptions were the auto data provided by Texas and the homeowners data provided by California. Mr. Chou said even if Texas and California cannot report, the Working Group should still investigate the possibility of a faster timeline.

Birny Birnbaum (Center for Economic Justice—CEJ) said his proposal for data collection submitted to the Blanks (E) Working Group was the catalyst for this discussion. He said the responses from the statistical agents make it clear that his proposal for data collection is the most efficient method to get average premium data on these lines of business.

Mr. Chou said even if Texas and California cannot report, the Working Group should still investigate the possibility of a faster timeline. Mr. Birnbaum said the Insurance Services Office (ISO) indicated that it could speed up the reporting, but the Independent Statistical Service (ISS) indicated that it would not be able to provide its data until late in the year following the end of the data year. Al Burton (ISS) said companies report to the ISS annually in the summer of the next year following the end of the data year. He said submitted data is not necessarily ready to be used and needs to be quality checked. Mr. Birnbaum said the standard statistical reports that statistical agents collect from insurers have a tremendous amount of claims data and a greater level of detail than is requested in his proposal. He said his proposal is not intended to replace the information that is provided by the Homeowners Report and Auto Report. He said it should not take two years after the experience period for state insurance regulators to know what the average premiums are in their state.

Tip Tipton (Thrivent) said the main concern with Mr. Birnbaum’s proposal is that the financial annual statement is used by state insurance regulators for solvency purposes and financial reporting. He said bringing in this type of statistical data would be excessive and that it is not the appropriate place to gather this data.

Mr. Chou asked if the timeline could be sped up if the requested data was only for premiums and exposure, and not claims. Mr. Burton said when compiling the Texas data, the last of the data sources used typically becomes available 10–12 months after the end of the year. He said they would have a hard time shifting resources from other statutorily required reporting in order to complete this data request faster. Mr. Chou asked if the data source that delays Texas reporting could be improved. Mr. Burton said the data source has a statistical plan that has been approved by state insurance regulators in every state and that requesting a less detailed report to speed up the timeline would require the data source to file a new statistical plan with regulators.

Ralph Blanchard (Travelers Insurance) asked if there was a difference in the data quality scrubbing in the data being requested in Mr. Birnbaum’s proposal and the data submitted for the statistical reports. Stephen Clark (ISO) said it would be a challenge to achieve good data quality across the industry with the annual statement data. He said data quality is extremely important with the data that the ISO submits for the statistical reports. He said if there is a willingness to accept lesser data quality checks, it may be possible to accelerate the timeline. Mr. Burton (ISS) agreed that less rigorous data checks could speed up the timeline, but it would still depend on when they receive the data from companies. Mr. Birnbaum said the data reported in the annual statement would not be as granular as the data currently requested in the statistical reporting. He said statistical agents that...
receive transaction-level data are able to quality check their data much quicker. He said the data quality checks that go into the statistical reporting are much more time-consuming than the data in the annual statement because of its granularity.

Mr. Chou asked if Mr. Birnbaum’s annual statement proposal is adopted, is there a concern that average premium numbers derived from that data could be significantly different from the statistical reports that would be released two years later and if there could be misuse of those numbers. Mr. Birnbaum said he would not expect those numbers to be significantly different. He said data such as premium and exposures should be simple for companies to report on a statewide basis. He said he is not concerned with misuse because currently the statistical reports are two years behind, and the use of two-year-old average premium data would be more concerning.

Mr. Schwartz asked why it would take 10 months to report to submit data when companies should have the premium and exposure data shortly after the end of the year. He said the Working Group should spend time researching why certain companies cannot provide that data sooner and if there is a way to speed up the process. Ms. Darby asked if the data source for Texas could speed up their reporting if only premium and exposure data was collected. Mr. Burton said the earned exposure is what takes a long time to collect, and some larger companies are not able to submit that data quickly. He said it would require analysis to see if the report can be submitted without the earned exposure piece.

Mr. Bradner said the statistical data that is submitted to states involves an antiquated process that needs change and updating. Mr. Birnbaum said if all statistical agents were receiving transactional data, it would be much quicker to report that data. He said that type of reporting would require a rethinking of the statistical process. He said his proposal is not intended to do that and that it is a modest proposal to get specific information. Mr. Chou asked if the Working Group is fine with the current antiquated process of data collection or if they should investigate an alternative that would offer a more updated and technological approach. Ms. Darby agreed that the Working Group should continue to investigate the statistical reporting process and how it can be improved without losing data quality.

Ms. Darby said from the responses of the submitting statistical agents, she does not see a way to provide the data in its current form any faster. Mr. Citarella said his response to the request from the Casualty Actuarial and Statistical (C) Task Force would be that the Working Group would not recommend sacrificing completeness for speed.

Ms. Darby said the Working Group will hold another meeting to have a more in-depth discussion with the statistical agents about what information they would be able to provide and what can be done to speed up their processes.

Having no further business, the Statistical Data (C) Working Group adjourned.
Comments of the Center or Economic Justice

To the NAIC Casualty Actuarial and Statistical Task Force

Blanks Referral for Proposal 2021-11BWG

October 11, 2021

In response to the Blanks Working Group referral to CASTF, CEJ urge CASTF to recommend adoption of Blanks Proposal 2021-11BWG for the following reasons.

1. The addition of two data elements – written exposures and earned exposures – to the current reporting of written premium and earned premium for the private passenger auto and homeowners lines of business will provide useful and relevant information for regulators, policymakers and the public by providing some of the same information in current CASTF reports but two or more years earlier.

2. Contrary to industry claims, the additional data elements – and average premium calculations generated – will not be misleading to regulators, policymakers or the public.

3. The additional data elements complement CASTF’s statistical reports which provide more granular and additional data analysis.

4. The additional data elements are financial information suited to reporting through the annual and quarterly financial statements. By reporting through the financial statement infrastructure, the data will be comprehensive, uniform and timely.

5. There is no meaningful alternative – speeding up reporting by statistical agents and states to produce the same limited information is not feasible with the current statistical agent infrastructure.


Additional Issue More Relevant for Blanks Working Group consideration

7. There will be a non-material cost burden on insurers to report the additional data elements.
The addition of two data elements – written exposures and earned exposures – to the current reporting of written premium and earned premium for the private passenger auto and homeowners lines of business will provide useful and relevant information for regulators, policymakers and the public by providing some of the same information in current CASTF reports but two or more years earlier.

The NAIC and individual states have determined that average personal auto premium and average homeowners premium are relevant and useful information for regulators, policymakers and the public, as evidenced by the publication of these values in the Auto Insurance Database Report and the Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner’s Insurance Report.

For example, on page 3 of the 2021 Auto Insurance Database Report, the average expenditure calculation is shown as total personal auto written premium divided by liability written exposures. This calculation can be exactly replicated with the data reported pursuant to 2021-11BWG – nearly two years sooner than the publication of the Auto Insurance Database Report.

Similarly, the average premium in the Homeowners report is calculated by dividing written premium by written exposures. Written exposures are expressed as house-years. The report includes a table aggregating written exposures by homeowners owner-occupied and homeowners tenants and condo/co-op. The report calculates total average premium by dividing written premium by written exposures for homeowners owner-occupied policy forms and for tenant/condo/coop policy forms. 2021-11BWG allows exact replication of the tenant/condo/coop calculation while permitting an owner-occupied calculation limited to homeowners policy forms – nearly two years sooner than the publication of the Homeowners report.

If the publication of average premium for personal auto and residential property insurance is sufficiently relevant and important for the NAIC to publish these values, it is equally or more relevant and important to provide data permitting these calculations in a far more timely manner.

Contrary to industry claims, the additional data elements – and average premium calculations generated – will not be misleading to regulators, policymakers or the public.

Some have argued that average premium calculations developed from data reported pursuant to 2021-11BWG would be misleading or confusing to consumers. This argument is logically and factually incorrect.
First, if the potential calculations with data reported pursuant to 2021-11BWG replicate calculations in the CASTF reports, it simply can’t be argued that the average premium values are misleading. In fact, by making an average premium value available much closer to the experience period, the average premium calculations generated from data reported pursuant to 2021-11BWG are more relevant and less misleading than values reported two years after the experience period.

For example, the NAIC issued a press release on March 9, 2021 announcing the release of the Auto Insurance Database Report. The release stated, “The national average annual expense per insured vehicle was $1,190 in 2018, a 20.87% increase from 2014.” When newspapers pick up this story, there is no caveat that the data are two to three years old and may not reflect current conditions. Rather, the logical response from media and consumers is that this information is relevant and current. By permitting the calculation of average premium values two years earlier than the CASTF reports, 2021-11BWG will reduce confusion and the potential for policymakers and consumers to be misled.

Second, some have argued that the CASTF reports are not misleading or confusing because the reports provide more detail and explanation about the tables in the reports. The additional data detail is important and useful for some purposes, but the fact remains that NAIC and state insurance department press releases and media coverage focus on the top line numbers, not the detailed analyses. Stated differently, providing a report with more detail and commentary is no guarantee that the detailed data or commentary will be used or relied upon.

Third, if confusion or misconception are a concern, there is nothing to prevent the NAIC – or state insurance departments – from issuing a press release or brief report with any caveats or commentary shortly after the 2021-11BWG data are reported.

Fourth, denying the collection and reporting of the additional data elements in 2021-11BWG based on false claims about misleading and confusing policymakers and consumers is simply censorship based on the implicit assumption that only insurers and regulators know how to analyze and present insurers’ financial information. This implicit assumption is forcefully disproved by the presence of scores of rating agencies, financial market analysis and academics who analyze and interpret insurers’ financial information.

The additional data elements complement CASTF’s statistical reports which provide more granular and additional data analysis.

As noted above, the CASTF reports contain far more and more detailed data than would be reported pursuant to 2021-11BWG. Consequently, 2021-11BWG complements the CASTF reports in the same way that Fast Track data reports complement annual reports from statistical agents or that quarterly financial statements complement annual financial statements.
The additional data elements are financial information suited to reporting through the annual and quarterly financial statements – comprehensive, uniform

Industry has incorrectly argued that the two additional data elements in 2021-11BWG are statistical data and not financial data and, consequently, do not belong in the quarterly and annual financial statements.

As evidenced by the recent efforts by the Statistical Working Group to explore the potential for timelier reporting by statistical agents of premium and exposure data, the defining characteristic of statistical reports is the provision of claims experience matched to exposures. It is this matching that requires statistical agents to wait 15 months after the end of the experience period to collect claims experience associated with exposures from that experience period.

In contrast written and earned premium and written and earned exposures are financial information available immediately after the end of the experience period. To understand why this is the case, consider how insurers calculate the written and earned premium values reported in the annual and quarterly financial statements.

Insurers maintain a database of sales transactions – records of when a new or renewal policy was issued and the amount of premium associated with that policy. When the insurer calculates written premium for an experience period, the insurer sums the premium on policies issued during the period and nets out return premium for net written premium during the period. When the insurer calculates the earned premium for the period, the insurer calculates the portion of the policy term occurring during the experience period, multiples this fraction times the policy premium and sums these amounts.

The calculation of written exposures and earned exposures is identical to the calculation of written and earned premium with the exception that instead of summing premium, the calculation sums vehicles insured and homes insured, respectively, for personal auto and homeowners. No claims information is involved and the same financial records used to calculated written and earned premium are used to calculate written and earned exposures.

There is no meaningful alternative – speeding up reporting by statistical agents and states to produce the same limited information is not feasible with current statistical agent infrastructure for statistical agents and states representing well over 50% of the market.

The Statistical Working Group investigated whether the statistical agents could speed up the delivery of their annual reports, generally, or just the premium and exposure data elements, specifically. The result of this investigation was clearly no.
It is important to set the baseline against which to compare the various stat agents’ and states’ responses. Insurers are required to submit the annual financial statement by March 1 and April 1, respectively, for key schedule and exhibits and remaining schedules and exhibits. Quarterly financial statements are due 45 days following the end of the first three experience quarters. This means that the by line by state data for the annual statement in 2021-11BWG is available to regulators shortly after the submission data and to the public about 30-45 days after the submission date. So, the by state by line data in the annual statement portion of 2021-11BWG is available to the public by around May 15 (though some purchases obtain annual statement data in April) and the by line data in the quarterly statement portion of 2021-11BWG is available to the public by around June 30, September 30 and December 30, respectively for Q1, Q2 and Q3 quarterly statements.

The Statistical Working Group received responses 15 statistical agents. Of the three main statistical agents – ISO, NISS and ISS, only ISO stated an ability to provide an earlier report of premiums and exposures – in May. NISS and ISS, who account for about 50% of the personal auto and homeowners statistical reporting, are not able to speed up delivery. While some state entities reported the ability to speed up delivery, most indicated they could not, including California with 11-12% of the total market.

Putting aside the obvious problems with usefulness of a minority of countrywide experience, even if the speeded up reporting was limited to the statistical agents and states who could provide the premium and exposure data sooner than the current schedule (and not all could meet a May deadline for full year reporting), the NAIC would have to collect and compile the information, which would take additional time.

The use of the annual and quarterly financial statement reporting reflected in 2021-BWG represents an extremely efficient method of collecting comprehensive and complete data in a uniform and consistent fashion in a timely manner.

**By virtue of financial statement reporting, 2021-11BWG includes some data quality checks.**

The instructions for reporting included 2021-11BWG require that the earned premium and written premium values tie to other exhibits in the annual and quarterly financial statements. These are core financial data points that, themselves, are typically used to verify and reconcile other data reports. For example, the statistical agent AAIA, in its response to the Statistical Working Group, states, “As far as how soon AAIS could get this data to the NAIC, our initial assessment is that if we started on the reconciliation when we get the preliminary annual statement data in May we should be able to finalize data by September.”
Additional Issue More Relevant for Blanks Working Group consideration: There will be a non-material cost burden on insurers to report the additional data elements.

Some have raised the argument that reporting of data pursuant to 2021-11BWG will be costly for insurers, although this claim of cost burden has not been supported by any evidence or logical explanation. In fact, it is demonstrable that any additional cost to insurers will be non-material.

Recall the discussion above about how insurers track sales transactions and calculate written and earned premium for financial statement reporting. With access to the transaction data that permits calculating written and earned premium, the analogous calculations of written and earned exposures are minor additions. This ease of calculation is evidenced by the response of ISO to the Statistical Working Group inquiry. Insurers reporting to ISO report transaction-detail data – similar to the data records maintained by insurers. By virtue of having transaction data, indicated the ability to report the premium and exposure data shortly after receipt from insurers.

2021-11BWG does not require insurers to collect any new data elements nor even to calculate new data elements. It simply asks insurers to report written and earned exposures at the same time and in the same detail and written and earned premiums are reported in financial statements.
October 8, 2021

Memo to: NAIC Casualty and Statistical Task Force (CASTF)
From: Ken Williams – CAS Staff Actuary
RE: CAS review of appointed actuary CE logs for NAIC compliance

The National Association of Insurance Commissioners (NAIC) developed new requirements for appointed actuaries associated with signing actuarial opinions for 2020 NAIC annual statements. Among these new requirements is that those appointed actuaries must include additional information on the type of continuing education (CE) obtained to meet applicable qualification standards. The information requested is related to meet the Specific Requirements for appointed actuaries from the American Academy of Actuary’s Qualification Standards (USQS). As part of this requirement, the CAS has agreed to submit an annual report to the NAIC summarizing the results of their review of appointed actuary records as part of the CAS’s normal CE compliance process.

As part of their annual cycle, the CAS has completed a review of 41 continuing education logs from those who indicated that they are meeting the Specific requirements of the USQS. Of these 41 logs, 34 used the excel template developed by the SOA and CAS under the guidance of the NAIC. Four submitted their CE in another excel form, and three submitted PDF copies of their CE logs.

Of the 41, four logs did not include the documentation of the required new NAIC categories. For the remaining 37, the results of the analysis are as follows.

Members meeting the appointed actuary requirement had an average of 41.5 total CE hours, and an average of 29.4 hours meeting the specific CE requirement. The range for specific CE was from 15.6 hours to 70.2 hours. The specific qualification requirements include a minimum of 30 CE hours, of which 15 must meet the specific requirements.

In terms of the seven primary NAIC categories, the percentage of actuaries reporting at least some CE in that category, and their average CE hours were:

<table>
<thead>
<tr>
<th>Primary Category</th>
<th>% Reporting some CE in this Category</th>
<th>Average CE hours in this Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Law &amp; Regulation</td>
<td>51%</td>
<td>2.6</td>
</tr>
<tr>
<td>Policy form, Coverage, Underwriting, &amp; Marketing</td>
<td>49%</td>
<td>7.1</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>22%</td>
<td>1.6</td>
</tr>
<tr>
<td>Reserves</td>
<td>92%</td>
<td>9.4</td>
</tr>
<tr>
<td>Requirements &amp; Practice Notes</td>
<td>78%</td>
<td>7.1</td>
</tr>
<tr>
<td>Business Skills</td>
<td>30%</td>
<td>5.6</td>
</tr>
<tr>
<td>Other</td>
<td>76%</td>
<td>11.7</td>
</tr>
</tbody>
</table>
Several of the above primary categories have secondary categories which further divide the type of CE learning. For those categories, the number reporting at least one instance of learning in the secondary categories and the average hours reported are:

<table>
<thead>
<tr>
<th>Policy form, Coverage, Underwriting &amp; Marketing</th>
<th>% Reporting some CE in this Category</th>
<th>Average CE hours in this Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form or Coverage</td>
<td>27%</td>
<td>4.1</td>
</tr>
<tr>
<td>Premium Rates or Ratemaking</td>
<td>27%</td>
<td>6.0</td>
</tr>
<tr>
<td>Underwriting and/or marketing</td>
<td>24%</td>
<td>2.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reinsurance</th>
<th>% Reporting some CE in this Category</th>
<th>Average CE hours in this Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reinsurance collateral</td>
<td>3%</td>
<td>1.2</td>
</tr>
<tr>
<td>Reinsurance collectability</td>
<td>3%</td>
<td>2.1</td>
</tr>
<tr>
<td>Reinsurance reserving</td>
<td>14%</td>
<td>1.4</td>
</tr>
<tr>
<td>Statutory accounting</td>
<td>16%</td>
<td>2.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reserves</th>
<th>% Reporting some CE in this Category</th>
<th>Average CE hours in this Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reserving Data</td>
<td>46%</td>
<td>3.4</td>
</tr>
<tr>
<td>Reserving Adjustments</td>
<td>84%</td>
<td>5.9</td>
</tr>
<tr>
<td>Reserving Calculations</td>
<td>35%</td>
<td>2.4</td>
</tr>
<tr>
<td>Reserving Analysis</td>
<td>38%</td>
<td>2.7</td>
</tr>
<tr>
<td>Statutory accounting</td>
<td>16%</td>
<td>2.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requirements &amp; Practice Notes</th>
<th>% Reporting some CE in this Category</th>
<th>Average CE hours in this Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Statement Instructions</td>
<td>43%</td>
<td>4.2</td>
</tr>
<tr>
<td>Practice Notes, ASOPs, etc.</td>
<td>8%</td>
<td>5.5</td>
</tr>
<tr>
<td>Statutory Accounting</td>
<td>57%</td>
<td>5.5</td>
</tr>
<tr>
<td>Solvency Calculations</td>
<td>16%</td>
<td>2.2</td>
</tr>
<tr>
<td>Company-specific</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>% Reporting some CE in this Category</th>
<th>Average CE hours in this Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounting other than Statutory</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Analytics</td>
<td>16%</td>
<td>2.2</td>
</tr>
<tr>
<td>Emerging Issues</td>
<td>57%</td>
<td>8.0</td>
</tr>
<tr>
<td>Modeling</td>
<td>16%</td>
<td>3.9</td>
</tr>
<tr>
<td>Professionalism</td>
<td>30%</td>
<td>4.9</td>
</tr>
<tr>
<td>Risk Management</td>
<td>27%</td>
<td>4.0</td>
</tr>
<tr>
<td>Other – not otherwise classified</td>
<td>19%</td>
<td>2.9</td>
</tr>
</tbody>
</table>
Please let me know if you need more information or would like further clarification of the above results.

Ken Williams

Ken Williams, FCAS, MAAA, Staff Actuary
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Casualty Actuarial and Statistical (C) Task Force
E-Vote
August 20, 2021

The Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Aug. 20, 2021. The following Task Force members participated: Grace Arnold, Chair, represented by Phil Vagliaturo (MN); James J. Donelon, Vice Chair, represented by Nichole Torblaa (LA); Jim L. Ridling represented by Daniel Davis (AL); Evan G. Daniels represented by Tom Zuppan (AZ); Ricardo Lara represented by Lynne Wehmueller (CA); Michael Conway represented by Mitchell Bronson (CO); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by David Christhilf (DC); David Altmaier represented by Sandra Starnes (FL); Colin M. Hayashida represented by Randy Jacobson (HI); Doug Ommen represented by Travis Grassel (IA); Dana Popish Severyinghaus represented by Judy Mottar (IL); Vicki Schmidt represented by Nicole Boyd (KS); Kathleen A. Birrane represented by Robert Baron (MD); Chlora Lindley-Myers and Cynthia Amann (MO); Mike Causey represented by Arthur Schwartz (NC); Barbara D. Richardson represented by Gennady Stolyarov (NV); Glen Mulready represented by Andrew Schallhorn (OK); Andrew R. Stolfi represented by David Dahl (OR); Doug Slape represented by Miriam Fisk (TX); Michael S. Pieciak represented by Rosemary Raszka (VT); and James A. Dodrill represented by Juanita Wimmer (WV).

1. **Adopted a Comment Letter on the U.S. Qualification Standards**

   The Task Force conducted an e-vote to consider adoption of a comment letter on the second exposure draft of the American Academy of Actuaries’ (Academy’s) *U.S. Qualification Standards* (Attachment Four-A) and send it to the Academy. The motion passed unanimously.

   Having no further business, the Casualty Actuarial and Statistical (C) Task Force adjourned.
August 20, 2021

To: The Board of Directors of the American Academy of Actuaries  
The Committee on Qualifications of the American Academy of Actuaries  

From: Phil Vigliaturo, ACAS  
Chair of the Casualty Actuarial and Statistical (C) Task Force  

SENT VIA EMAIL TO USQSComments@actuary.org

Re: Proposed revision of the Qualification Standards (including Continuing Education Requirements) for Actuaries Issuing Statements of Actuarial Opinion in the United States

To begin, the Casualty Actuarial and Statistical (C) Task Force (CASTF) would like to express its appreciation to the Academy for the thoughtful and reasonable ways in which the CASTF’s comments on the First Exposure Draft were reflected in the Second Exposure Draft. The following observations arose out of further discussions among CASTF members subsequent to their review of the Second Exposure Draft.

1. Section 2.1(a): It appears that, with the revisions in the Second Exposure Draft, there is no longer a membership requirement to be part of a U.S. or IAA professional actuarial organization. One must complete basic education and obtain one of the designations identified in Section 2.1(a), but then it appears there are no longer membership requirements once one has done so. On the other hand, the CASTF recognizes that footnote 2 in Section 1 of the U.S. Qualification Standards states that “The word ‘actuary’ as used herein means an actuary who is a member of any actuarial organization that requires its members to meet the USQS when practicing in the United States.” Therefore, the U.S. Qualification Standards are only binding upon members of actuarial organizations that require adherence to the U.S. Qualification Standards. This is, indeed, also the case today.

The CASTF considers it to be valuable for practicing actuaries in the U.S. to be members of an organization that agrees to require members to adhere to the Qualification Standards and be subject to professional counseling and discipline. It is hoped that insurers share this recognition of the value of actuarial designations and will not be disincentivized from supporting the membership dues for their employees who have become credentialed. Moreover, there are situations in which, to satisfy regulatory requirements, an actuary would need to be credentialed and remain a member of an actuarial organization. For example, the NAIC Annual Statement Instructions – Property/Casualty require an Appointed Actuary to have obtained and to maintain an Accepted Actuarial Designation, as defined therein. The CASTF brings this to the Academy’s
attention to underscore the continued importance of actuarial designations in fulfilling regulatory purposes such as issuing a Statement of Actuarial Opinion in connection with the NAIC Property/Casualty Annual Statement. Outside of those purposes, utilizing credentialed actuaries to comply with other regulatory requirements, such as providing support on rate filings, is also desirable and tends to improve the quality of an insurer’s work product. The CASTF would be interested in the Academy’s perspective regarding what kinds of incentives would remain for individuals who are subject only to the General Qualification Standard to maintain their actuarial designations subsequent to the revisions in the Second Exposure Draft.

2. **Section 2.1(d):** The CASTF previously stated that “it was reasonable and appropriate for the Academy to have removed the specific listing of current SOA specialty tracks (or the lack of specialty tracks in the CAS or ASPPA), since the absence of such references would be compatible with potential future additions or revisions to specialty tracks by the relevant actuarial societies without necessitating a revision to the Qualification Standards at each future time that such changes occur.” However, the CASTF would also like clarification from the Academy as to what requirements would apply, for example, to an actuary credentialed by the SOA who obtained his or her Fellowship in the SOA before the SOA established its General Insurance Track. Likewise, an analogous situation can be considered in an area such as life insurance, for which the CAS has not established any specialized education. Would a person who obtained his or her Fellowship in the CAS be eligible to practice in the life insurance area without passing any life-insurance-specific exams if all other requirements have been met?

It is stated that “if education relevant to the particular subject of the SAO was available when the actuary chose a specific area of practice and obtained their designation in that area of practice, the actuary must have completed such education.” It would appear that this would mean that, if at the time the actuary chose a specific area of practice, only one actuarial society offered specialized education in that area of practice, then this actuary would need to either have obtained that specialized education from that actuarial society, or else to have qualified pursuant to Section 4. Changes in Practice and Application. If this is the case, then the CASTF would request confirmation that the Academy interprets the Second Exposure Draft of the U.S. Qualification Standards in the same manner.

3. **Section 3.1.1.2:** Previously, the CASTF commented on Section 3.1.1.2 that “The addition of ‘the Society of Actuaries’ as one of the providers for relevant examinations for the Statement of Actuarial Opinion with regard to the NAIC Property and Casualty Annual Statement is important to achieve consistency with the recent revisions to the NAIC Statement of Actuarial Opinion Instructions. The revision proposed here by the Academy is therefore necessary and appropriate.”

However, the CASTF also considers it important to add a reference to the NAIC Statement of Actuarial Opinion (SAO) Instructions – Property/Casualty, since the revised Section 3.1.1.2 does not contain all of the NAIC requirements for signing an NAIC Property/Casualty Annual Statement SAO. The CASTF recognizes that there is a benefit to the Qualification Standards being more broadly worded than the NAIC Statement of Actuarial Opinion Instructions, since this would prevent a situation where the Qualification Standards would need to be amended every time the NAIC Statement of Actuarial Opinion Instructions would be amended. However, a revision
(shown in bold for this letter only) along the following lines would aid actuaries to understand there are additional qualification requirements placed upon Appointed Actuaries and also preserve the relevance of the Qualification Standards if the NAIC Statement of Actuarial Opinion Instructions are ever amended in the future:

“3.1.1.2 Statement of Actuarial Opinion, NAIC Property and Casualty Annual Statement — An actuary should successfully complete relevant examinations administered by the American Academy of Actuaries, the Casualty Actuarial Society, or the Society of Actuaries on the following topics: (a) policy forms and coverages, underwriting, and marketing, (b) principles of ratemaking, (c) statutory insurance accounting and expense analysis, (d) premium, loss, and expense reserves, and (e) reinsurance. Moreover, an actuary should meet all of the requirements to be a Qualified Actuary as set forth in the NAIC Statement of Actuarial Opinion Instructions – Property/Casualty.”

4. UNDER THE REVIEW: Referring to 2.1 d) 2; 2.1 d) 3; 2.1.1 b); and 3.2, It would be helpful if the phrase “under the review” could be clarified.

5. Appendix 1, Section III: While the CASTF recognizes that the Academy is not proposing to make any changes to Appendix 1 Section III – Application of U.S. Qualification Standards to Public Service Actuaries – the CASTF wishes to state for the record that there remains significant disagreement with Appendix 1 Section III among regulatory actuaries, both in regard to the existence of such an appendix as well as some of the specific activities enumerated therein as being SAOs. It remains the view of many regulatory actuaries that their authority as regulators derives from State law and may not be restricted by the standards of a private organization that is predominantly comprised of practitioners within the regulated industry. While the CASTF is supportive of many of the revisions proposed by the Academy within the U.S. Qualification Standards, the CASTF wishes to make this comment on Appendix 1 Section III to avoid the impression that absence of comment regarding this matter might signify any manner of implicit agreement. Further, CASTF prefers for this section to be deleted. By singling out the group of public service actuaries for a special set of standards, the general public may get the perception that public service actuaries are held to a different set of standards than all other actuaries.

If you have any questions, please contact Kris DeFrain (kdefrain@naic.org) at the NAIC.

Cc: Kris DeFrain (NAIC)
The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force conducted an e-vote that concluded Sept. 23, 2021. The following Working Group members participated: Anna Krylova, Chair (NM); Amy Waldhauer (CT); David Christhilf (DC); Judy Mottar (IL); Sandra Darby (ME); Gordon Hay (NE); Andrew Schallhorn (OK); and James DiSanto (PA).

1. **Adopted the 2021 Regulatory Guidance**


Having no further business, the Actuarial Opinion (C) Working Group adjourned.
REGULATORY GUIDANCE on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2021

Prepared by the NAIC Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force

The NAIC Actuarial Opinion (C) Working Group (Working Group) of the Casualty Actuarial and Statistical (C) Task Force believes that the Statement of Actuarial Opinion (Actuarial Opinion), Actuarial Opinion Summary (AOS), and Actuarial Report are valuable tools in serving the regulatory mission of protecting consumers. This Regulatory Guidance document supplements the NAIC Annual Statement Instructions – Property/Casualty (Instructions) in an effort to provide clarity and timely guidance to companies and Appointed Actuaries regarding regulatory expectations on the Actuarial Opinion, AOS, and Actuarial Report.

An Appointed Actuary has a responsibility to know and understand both the Instructions and the expectations of state insurance regulators. One expectation of regulators clearly presented in the Instructions is that the Actuarial Opinion, AOS, and supporting Actuarial Report and workpapers be consistent with relevant Actuarial Standards of Practice (ASOPs).

2021 Editorial Change to the Instructions
As a result of the Casualty Actuarial Society’s rescinding of the Statement of Reserving Principles this year, editorial changes were made to the Instructions to remove the reference to “principles.” The Appointed Actuary should be aware of this as it would impact the wording in item b. in the Opinion paragraph.

There have been changes to the Instructions for 2018 and 2019. As a result of these changes, the Instructions now:

- Include a new definition for “Accident & Health (A&H) Long Duration Contracts” in order to draw a distinction between these contracts and the Property and Casualty (P&C) Long Duration Contracts whose unearned premium reserves are reported on Exhibit A, Items 7 and 8,
- Add a reference to SSAP No. 65 in the definition of P&C Long Duration Contracts,
- Include a new disclosure item on Exhibit B for net reserves associated with A&H Long Duration Contracts,
- State that the Actuarial Report should disclose all reserve amounts associated with A&H Long Duration Contracts, and
- State that the Actuarial Report and workpapers summarizing the asset adequacy testing of long-term care contracts must be in compliance with Actuarial Guideline LI – The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) of the Accounting Practices and Procedures Manual.
- Pursuant to efforts undertaken by the Task Force and the Executive (EX) Committee, the definition of “Qualified Actuary” is significantly revised and a new requirement called “qualification documentation” was added. These changes are described in this Regulatory Guidance document and additional guidance is offered to assist an Appointed Actuary in creating qualification documentation.

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Adopted by the Actuarial Opinion (C) Working Group: September 23, 2021

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I. General comments

A. Reconciliation between documents

If there are any differences between the values reported in the Actuarial Opinion, AOS, Actuarial Report, and Annual Statement, the Working Group expects Appointed Actuaries to include an explanation for these differences in the appropriate document (Actuarial Opinion, AOS, or Actuarial Report). The use of a robust peer review process by the Appointed Actuary should reduce reporting errors and non-reconciling items.

One situation in which a legitimate difference might arise is in the case of non-tabular discounting: The direct and assumed loss reserves on line 3 of the Actuarial Opinion’s Exhibit A come from Schedule P, Part 1, which is gross of non-tabular discounting, while the Actuarial Report and AOS might present the direct and assumed loss reserves on a net of discounting basis.

B. Role of illustrative language in the Instructions

While the Instructions provide some illustrative language, the Working Group encourages Appointed Actuaries to use whatever language they believe is appropriate to clearly convey their opinion and the basis for that opinion. In forming their opinion, Appointed Actuaries should consider company-specific characteristics such as intercompany pooling arrangements; recent mergers or acquisitions; and significant changes in operations, product mix, or reinsurance arrangements.

C. Qualified Actuary definition

With the introduction of an additional educational track for property and casualty (P/C) actuaries, the NAIC needed to consider revisions to the definition of “Qualified Actuary.” Upon receiving advice from a consultant on the NAIC’s definition of a “Qualified Actuary,” the NAIC began a project to re-define a Qualified Actuary using objective criteria. Upon nomination by the Casualty Actuarial Society (CAS), Society of Actuaries (SOA), and the American Academy of Actuaries (Academy), many Appointed Actuaries and other subject matter experts volunteered to assist the NAIC. The NAIC’s P/C Appointed Actuary Job Analysis Project resulted in documentation of knowledge statements, or what an Appointed Actuary may need to know and do. The NAIC’s P/C Educational Standards and Assessment Project resulted in documentation of which elements in each knowledge statement should be included in basic education as a minimum standard, with the remaining elements achievable through experience or continuing education. Using the minimum educational standards, the NAIC and subject matter experts assessed the CAS and SOA syllabi and reading materials. TheCAS and SOA have made or agreed to make specific changes to their syllabi and/or reading materials to meet the standards. The revised syllabi and reference materials are required to be in place by Jan. 1, 2021.

As a result of these NAIC projects, the definition of “Qualified Actuary” was crafted to include basic education requirements and professionalism requirements (e.g. application of U.S. Qualification Standards, Code of Conduct, and ABCD). The definition of Qualified Actuary replaces the requirement to be “a member in good standing of the Casualty Actuarial Society” with a requirement to obtain and maintain an “Accepted Actuarial Designation.” An Accepted Actuarial Designation is one that was considered by the NAIC to meet the NAIC’s minimum educational standards for an Appointed Actuary. See the Instructions for the list of Accepted Actuarial Designations. It is important to note that some designations are accepted as meeting the basic education standards only if certain specific exams and/or tracks are successfully completed (with exceptions noted in the exam substitutions table of the Instructions). The NAIC process requires a recurring assessment of the “Qualified Actuary” definition every 5-10 years.

The NAIC does not intend to retroactively change requirements for Appointed Actuaries. If an actuary previously met the 2018 qualified actuary definition but lacks the specific exams and/or tracks under the new definition, the Instructions provide a list of acceptable substitutions.

D. Qualification documentation

The 2019 Instructions require the Appointed Actuary to provide “qualification documentation” to the Board of Directors upon initial appointment and annually thereafter. The documentation provided to the Board must be available to the
E. Replacement of an Appointed Actuary

The Instructions require two letters when the Board replaces an Appointed Actuary: one addressed from the insurer to the domiciliary commissioner, and one addressed from the former Appointed Actuary to the insurer. The insurer must provide both of these letters to the domiciliary commissioner.

The detailed steps are as follows:
1. Within 5 business days, the insurer shall notify its domiciliary insurance department that the former Appointed Actuary has been replaced.
2. Within 10 business days of the notification in step 1, the insurer shall provide the domiciliary commissioner with a letter stating whether in the 24 months preceding the replacement, there were disagreements with the former Appointed Actuary. The Instructions describe the types of disagreements required to be reported in the letter.
3. Within the same 10 business days referred to in step 2, the insurer shall, in writing, request that its former Appointed Actuary provide a letter addressed to the insurer stating whether the former Appointed Actuary agrees with the statements contained in the insurer’s letter referenced in step 2.
4. Within 10 business days of the request from the insurer described in step 3, the former Appointed Actuary shall provide a written response to the insurer.
5. The insurer shall provide the letter described in step 2 and the response from the former Appointed Actuary described in step 4 to the domiciliary commissioner.

Regarding the disagreements referenced in step 2 above, regulators understand that there may be disagreements between the Appointed Actuary and the insurer during the course of the Appointed Actuary’s analysis that are resolved by the time the Appointed Actuary concludes the analysis. For instance, the Appointed Actuary’s analysis may go through several iterations, and an insurer’s comments on the Appointed Actuary’s draft Actuarial Report may prompt the Appointed Actuary to make changes to the report. While regulators are interested in material disagreements regarding differences between the former Appointed Actuary’s final estimates and the insurer’s carried reserves, they do not expect notification on routine discussions that occur during the course of the Appointed Actuary’s work.

F. Reporting to the Board of Directors

The Appointed Actuary is required to report to the insurer’s Board every year, and the Instructions were amended in 2016 to require the Board’s minutes to specify the manner in which the Appointed Actuary presented the required information. This may be done in a form of the Appointed Actuary’s choosing, including, but not limited to, an executive summary or PowerPoint presentation. The Working Group strongly encourages the Appointed Actuary to present his or her analysis in person so that the risks and uncertainties that underlie the exposures and the significance of the Appointed Actuary’s findings can be adequately conveyed and discussed. Regardless of how the Appointed Actuary presents his or her conclusions, the Actuarial Report must be made available to the Board.

Management is limited to reporting single values on lines 1 and 3 of the Liabilities, Surplus, and Other Funds page of the balance sheet. However, actuarial estimates are uncertain by nature, and point estimates do not convey the variability in the projections. Therefore, the Board should be made aware of the Appointed Actuary’s opinion regarding the risk of material adverse deviation, the sources of risk, and what amount of adverse deviation the Appointed Actuary judges to be material.
Adopted by the Actuarial Opinion (C) Working Group: September 23, 2021

G. Requirements for pooled companies

Effective with the 2014 Instructions, requirements for companies that participate in intercompany pools are as follows:

For all intercompany pooling members:

- Text of the Actuarial Opinion should include the following:
  - Description of the pool
  - Identification of the lead company
  - A listing of all companies in the pool, their state of domicile, and their respective pooling percentages
- Exhibits A and B should represent the company’s share of the pool and should reconcile to the financial statement for that company

For intercompany pooling members with a 0% share of the pooled reserves:

- Text of the Actuarial Opinion should be similar to that of the lead company
- Exhibits A and B should reflect the 0% company’s values
  - Response to Exhibit B, Item 5 (materiality standard) should be $0
  - Response to Exhibit B, Item 6 (risk of material adverse deviation) should be “not applicable”
- Exhibits A and B of the lead company should be filed with the 0% company’s Actuarial Opinion
- Information in the AOS should be that of the lead company

Note the distinction between pooling with a 100% lead company with no retrocession and ceding 100% via a quota share reinsurance agreement. The regulator must approve these affiliate agreements as either an intercompany pooling arrangement or a quota share reinsurance agreement. The proper financial reporting is dependent on the approved filings, regardless of how company management regards its operating platform.

For intercompany pooling members with a greater than 0% share of the pooled reserves, regulators encourage the Appointed Actuary to display values in the AOS on a pooled (or consolidated) basis in addition to the statutory entity basis. This can be accomplished by displaying two tables of information.

H. Explanation of adverse development

1. Comments on unusual Insurance Regulatory Information System (IRIS) ratios in the Actuarial Opinion

   The Appointed Actuary is required to provide comments in the Actuarial Opinion on factors that led to unusual values for IRIS ratios 11, 12, or 13. The Working Group considers it insufficient to attribute unusual reserve development to “reserve strengthening” or “adverse development” and expects the Appointed Actuary to provide insight into the company-specific factors which caused the unusual value. Detailed documentation should be included in the Actuarial Report to support statements provided in the Actuarial Opinion.

2. Comments on persistent adverse development in the AOS

   The Appointed Actuary is required to comment on persistent adverse development in the AOS. Comments can reflect common questions that regulators have, such as:
   - Is development concentrated in one or two exposure segments, or is it broad across all segments?
   - How does development in the carried reserve compare to the change in the Appointed Actuary’s estimate?
   - Is development related to specific and identifiable situations that are unique to the company?
   - Does the development or the reasons for development differ depending on the individual calendar or accident years?
Adopted by the Actuarial Opinion (C) Working Group: September 23, 2021

I. Revisions

When a material error in the Actuarial Opinion or AOS is discovered by the Appointed Actuary, the company, the regulator, or any other party, regulators expect to receive a revised Actuarial Opinion or AOS.

Regardless of the reason for the change or refiling, the company should submit the revised Actuarial Opinion in hard copy to its domiciliary state and electronically to the NAIC. The company should submit the revised AOS in hard copy to the domiciliary state but should not submit the document to the NAIC.

A revised Actuarial Opinion or AOS should clearly state that it is an amended document, contain or accompany an explanation for the revision, and include the date of revision.

II. Comments on Actuarial Opinion and Actuarial Report

A. Review date

The illustrative language for the Scope paragraph includes “… and reviewed information provided to me through XXX date.” This is intended to capture the ASOP No. 36 requirement to disclose the date through which material information known to the Appointed Actuary is included in forming the reserve opinion (the review date), if it differs from the date the Actuarial Opinion is signed. When the Appointed Actuary is silent regarding the review date, this can indicate either that the review date is the same as the date the Actuarial Opinion is signed or that the Appointed Actuary overlooked this disclosure requirement. When the Appointed Actuary’s review date is the same as the date the Actuarial Opinion is signed, regulators suggest the Appointed Actuary clarify this in the Actuarial Opinion by including a phrase such as “… and reviewed information provided to me through the date of this opinion.”

B. Making use of another’s work

If the Appointed Actuary makes use of the work of another not within the Appointed Actuary’s control for a material portion of the reserves, the Instructions say that the Appointed Actuary must provide the following information in the Actuarial Opinion:

- The person’s name;
- The person’s affiliation;
- The person’s credential(s), if the person is an actuary; and
- A description of the type of analysis performed, if the person is not an actuary.

Furthermore, Section 4.2.f of ASOP No. 36 says that the actuary should disclose whether he or she reviewed the other’s underlying analysis and, if so, the extent of the review. Though this is not mentioned in the ASOP, the Working Group encourages the Appointed Actuary to consider discussing his or her conclusions from the review.

Section 3.7.2 of ASOP No. 36 describes items the actuary should consider when determining whether it is reasonable to make use of the work of another. One of these items is the amount of the reserves covered by the other’s analyses or opinions in comparison to the total reserves subject to the actuary’s opinion. The Working Group encourages the Appointed Actuary to disclose these items in the Actuarial Opinion by providing the dollar amount of the reserves covered by the other’s analyses or opinions and the percentage of the total reserves subject to the Appointed Actuary’s opinion that these other reserves represent.

C. Points A and B of the Opinion paragraph when opinion type is other than reasonable

Regulators encourage Appointed Actuaries to think about their responses to point A (meet the requirements of the insurance laws of the state) and point B (computed in accordance with accepted actuarial standards) of the Opinion paragraph when they issue an Actuarial Opinion of a type other than “Reasonable.”
D. Conclusions on a net versus a direct and assumed basis

Unless the Appointed Actuary states otherwise, regulators will assume that the Appointed Actuary’s conclusion on the type of opinion rendered, provided in points C and D of the Opinion paragraph, applies to both the net and the direct and assumed reserves. If the Appointed Actuary reaches different conclusions on the net versus the direct and assumed reserves, the Appointed Actuary should include narrative comments to describe the differences and clearly convey a complete opinion. The response to Exhibit B, Item 4 should reflect the Appointed Actuary’s opinion on the net reserves.

Similarly, the materiality standard in Exhibit B, Item 5 and the RMAD conclusion in Exhibit B, Item 6 should pertain to the net reserves. If the Appointed Actuary reaches a different conclusion on the risk of material adverse deviation in the net versus the direct and assumed reserves, the Appointed Actuary should include a Relevant Comments paragraph to address the differences. Regulators understand that a net versus a direct and assumed RMAD will have different meanings and, potentially, different materiality standards.

E. Unearned premium for P&C Long Duration Contracts

Exhibit A, Items 7 and 8 require disclosure of the unearned premium reserve for P&C Long Duration Contracts. The Instructions require the Appointed Actuary to include a point D in the Opinion paragraph regarding the reasonableness of the unearned premium reserve when these reserves are material.

The Working Group expects that the Appointed Actuary will include documentation in the Actuarial Report to support a conclusion on reasonableness whenever point D is included in the Actuarial Opinion. This documentation may include the three tests of SSAP No. 65 or other methods deemed appropriate by the Appointed Actuary to support his or her conclusion.

Regulators see many opinions where dollar amounts are included in Exhibit A, Items 7 and 8; some opinions include a Relevant Comments paragraph discussing these amounts and some do not. Regulators would prefer at a minimum that Appointed Actuaries include some discussion in Relevant Comments on these amounts including an explicit statement as to whether these amounts are material or immaterial.

F. Other premium reserve items

With regard to “Other Premium Reserve Items” in Exhibit A, Item 9, the Appointed Actuary should include an explanatory paragraph about these premium reserves in Relevant Comments and state whether the amounts are material or immaterial. If the amounts are material, and the Appointed Actuary states the amounts are reasonable in an Opinion paragraph, regulators would expect the actuarial documentation to support this conclusion in the Actuarial Report.

Typical items regulators see listed as “Other Premium Reserve Items” are Medical Professional Liability Death, Disability & Retirement (DD&R) unearned premium reserves (UPR) and Other Liability Claims DD&R UPR. Depending on the nature of these exposures, these items may be also listed on Exhibit B, Line 12.2 as claims made extended UPR.

G. The importance of Relevant Comments paragraphs

The Working Group considers the Relevant Comments paragraphs to be the most valuable information in the Actuarial Opinion. Relevant Comments help the regulator interpret the Actuarial Opinion and understand the Appointed Actuary’s reasoning and judgment. In addition to the required Relevant Comments, the Appointed Actuary should consider providing information on other material items such as reinsurance with affiliates, mergers or acquisitions, other premium reserves, and catastrophe risk.

H. Risk of Material Adverse Deviation

The Relevant Comments paragraphs on the Risk of Material Adverse Deviation (RMAD) are particularly useful to regulators. The first two RMAD comments below respond to questions that Appointed Actuaries have posed to regulators. The second two stem from regulators’ reviews of Actuarial Opinions.
1. **No company-specific risk factors** – The Appointed Actuary is asked to discuss company-specific risk factors regardless of the RMAD conclusion. If the Appointed Actuary does not believe that there are any company-specific risk factors, the Appointed Actuary should state that.

2. **Mitigating factors** – Regulators generally expect Appointed Actuaries to comment on significant company-specific risk factors that exist prior to the company’s application of controls or use of mitigation techniques. The company’s risk management behaviors may, however, affect the Appointed Actuary’s RMAD conclusion.

3. **Consideration of carried reserves, materiality standard, and reserve range when making RMAD conclusion** – When deciding whether RMAD exists, the Appointed Actuary should consider the materiality standard in relation to the range of reasonable estimates and the carried reserves. For example, RMAD should likely exist when the sum of the materiality standard plus the carried reserves is within the range of reasonable estimates. Regardless, the Appointed Actuary should support the conclusion of whether RMAD exists.

4. **Materiality standards for intercompany pool members** – With the exception of intercompany pooling members that retain a 0% share, each statutory entity is required to have a separate Actuarial Opinion with its own materiality standard. Where there are no unusual circumstances to consider, it may be acceptable to determine a standard for the entire pool and assign each member its proportionate share of the total. It is not appropriate to use the entire amount of the materiality threshold for the pool as the standard for each individual pool member.

I. **Regulators’ use of the Actuarial Report**

Regulators should be able to rely on the Actuarial Report as an alternative to developing their own independent estimates. A well-prepared and well-documented Actuarial Report that complies with ASOP No. 41 can provide a foundation for efficient reserve evaluation during a statutory financial examination. This expedites the examination process and may provide cost savings to the company.

1. **Schedule P reconciliation**

The Working Group acknowledges that myriad circumstances (such as mergers, acquisitions, changes in claim systems, and the use of underwriting year data in the analysis) may make it difficult for the Appointed Actuary to reconcile the analysis data to Schedule P. The Working Group encourages Appointed Actuaries to disclose reconciliation issues in the Actuarial Report. If the data cannot be reconciled, the Appointed Actuary should document the reasons.

The Working Group believes that:

- A summary reconciliation that combines all years and all lines is an insufficient demonstration of data integrity. A reconciliation should include enough detail to reflect the segmentation of exposures used in the reserve analysis, the accident years of loss activity and the methods used by the Appointed Actuary. While it is important that the Appointed Actuary is provided with complete and accurate data, reconciling the data *provided* to the Appointed Actuary to Schedule P is not sufficient to demonstrate that the data *used* by the Appointed Actuary reconciles to Schedule P. It is important for the Appointed Actuary to demonstrate that in the process of performing the actuarial analysis, data was neither created nor destroyed. This is commonly accomplished by showing a clear mapping from the Appointed Actuary’s analysis exhibits to the actuarial data shown in the Schedule P reconciliation.

- The Appointed Actuary should map the data groupings used in the analysis to Schedule P lines of business and should provide detailed reconciliations of the data at the finest level of segmentation that is possible and practical. The Working Group recognizes that the Appointed Actuary chooses the data segmentation for the analysis and that there is often not a direct correspondence between analysis segments and Schedule P lines of business.

- The Appointed Actuary should reconcile all data material to the analysis, including claim counts and earned premium if appropriate. If the Appointed Actuary chooses not to reconcile certain data elements used in the analysis, such as claim counts, a brief explanation should be included in the Actuarial Report to make it clear that these elements were not inadvertently overlooked.
Adopted by the Actuarial Opinion (C) Working Group: September 23, 2021

- Schedule P reconciliations are expected to be performed on both a Direct & Assumed basis and a Net of Reinsurance basis. If circumstances specific to the company lead the Appointed Actuary to perform the reconciliation on only one basis, the rationale for this decision should be explained in the Actuarial Report. Similarly, while the reconciliation of the loss-related elements, such as Defense & Cost Containment and Adjusting & Other expenses, is generally expected to be on the same level as used in the analysis underlying the Actuarial Opinion, the Appointed Actuary has the discretion to deviate as long as the rationale is explained in the Actuarial Report.
- The Instructions require that the Appointed Actuary include an explanation for any material differences in the Schedule P Reconciliation. When differences appear in the reconciliation but are viewed as immaterial by the Appointed Actuary, the Appointed Actuary should acknowledge the immateriality of the differences in the Actuarial Report in order to assure regulators that the Appointed Actuary is aware of the differences and has considered the potential impact of the differences on the analysis underlying the Actuarial Opinion.

The Working Group draws a distinction between two types of data checks:
- The Schedule P reconciliation performed by the Appointed Actuary. The purpose of this exercise is to show the user of the Actuarial Report that the data significant to the Appointed Actuary’s analysis ties to the data in Schedule P.
- Annual testing performed by independent CPAs to verify the completeness and accuracy of the data in Schedule P or the analysis data provided by the company to the Appointed Actuary.

One key difference is that independent CPAs generally apply auditing procedures to loss and loss adjustment expense activity that occurred in the current calendar year (for example, tests of payments on claims for all accident years that were paid during the current calendar year). Projection methodologies used by Appointed Actuaries, on the other hand, often use cumulative loss and loss adjustment expense data, which may render insufficient a testing of activity during the current calendar year alone.

Along similar lines, regulators encourage Appointed Actuaries to consider whether a reconciliation of incremental payments during the most recent calendar year for all accident/report years combined provides sufficient assurance of the integrity of the data used in the analysis, given that development factors are generally applied to cumulative paid losses by accident/report year.

2. Change in estimates

The Working Group expects the Appointed Actuary to discuss any significant change in the Appointed Actuary’s total estimates from the prior Actuarial Report. However, an explanation should also be included for any significant fluctuations within accident years or segments. When preparing the change-in-estimates exhibits, the Appointed Actuary should choose a level of granularity that provides meaningful comparisons between the prior and current year’s results.

3. Narrative

The narrative section of the Actuarial Report should clearly convey the significance of the Appointed Actuary’s findings and conclusions, the uncertainty in the estimates, and any differences between the Appointed Actuary’s estimates and the carried reserves.

4. Support for assumptions

Appointed Actuaries should support their assumptions. The use of phrases like “actuarial judgment,” either in the narrative comments or in exhibit footnotes, is not sufficient. A descriptive rationale is needed.

The selection of expected loss ratios could often benefit from expanded documentation. When making their selection, Appointed Actuaries should consider incorporating rate changes, frequency and severity trends, and other adjustments needed to on-level the historical information. Historical loss ratio indications have little value if items such as rate actions, tort reform, schedule rating adjustments, or program revisions have materially affected premium adequacy.
5. Support for roll forward analyses

The Working Group recognizes that the majority of the analysis supporting an Actuarial Opinion may be done with data received prior to year-end and “rolled forward” to year-end. By reviewing the Actuarial Report, the regulator should be able to clearly identify why the Appointed Actuary made changes in the ultimate loss selections and how those changes were incorporated into the final estimates. A summary of final selections without supporting documentation is not sufficient.

J. Exhibits A and B

1. “Data capture format”

The term “data capture format” in Exhibits A and B of the Instructions refers to an electronic submission of the data in a format usable for computer queries. This process allows for the population of an NAIC database that contains qualitative information and financial data. Appointed Actuaries should assist the company in accurately completing the electronic submission.

2. Scope of Exhibit B, Item 12

Exhibit B, Item 12 requests information on extended loss and unearned premium reserves for all property/casualty lines of business, not just medical professional liability. The Schedule P Interrogatories referenced in the parenthetical only address reserves associated with yet-to-be-issued extended reporting endorsements offered in the case of death, disability, or retirement of an individual insured under a medical professional liability claims-made policy.

3. Exhibit B, Item 13

The Working Group added disclosure item Exhibit B, Item 13 in 2018. This item requests information on reserves associated with “A&H Long Duration Contracts,” defined in the Instructions as “A&H contracts in which the contract term is greater than or equal to 13 months and contract reserves are required.”

This disclosure item was added for several reasons:

- **A desire by regulators to gain a greater understanding of property and casualty insurers’ exposure to A&H Long Duration Contracts.**
  - This guidance does not specify how P&C insurers should report the liabilities associated with A&H Long Duration Contracts on the annual statement. Through work performed on financial examinations, regulators have found that P&C insurers may include the liabilities in various line items of the Liabilities, Surplus and Other Funds page. SSAP No. 54R provides accounting guidance for insurers.
  - Regardless of where the amounts are reported on the annual statement, the materiality of the amounts, and whether the insurer is subject to AG 51, the Appointed Actuary should disclose the amounts associated with A&H Long Duration Contracts on Exhibit B, Item 13. The Appointed Actuary should provide commentary in a Relevant Comments paragraph in accordance with paragraph 6.C of the Instructions. The Appointed Actuary should also disclose all reserve amounts associated with A&H Long Duration Contracts in the Actuarial Report.

- **The adoption of AG 51 in 2017.** On August 9, 2017, the NAIC’s Executive (EX) Committee and Plenary adopted AG 51 requiring stand-alone asset adequacy analysis of long-term care (LTC) business. The text of AG 51 is included in the March 2019 edition of the NAIC’s Accounting Practices and Procedures Manual. The effective date of AG 51 was December 31, 2017, and it applies to companies with over 10,000 inforce lives covered by LTC insurance contracts as of the valuation date. The Instructions state that the Actuarial Report and workpapers summarizing the asset adequacy testing of LTC business must be in compliance with AG 51 requirements.

- **Recent adverse reserve development in LTC business.** Regulators expect Appointed Actuaries to disclose company-specific risk factors in the Actuarial Opinion. Given the recent adverse experience for LTC
Adopted by the Actuarial Opinion (C) Working Group: September 23, 2021

business, Appointed Actuaries should consider whether exposure to A&H Long Duration Contracts poses a risk factor for the company.

The Appointed Actuary is not asked to opine on the reasonableness of the reserves associated with A&H Long Duration Contracts except to the extent that the reserves are included within the amounts reported on Exhibit A of the Actuarial Opinion. For this reason, the Working Group intentionally excluded Items 13.3 and 13.4 from this sentence in paragraph 4 of the Instructions: “The Appointed Actuary should state that the items in the SCOPE, on which he or she is expressing an opinion, reflect Disclosure items 8 through 13.2 in Exhibit B.” Exhibit B, Item 13.1 asks the Appointed Actuary to disclose the reserves for A&H Long Duration Contracts that the company carries on the Losses line of the Liabilities, Surplus and Other Funds page. The Appointed Actuary is not asked to opine on the reasonableness of the reserves disclosed on Exhibit B, Item 13.1 in isolation, but these reserves are a subset of the amount included on Exhibit A, Item 1, and Exhibit A lists amounts with respect to which the Appointed Actuary is expressing an opinion. The same is true for Exhibit B, Item 13.2, whose reserves are a subset of the amount included on Exhibit A, Item 2.

A&H Long Duration Contracts are distinct from P&C Long Duration Contracts. There were no changes to the opinion requirements in 2018 regarding P&C Long Duration Contracts, but the Working Group added a reference to SSAP No. 65 in the definition of “P&C Long Duration Contracts” to clarify the difference between “A&H Long Duration Contracts” and “P&C Long Duration Contracts.” The newly-added mention of SSAP No. 65 in the Instructions is not intended to change the Appointed Actuary’s treatment of P&C Long Duration Contracts in the Actuarial Opinion or the underlying analysis, but insurers and Appointed Actuaries may refer to SSAP No. 65, paragraphs 21 through 33 for a description of the three tests, a description of the types of P&C contracts to which the tests apply, guidance on the minimum required reserves, and instructions on the Actuarial Opinion and Actuarial Report.
III. Comments on AOS

A. Confidentiality

The AOS is a confidential document and should be clearly labeled and identified prominently as such. The AOS is not submitted to the NAIC. The Working Group advises the Appointed Actuary to provide the AOS to company personnel separately from the Actuarial Opinion and to avoid attaching the related Actuarial Opinion to the AOS.

B. Different requirements by state

Not all states have enacted the NAIC Property and Casualty Actuarial Opinion Model Law (#745), which requires the AOS to be filed. Nevertheless, the Working Group recommends that the Appointed Actuary prepare the AOS regardless of the domiciliary state’s requirements, so that the AOS will be ready for submission should a foreign state – having the appropriate confidentiality safeguards – request it.

Most states provide the Annual Statement contact person with a checklist that addresses filing requirements. The Working Group advises the Appointed Actuary to work with the company to determine the requirements for its domiciliary state.

C. Format

The purpose of the AOS is to show a comparison between the company’s carried reserves and the Appointed Actuary’s estimates. Because the AOS is a synopsis of the conclusions drawn in the Actuarial Report, the content of the AOS should reflect the analysis performed by the Appointed Actuary. Therefore, all of the Appointed Actuary’s calculated estimates, including actuarial central estimates and ranges, are to be presented in the AOS consistent with estimates presented in the Actuarial Report.

The American Academy of Actuaries’ Committee on Property and Liability Financial Reporting provides illustrative examples in its annual practice note “Statements of Actuarial Opinion on Property and Casualty Loss Reserves” that show how the Appointed Actuary might choose to display the required information. These examples present the numerical data in an easy-to-read table format.

IV. Guidance on qualification documentation

The Instructions have been modified for 2019 to require the Appointed Actuary to document qualifications in what is called “qualification documentation.” The qualification documentation needs to be provided to the Board of Directors at initial appointment and annually thereafter.

The following provides guidance Appointed Actuaries may find useful in drafting qualification documentation. Appointed Actuaries should use professional judgment when preparing the documentation and need not use the sample wording or format provided below. As a general principle, Appointed Actuaries should provide enough detail within the documentation to demonstrate that they satisfy each component of the ‘Qualified Actuary’ definition. In crafting the qualification documentation it may be helpful to think about what is important for the Board of Directors to know about their Appointed Actuary’s qualifications, and to remember that documentation should be relevant to the subject of the Actuarial Opinion being issued.

A. Brief biographical information

- The Appointed Actuary may provide resume-type information.
- Information may include the following:
  - professional actuarial designation(s) and year(s) first attained
  - insurance or actuarial coursework or degrees;
  - actuarial employment history: company names, position title, years of employment, and relevant information regarding the type of work (e.g., reserving, ratemaking, ERM)
B. “Qualified Actuary” definition

The Appointed Actuary should provide a description of how the definition of “Qualified Actuary” in the Instructions is met or expected to be met (in the case of continuing education) for that year. The Appointed Actuary should provide information similar to the following. Items (i) through (iii) below correspond with items (i) through (iii) in the Qualified Actuary definition.

(i) “I meet the basic education, experience and continuing education requirements of the Specific Qualification Standards for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement, as set forth in the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States (U.S. Qualification Standards), promulgated by the American Academy of Actuaries (Academy). The following describes how I meet these requirements:

a. Basic education:”

[Option 1] “met through relevant examinations administered by the Casualty Actuarial Society;” or

[Option 2] “met through alternative basic education.” The Appointed Actuary should further review documentation necessary per section 3.1.2 of the U.S. Qualification Standards.

b. “Experience requirements: met through relevant experience as described below.”

• To describe the Appointed Actuary’s responsible experience relevant to the subject of the Actuarial Opinion, information may include specific actuarial experiences relevant to the company’s structure (e.g., insurer, reinsurer, RRG), lines of business, or special circumstances.
• Experiences may include education (through organized activities or readings) about specific types of company structures, lines of business, or special circumstances.

c. “Continuing education: met (or expected to be met) through a combination of [industry conferences; seminars (both in-person and webinar); online courses; committee work; self-study; etc.], on topics including _______ (provide a brief overview of the CE topics. For example, ‘trends in workers’ compensation’ or ‘standards of actuarial practice on reserving.’). A detailed log of my continuing education credit hours is available upon request.”

• Section 3.3 of the Specific Qualification Standards for Statements of Actuarial Opinion, NAIC Property and Casualty Annual Statement requires the Appointed Actuary to earn 15 hours of CE on topics mentioned in Section 3.1.1.2. The Appointed Actuary should consider providing expanded detail on the completion (or planned completion) of these hours in the CE documentation.

(ii) “I have obtained and maintain an Accepted Actuarial Designation.” One of the following statements may be made, depending on the Appointed Actuary’s exam track:

• “I am a Fellow of the CAS (FCAS) and my basic education includes credit for Exam 6 – Regulation and Financial Reporting (United States).”
• “I am an Associate of the CAS (ACAS) and my basic education includes credit for Exam 6 – Regulation and Financial Reporting United States) and Exam 7 – Estimation of Policy Liabilities, Insurance Company Valuation, and Enterprise Risk Management.”
• “I am a Fellow of the SOA (FSA) and my basic education includes completion of the general insurance track, including the following optional exams: the United States’ version of the Financial and Regulatory Environment Exam and the Advanced Topics in General Insurance Exam.”
Alternatively, if the actuary was evaluated by the Academy's Casualty Practice Council and determined to be a Qualified Actuary, the Appointed Actuary may note such and identify any restrictions or limitations, including those for lines of business and business activities.

(iii) “I am a member of [professional actuarial association] that requires adherence to the same Code of Professional Conduct promulgated by the Academy, requires adherence to the U.S. Qualification Standards, and participates in the Actuarial Board for Counseling and Discipline when its members are practicing in the U.S.”

C. CE logging procedure

The Casualty Actuarial and Statistical (C) Task Force continues to work with the CAS and SOA to identify types of learning that P/C Appointed Actuaries are using to meet continuing education (CE) requirements for ‘Specific Qualification Standards’ today and whether more specificity should be added to the P/C Appointed Actuaries' CE requirements to ensure CE is aligned with the educational needs for a P/C Appointed Actuary.

The Task Force has adopted a project plan that includes requirements for 1) categorization of CE in the Appointed Actuaries’ CE log and 2) CE log reviews by the CAS/SOA of a percentage of Appointed Actuaries. Starting with year-end 2020, Appointed Actuaries selected for review by the CAS or SOA must either use a specific logging format for their CE logs or add a column to one’s current log. Appointed actuaries are encouraged to categorize their CE throughout the year, since waiting until the review (if selected) may compromise the accuracy of categorization. While selected Appointed Actuaries will submit their individual logs, the CAS and SOA will only share aggregated information with the NAIC.

Please refer to the CAS and SOA for information on CE logging and submission instructions, CE categories, and categorization rules.

D. Proposed deadline for qualification documentation

The Working Group is considering establishing a deadline for the Appointed Actuary to submit its qualification documentation to the Board of Directors. The deadline is expected to be in the latter part of the year. If this revision is affirmed, it is expected to become effective for the 2022 Opinion, meaning that Appointed Actuaries should plan to provide their qualification documentation to the Board no later than the deadline to be announced in the 2022 Instructions.

V. COVID-19

COVID-19 and related economic events have had a significant impact on insurance liabilities for some lines of business. Furthermore, the effects of COVID-19 could extend to other aspects of the company’s operations and the claims process. The Appointed Actuary should consider the direct impacts to loss and unearned premium reserves, claims patterns and loss trends, collectability of reinsurance and/or premiums, exposure, etc., as well as indirect impacts such as claims handling delays and procedural changes resulting from public health orders. It is important for the Appointed Actuary to understand the company’s treatment of any changes stemming from COVID-19, for example premium refunds or rate reductions, in the annual financial statement. The impact of such financial reporting on assumptions and methods used in the actuarial analysis should be discussed within the Actuarial Report.

If the impact on reserves is significant, the actuary should make relevant comments on COVID-19 impacts and discuss the corresponding actuarial assumptions in the Statement of Actuarial Opinion. Otherwise, Appointed Actuaries are still strongly encouraged to mention their review of COVID-19 effects on the company in the Statement of Actuarial Opinion, to demonstrate that it has not been overlooked or disregarded.
Adopted by the Actuarial Opinion (C) Working Group: September 23, 2021

Actuaries may refer to the Statement of Actuarial Opinion Instructions, ASOPs, and Statutory Accounting Principles Working Group documents (particularly INT 20-08) for further instruction. The COVID-19 FAQ document, published by COPLFR and available on the American Academy of Actuaries website, can serve as an additional resource for practical consideration.
The Actuarial Opinion (C) Working Group of the Casualty Actuarial and Statistical (C) Task Force met Sept. 2 and Sept. 8, 2021. The following Working Group members participated: Anna Krylova, Chair (NM); Miriam Fisk, Vice Chair (TX); Susan Andrews, Qing He, and Amy Waldhauer (CT); David Christhilf (DC); Chantel Long, Reid McClintock, and Judy Mottar (IL); Sandra Darby (ME); Gordon Hay (NE); Tom Botsko (OH); Andrew Schallhorn (OK); and James Di Santo (PA). Also participating were: Kevin Dyke (MI); and Arthur Schwartz (NC).

1. Discussed the 2021 Regulatory Guidance

Ms. Krylova led discussions on the draft *Regulatory Guidance on Property and Casualty Statutory Statements of Actuarial Opinion, Actuarial Opinion Summaries, and Actuarial Reports for the Year 2021* (Regulatory Guidance). She said she used comments submitted by Stephen J. Koca (Milliman) and Michelle L. Iarkowski (Risk & Regulatory Consulting LLC) to compile a list of issues (Attachment Six-A).

The Working Group agreed to make some changes to the Schedule P reconciliation section. Guidance will be added to say a reconciliation of the data provided to the actuary to Schedule P is not sufficient; rather, reconciliation of the data used by the actuary to Schedule P is needed. Additional guidance about documentation and explanations will also be added to the Schedule P reconciliation section.

In the continuing education (CE) logging procedure and the COVID-19 sections, the Working Group agreed to make some editorial changes.

The Working Group discussed potential guidance on whether the qualification documentation should be provided for each individual entity or whether it could be provided to the group. Ms. Krylova said this might not be an actuarial issue, but rather a financial issue to ask for feedback. Every annual statement is required to be accompanied by a statement from a Certified Public Accountant (CPA), so the Working Group might wish to replicate requirements of the CPA’s opinion as to whether it is done on a company or group basis. Ralph Blanchard (Travelers) said the Board of Directors is defined in the annual statement to include the designated board of directors, its equivalent, or an appropriate committee reporting to the Board. Kathleen C. Odomirok (American Academy of Actuaries—Academy) requested that the Statement of Actuarial Opinion (SAO) instructions be clear so actuaries will not have to wait for a financial reprimand. The Working Group will discuss the SAO instructions on a future call.

Mr. Schwartz asked if the historical instruction changes could be eliminated, acronyms could be revised, and the introductory paragraph could be revised. The Working Group discussed proposed changes and agreed to postpone further discussion until next year’s Regulatory Guidance is drafted.

Ms. Mottar suggested adding a paragraph about the Working Group’s future plan to potentially add a deadline for filing submission of qualification documentation to the Board. Ms. Krylova will add that information. The Working Group will hold an e-vote after receiving a final version of the Regulatory Guidance.

Having no further business, the Actuarial Opinion (C) Working Group adjourned.

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<table>
<thead>
<tr>
<th>Issue/Comment</th>
<th>Response/Proposed Change</th>
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<tr>
<td>(Stephen K) &quot;The Appointed Actuary should clearly demonstrate to a regulator or other user of the Actuarial Report how the actuarial data shown in the Schedule P reconciliation is aggregated from the liability groupings in the supporting actuarial analysis prior to reconciliation of that data to Schedule P.&quot; This sentence is applicable in the situation where the actuarial analysis groupings are more granular than Schedule P line of business groupings. The opposite situation is also possible where the actuarial analysis groupings are more broad. In the latter situation, is the expectation that the Appointed Actuary would a) disaggregate the data used in their analysis to match the individual Schedule P lines of business; b) aggregate the Schedule P data to match the groupings used in their analysis.</td>
<td>To be discussed.</td>
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<td>(Stephen K) &quot;If the Appointed Actuary chooses not to reconcile certain data elements used in their analysis, such as claim counts or other commonly used data that regulators may expect to see, a brief explanation should be included in the Actuarial Report to make it clear that these elements were not inadvertently overlooked.&quot; Suggested addition to the above sentence (underlined). In addition, clarification of what is meant by “other commonly used data” would be helpful.</td>
<td>To be discussed.</td>
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<td>(Stephen K) “Schedule P reconciliations may be performed on a Direct and Assumed basis, Net of Reinsurance basis, or both. Selecting the basis is left to the Appointed Actuary’s discretion, but the rationale for choosing one way over the other should be explained in the Actuarial Report.” My interpretation of the Instructions is that both Direct and Assumed basis and Net basis data are to be reconciled to Schedule P. This sentence implies there is an option and regulators do not expect to see both as long as the rationale is disclosed. Is it possible to provide examples of rationale that may be acceptable for doing the reconciliation only on a net basis, or only on a direct and assumed basis?</td>
<td>Suggested revision: “Schedule P reconciliations are expected to be performed on both a Direct &amp; Assumed basis and a Net of Reinsurance basis. If circumstances specific to the company lead the Appointed Actuary to perform the reconciliation on only one basis, the reasoning for this decision should be explained in the Actuarial Report.”</td>
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<td>(Stephen K) “Schedule P reconciliations resulting in differences that are not minimal should be addressed in the Actuarial Report discussion, even if they are immaterial to the analysis, in order to assure regulators that the Appointed Actuary is aware of the differences and has sought an explanation for them.” I believe this sentence places more requirements on the Appointed Actuary than the Instructions state: “An explanation should be provided for any material differences.”</td>
<td>Suggested Revision: “The Instructions require that the Appointed Actuary include an explanation for any material differences in the Schedule P Reconciliation. When differences appear in the reconciliation but are viewed as immaterial by the Appointed Actuary, the Appointed Actuary should acknowledge the immateriality of the differences in the Actuarial Report in order to assure...&quot;</td>
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Can further clarification be provided for what "not minimal" means? Perhaps an example of a situation that would qualify?

regulators that the Appointed Actuary is aware of the differences and has considered the potential impact of the differences on the analysis underlying the Actuarial Opinion.”

(Michelle I)

The Instructions can’t be changed until 2022 to remove the reference to “principles” in this language:

The OPINION paragraph should include a sentence that at least covers the points listed in the following illustration:

“In my opinion, the amounts carried in Exhibit A on account of the items identified:

A. Meet the requirements of the insurance laws of (state of domicile).
B. Are computed in accordance with accepted actuarial standards and principles.
C. Make a reasonable provision for all unpaid loss and loss adjustment expense obligations of the Company under the terms of its contracts and agreements.”

So that means the 2021 Instructions are going to ask for the “and principles” language in item B – even though we know that the reserving principles were repealed and that they therefore won’t be in effect when actuaries sign their 2021 opinions. So the 2021 Instructions are asking the AA to make a statement that isn’t really true (which is why it would be changed in 2022...).

We’ve submitted a request to the Blanks WG to remove the reference to the principles in this paragraph. Since this change is an editorial one, they should be able to make it for the 2022 Instructions.
Schedule P Reporting for Retroactive Reinsurance Accounting Exceptions
CASTF response to SAPWG Ref 2019-49

December 7, 2021, Draft

- CASTF Subgroup
  - Gordon Hay, FCAS, MAAA, CPCU – Nebraska
  - Miriam Fisk, FCAS, FCAS, MAAA, ASA – Texas
  - Tom Botsko, ACAS – Ohio
- NAIC Staff
  - Robin Marcotte
  - Kris DeFran, FCAS, MAAA, CPCU

COPLFR’s May 2019 Letter to CASTF and SAPWG

- Asserted ambiguity in the accounting/reporting requirements for affiliated retroactive reinsurance agreements that meet the requirements for “Prospective Reinsurance Accounting” treatment
- Attributed materially different presentations in Schedule P by different companies to that ambiguity
- Recommended that this asserted ambiguity be addressed by improved clarity in SSAP 62R and the Annual Statement Instructions, “given that industry Schedule P is utilized for risk-based capital (RBC) purposes as well as other purposes”

SSAP 62R
P&C Reinsurance Accounting (SSAP 62R)

Deposit Accounting (paragraphs 49-51)
- Used when the agreement does not transfer risk
- Paragraph 51 requires retroactive reinsurance agreements involving a deposit in the insurer’s books not allow the deposit asset to be admitted

Retroactive Reinsurance Accounting (paragraphs 52-53)
- Deposits are not allowed in the insurer’s books
- Net premiums – Gross premium – Ceded premium
- Net loss and LAE – Gross loss and LAE – Ceded loss and LAE

Retrocession Reinsurance Accounting (paragraphs 54-55)
- Coding entity – loss and LAE reserves & schedules do not take credit for retroactive reinsurance
- Assuming entity – loss and LAE reserves & schedules exclude assumed retroactive reinsurance
- Balance sheet under-assuming
  - Amount of retroactive reinsurance failed (contra-liability) or assumed (liability)
  - Special surplus from retroactive reinsurance
- Assumed statement under the retroactive reinsurance gain/loss included under Other Income

Exceptions “accounted for as prospective reinsurance agreements unless otherwise provided” in SSAP 62R

- a. Structured settlement annuities
- b. Novations
- c. Commutations
- d. Intercompany reinsurance agreements with no surplus gain
- e. Property/casualty run-off agreements

36.a: Structured settlement annuities

Definition & Requirements
- Annuites for individual claims purchased to implement settlements of policy obligations

Accounting
- Accounting guidance is provided in SSAP 21R (Other Admitted Assets) and SSAP 65 (P&C Contracts)
- Not specified in SSAP 62R, other than being an exception to retroactive reinsurance accounting

36.b: Novations

Definition & Requirements
- Original insurer’s obligations are completely extinguished, resulting in no further exposure to loss arising on the business novated
- Parties are not affiliates (or if affiliates, that the transaction has the prior approval of the domiciliary regulators of the parties)
- The accounting for the original reinsurance agreement will not be altered from retroactive to prospective

Prospective Reinsurance Accounting
- SSAP 62R, paragraph 39
  - Original insurer reports amounts paid as reduction of written and earned premiums, and unearned premiums to the extent that premiums have not been earned
  - Novated loss and LAE reserves are written off through accounts, exhibits, and schedules in which they were originally recorded
  - Assuming insurer reports amounts received as written and earned premiums, and obligations assumed as incurred losses
36.c: Commutations

**Definition & Requirements**
- Complete and final settlement and discharge of all present and future obligations between the parties arising out of the (commuted portion of the) original agreement

**Accounting**
- SSAP 62R, paragraphs 94-97
- Commuted balances are written off through accounts, exhibits, and schedules in which they were originally recorded
- Any net gain or loss (to either party) is reported as underwriting income
- Ceding in the commuted agreement records cash received as negative paid loss

36.d: Intercompany reinsurance, without surplus gain

**Definition & Requirements**
- Companies are 100% owned by a common parent or ultimate controlling person.
- There is no surplus gain to the ceding entity as a result of the transaction.

**Prospective Reinsurance Accounting**
- *Note: This exception is the focus of the CORFR letter.*
- Explicitly "shall be accounted for as prospective reinsurance agreements"

37: Cession to an affiliate, with surplus gain

**Definition & Requirements**
- Companies are affiliated or under common control (as defined in Appendix A-446)
- Retroactive reinsurance results in surplus gain to the ceding entity (with or without risk transfer)

**Accounting**
- SSAP 62R, paragraph 37
- Requires *broad* version of deposit accounting
- Consideration paid is recorded as a deposit and reported as a non-admitted asset
- No deduction made from ceding entity’s loss and LAE reserves

36.e: Property/casualty run-off agreements

**Definition & Requirements**
- Can only cover liabilities relating to lines of business or specific market segments no longer actively marketed by the transferring entity
- Transferring entity remains primarily liable to the policyholder under the original contracts
- Agreements between affiliates or insurers under common control are not eligible for this exception
- Accounting treatment must be approved by the domiciliary regulators of the transferring entity and the assuming entity
- Cannot be cancelable by either party for any reason

**Accounting**
- SSAP 62R, paragraph 102-105
- Transferring entity records consideration paid to the assuming entity as a paid loss
- Assuming entity records consideration received as a negative paid loss
- Transferring entity records increase in ceded reinsurance receivable for the amount of the transferred reserve
- Assuming entity reports the business in the same lines of business and same level of detail as reported by the original insurer
Schedule P Instructions

**Note:** This is consistent with SSAP 62R, paragraph 34.

**Retroactive Reinsurance**

Retroactive reinsurance should not be reflected in Schedule P. The transferor in such an agreement must record, without recognition of the retroactive reinsurance, its loss and loss adjustment expense reserves on a gross basis on its balance sheet and in all schedules and exhibits. The transferee in such an agreement must exclude the retroactive reinsurance from its loss and loss expense reserves and from its schedules and exhibits.

**Premium and Losses**

Earned premium is on a calendar-year basis. Losses incurred should be assigned to the year in which the event occurred that triggered coverage under the contract. This may be a date of accident (occurrence policies), a date of report (claims-made policies), a policy issue date (tail policies), or a date of discovery (fidelity and surety).

**Intercompany Pooling**

If the reporting entity participates in a pooling agreement, show only its share of the business, not the total for all participants.

When changes to pooling agreements impact prior accident years, historical data values in Schedule P Parts, 1 through 6 should be restated based on the new pooling percentage. This should be done to present meaningful development patterns in Schedule P. When pooling changes only impact future accident years, no restatement of historical values should be made.

**Note:** This differs from SSAP 62R, paragraphs 36d and 37.
CASTF Discussion

Applying Retroactive Reinsurance Exception in Schedule P

- Schedule P Instructions are explicit for Intercompany Pooling Agreements, including when the agreement has a retroactive component
  - “When changes to pooling agreements impact prior accident years, historical data values in Schedule P Parts, 1 through 5 should be restated based on the new pooling percentage.”
- Schedule P Instructions provide no explicit guidance for any of the SSAP 62R, paragraph 36 exceptions
- Esp., paragraph 36d. LPT’s create Schedule P distortions
  - LPT ceded losses are reported by accident year
  - Schedule P Instructions state premium should be calendar year earned premium (not allocated to prior years)
  - Agree with COSUS that 8 GECO companies did allocate Cal Year 2014 ended LPT premium to current year despite instructions
  - Pooling P. 100% related loss ratios, and large related balances in most recent Acc Years, produced a very favorable-looking net loss ratio trend
  - Most have recorded LPT premium in current calendar year on Schedule P. Creditor’s result is almost favorable prior years’ development offset by high current Acc Year net loss ratio. Reinsurer’s result is abrupt advance prior years’ development offset by low current Acc Year net loss ratio.

Proposal: Clarify Schedule P Instructions for “prospective reporting exceptions”

- The Schedule P Instructions are silent regarding novations and paragraph 36d agreements, which both receive prospective accounting treatment.
- Schedule P Instructions should provide explicit guidance for the SSAP 62R, paragraph 36c and 36d exceptions.
- There will be distortions in Schedule P when applying prospective accounting to retroactive reinsurance.

Proposal

Add Schedule P reporting instructions for the exceptions listed in SSAP 62R, paragraph 36c and 36d.
Caveats

• Clarity in SSAP 62R and Schedule P Instructions should reduce but will not eliminate variations in Schedule P presentation or distortions to (industry) RBC.
  • Intentional variations observed in Schedule P presentation for paragraph 36d exceptions were due to states’ direction, not ambiguity in SSAP 62R.
  • Variations may be unintentional, particularly when the cedant and its domicile are not accustomed to prescribed accounting treatment for exceptions.
  • Paragraph 36d agreements have been used to cede material portfolios to an affiliate with the same ultimate owner, but outside the NAIC financial reporting system, where:
    • Subsequent development is omitted from the Industry Schedule P data
    • Retrocession may proceed without deferred surplus recognition

Other Possible Actions

• Related to SSAP 62R, paragraph 36d exceptions:
  • Stop prescribing prospective reinsurance accounting
  • Specify a method for allocation of premium to prior years instead of being reported in the current calendar year
  • Expand Schedule P interrogatories or Note 23 disclosures to provide more information about these agreements
  • Add a Schedule P line of business
  • Unacceptable option: Specify that the consideration paid is reported as loss (positive paid loss by cedant, negative paid loss by assuming entity) instead of premium
    • This is commutation accounting and is not consistent with prospective accounting, although it has been advocated by some companies.
  • Add Schedule P reporting instructions for the SSAP 62R, paragraph 36 exceptions that don’t receive prospective accounting treatment (Structured Settlements, Commutations, and qualifying Run-off agreements)
  • Discuss whether SSAP 62R, paragraph 37 is overly punitive
Introduction

- GLM's are industry standard
- The CASTF White Paper for Predictive Models is focused primarily on GLM's
- Some companies are experimenting with more sophisticated models
  - GAM - Similar to GLM's, but with non-parametric "smoothed" terms
  - Tree Based Models - Based on a collection of multiple decision trees
  - Neural Networks - Mostly for generating scores based on images
- The NAIC model review team has reviewed the above model types without CASTF guidance
- Today’s focus is on Random Forests (a type of Tree Based Model)

Tree Based Models

- Models that can be represented as a decision tree or a collection of decision trees
- Types of Tree Based Models
  - Single decision Tree
  - "Bagged" Trees
  - Random Forest
  - Gradient Boosting Machine (XGBoost)
- Supervised Model
  - There is still a target variable
    - Classification: Renew/Non-renew, Claim/No Claim, Fraud/No Fraud
    - Regression: Frequency, Severity, Pure Premium
- Today’s focus will be on Random Forest Models
Tree Based Model

- Single Decision Tree
- Easy to Understand
- Mimics how people make decisions
- Easily interpreted
- Classification returns a likelihood

Prior Claim?

Age < 20?

10%
8%
7%
3%

Tree Based Model

- Single Decision Tree
- Easy to Understand
- Mimics how people make decisions
- Easily interpreted
- Classification returns a likelihood

Prior Claim?

Age < 20?

10%
8%
7%
3%

Tree Based Model

- Terminology
  - Nodes
  - Root
  - Sub-Node
  - Parent/Child
  - Splitting
  - Branch
  - Sub-Tree

Prior Claim?

Age < 20?

$20  $16  $14  $6

$20  $16  $14  $6

$20  $16  $14  $6
**Bagged Trees**

- Most Tree-Based Models are an "ensemble" of models
- "Bagged" Trees are based on multiple trees
- "Bagged" comes from "bootstrap aggregated"
- Each tree is grown the same way
- The difference is each tree is based on a different bootstrap sample
- The same variables are considered in each tree
- Final prediction is the average of each tree’s prediction

**Random Forest**

- Random Forest
- Each tree is grown the same way
- The difference is each tree is based on a different bootstrap sample
- Additionally: Randomly chosen variables considered at each split
- Each tree is grown the same way
- Final prediction is the average of each tree’s prediction
- Advantages
  - Trees are substantially different
  - Each tree not based on the same sample
  - Each split not based on the same variables

**Example**

- 22 year old driver, no prior claims
- 5 year old vehicle, $15,000 vehicle
- ($10+$15)/2 = $12.5

**Interpretation gets difficult**

- Trees can get very deep
- There can be 100’s or 1,000’s of trees
- Many GLM statistical tests no longer apply
- There are many hyperparameters
- Selections may materially impact the model
- Selections should be checked for reasonability
Random Forest

- Hyperparameters
- Number of trees
- Criteria on which to split
- Bootstrap sample size (% of rows)
- When to stop splitting
- Max Tree Depth
- Minimum Node Size
- Max Leaf Nodes
- Random Variables for each split (# of columns)

Random Forest Challenges

- Interpretability
- Prone to Overfit
- Auditability

Challenges - Interpretability

- GLMs
  - Produce one set of model output
  - P-values provide a measure of statistical significance
  - Higher values can be prioritized for further review
  - Log-linear model coefficients are easy to understand
  - Beta < 0 is a discount, Beta > 0 is surcharge

- RFs
  - It is hard to digest the net impact of a collection of trees
  - Variable Importance Plots highlight which variables are relatively less important
  - Interpretability plots help understand the impact of a variable upon the model
Variable Triaging

- Variable Importance Plots
  - Provide a measure of which variables are relatively more important than others
  - Variables with low importance measures aren’t necessarily unimportant, but they might be
  - Further scrutiny may be appropriate for variables with a low importance measure
  - Similar to looking at variables with high p-values in a GLM
- Types of variable importance
  - Gain: improvement in prediction accuracy from feature
  - Cover: Number of observations influenced
  - Frequency: Number of times used to split data

Interpretability Plots

- Partial Dependence Plots
  - Computes the marginal effect of a given feature on the prediction
  - Fixes the value of the predictor variable of interest, calculating the model prediction for each observation using the fixed value
  - Repeat for all values of the predictor variable

- Accumulated Local Effects
  - Better option in the case of correlated features
  - Calculates and accumulates incremental changes in the feature effects
  - Shows the expected and centered effects of a feature, like a coefficient in a GLM

- Shapely Additive Explanations
  - How much that feature moves the prediction away from the overall average prediction.
  - Feature increases predicted value higher than average value.
  - Feature decreases predicted value lower than average value.
Challenges - Prone to Overfit

- Review Hyperparameters
  - Number of trees should be large enough, but no larger
  - Look at plot to minimize OOB/Test Error or Deviance
  - Bootstrap sample size (% of rows)
  - Rule of Thumb: Max depth of > 8 may be too high
- Tree Complexity
  - Minimum node size should be set high enough for reasonable credibility
- Look at plot to minimize OOB/Test Error or Deviance
- Other hyperparameters should be disclosed and briefly commented on
  - Minimum node size should be set high enough for reasonable credibility
- Random Variables tried for each split (# of columns)
- Criteria to split should match the model purpose (classification, regression)
- Review lift charts on test/holdout data

Challenges - Auditability

- **GLM's**
  - Indicated factors are reproducible if you have the coefficients and link function
  - Indicated factors can be stored in lookup tables
  - Auditing model predictions could easily be done, even for a large number of risks
- **RF's**
  - Complete documentation means diagrams or if statements representing every component tree
  - Sample calculations would include input variable values, each tree’s result, and the final result (average of the component trees)
  - A full audit of the logic would likely involve a significant amount of coding

<table>
<thead>
<tr>
<th>Model</th>
<th>Tree 1</th>
<th>Tree 2</th>
<th>Tree 3</th>
<th>Overall Prediction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>45</td>
<td>46</td>
<td>47</td>
<td>46</td>
</tr>
<tr>
<td>Prior Claims</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Vehicle Age</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>3</td>
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<td>Model</td>
<td>Prediction</td>
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<tr>
<td>Value</td>
<td>$40.00</td>
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</tbody>
</table>

Challenges - Auditability

- Random Forest Documentation
  - Exhibits could be made for spot checking against tree documentation
  - Input Predictors
  - Individual Tree Predictions
  - Overall Model Prediction (average)

Draft Random Forest Appendix For Discussion

- Sending out 2 versions
  - Track Changes: Highlights removed, changed, and added items to the GLM Appendix
  - Final: Updated with the tracked changes for easy reading
- Looking for feedback for future Random Forest reviews

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<td>$40.00</td>
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</tr>
</tbody>
</table>

However, auditing every prediction for a book of business would still be extremely difficult.
References

- Basic Decision Tree Terminology
  - https://medium.datadriveninvestor.com/the-basics-of-decision-trees-e5837c2a807
- Theoretical Introduction to Random Forest
  - Introduction to Statistical Learning (Chapter 8 - 8.2.2)
- Interpretable Machine Learning (Variable Importance and Interpretability Plots)
  - Book Club Presentation: https://www.youtube.com/watch?v=JyMfTAlkawk
- Tree-Based Models Book Club: https://youtu.be/6UCbpA4c99M

https://naiconline.sharepoint.com/:b/r/sites/NAICSUPPORTSTAFFHUB/MEMBER%20MEETINGS/FALL%202021/TF/CasesAct/cej_comments_castf_211011_blanks_exposure_counts.pdf?csf=1&web=1&c=LTYWBg
### A. SELECTING MODEL INPUT

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Available Data Sources</td>
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<tr>
<td>A.1.a</td>
<td>Review the details of sources for both insurance and non-insurance data used as input to the model (only need sources for filed input characteristics included in the filed model).</td>
<td>1</td>
<td>Request details of data sources, whether internal to the company or from external sources. For insurance experience (policy or claim), determine whether data are aggregated by calendar, accident, fiscal, or policy year and when it was last evaluated. For each data source, get a list of all data elements used as input to the model that came from that source. For insurance data, get a list all companies whose data is included in the datasets. Request details of any non-insurance data used (customer-provided or other), whether the data was collected by use of a questionnaire/checklist, whether data was voluntarily reported by the applicant, and whether any of the data is subject to the federal Fair Credit Reporting Act (FCRA). If the data is from an outside source, find out what steps were taken to verify the data was accurate, complete, and unbiased in terms of relevant and representative time frame, representative of potential exposures, and lacking in obvious correlation to protected classes. <strong>Note:</strong> Reviewing source details should not make a difference when the model is new or refreshed; refreshed models would report the prior version list with the incremental changes due to the refresh.</td>
</tr>
<tr>
<td>A.1.b</td>
<td>Reconcile aggregated insurance data underlying the model with available external insurance reports.</td>
<td>4</td>
<td>Accuracy of insurance data should be reviewed. It is assumed that the data in the insurer’s data banks is subject to routine internal company audits and reconciliation. “Aggregated data” is straight from the insurer’s data banks without further modification (i.e., not scrubbed or transformed for the purposes of modeling). In other words, the data would not have been specifically modified for the purpose of model building. The company should provide some form of reasonability check that the data makes sense when checked against other audited sources.</td>
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<tr>
<td>A.1.c</td>
<td>Review the geographic scope and geographic exposure distribution of the raw data for relevance to the state where the model is filed.</td>
<td>2</td>
<td>Many models are developed using a countrywide or a regional dataset. The company should explain how the data used to build the model makes sense for a specific state. The regulator should inquire which states were included in the data underlying the model build, testing, and validation. The company should explain why any states were excluded from the countrywide data. The company should provide an explanation where the data came from geographically and that it is a good representation for a state; i.e., the distribution by state should not introduce a geographic bias. However, there could be a bias by peril or wind-resistant building codes. Evaluate whether the data is relevant to the loss potential for which it is being used. For example, verify that hurricane data is only used where hurricanes can occur. The company should provide a demonstration that the model fits well on the specific state or surrounding region.</td>
</tr>
<tr>
<td>2. Sub-Models</td>
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<tr>
<td>A.2.a</td>
<td>Consider the relevance of (i.e., whether there is bias) of overlapping data or variables used in the model and sub-models.</td>
<td>3</td>
<td>Check if the same variables/datasets were used in the model, a sub-model, or as stand-alone rating characteristics. Random Forest models handle redundant variables by splitting on only one of the variables within each component tree. By contrast, GLM’s struggle with redundant variables as they try to include redundant variables simultaneously. However, best actuarial practice is to keep models as parsimonious as possible and only include additional variables that contribute significant additional predictive power.</td>
</tr>
</tbody>
</table>
| A.2.b | Determine if the sub-model was previously approved (or accepted) by the regulatory agency. | 1 | If the sub-model was previously approved/accepted, that may reduce the extent of the sub-model’s review. If approved, obtain the tracking number(s) (e.g., state, SERFF) and verify when and if it was the same model currently under review.  
**Note:** A previous approval does not necessarily confer a guarantee of ongoing approval; e.g., when statutes and/or regulations have changed or if a model’s indications have been undermined by subsequent empirical experience. However, knowing whether a model has been previously approved can help focus the regulator’s efforts and determine whether the prior decision needs to be revisited. In some circumstances, direct dialogue with the vendor could be quicker and more useful. |
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<tr>
<td>A.2.c</td>
<td>Determine if the sub-model output was used as input to the Random Forest; obtain the vendor name, as well as the name and version of the sub-model.</td>
<td>1</td>
<td>To accelerate the review of the filing, it may be desirable to request (from the company), the name and contact information for a vendor representative. The company should provide the name of the third-party vendor and a contact in the event the regulator has questions. The “contact” can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with a subject-matter expert (SME) at the vendor. Examples of such sub-models include credit/financial scoring algorithms and household composite score models. Sub-models can be evaluated separately and in the same manner as the primary model under evaluation. A sub-model contact for additional information should be provided. Sub-model SMEs may need to be brought into the conversation with regulators (whether in-house or third-party sub-models are used).</td>
</tr>
<tr>
<td>A.2.d</td>
<td>If using catastrophe model output, identify the vendor and the model settings/assumptions used when the model was run.</td>
<td>1</td>
<td>To accelerate the review of the filing, get contact information for the SME that ran the model and an SME from the vendor. The “SME” can be an intermediary at the insurer (e.g., a filing specialist), who can place the regulator in direct contact with the appropriate SMEs at the insurer or model vendor. For example, it is important to know hurricane model settings for storm surge, demand surge, and long-term/short-term views.</td>
</tr>
<tr>
<td>A.2.e</td>
<td>Obtain an explanation of how catastrophe models are integrated into the model to ensure no double-counting.</td>
<td>1</td>
<td>If a weather-based sub-model is input to the Random Forest under review, loss data used to develop the model should not include loss experience associated with the weather-based sub-model. Doing so could cause distortions in the modeled results by double-counting such losses when determining relativities or loss loads in the filed rating plan. For example, redundant losses in the data may occur when non-hurricane wind losses are included in the data while also using a severe convective storm model in the actuarial indication. Such redundancy may also occur with the inclusion of fluvial or pluvial flood losses when using a flood model or inclusion of freeze losses when using a winter storm model.</td>
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<td>Section</td>
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<tr>
<td>A.2.f</td>
<td>If using output of any scoring algorithms, obtain a list of the variables used to determine the score and provide the source of the data used to calculate the score.</td>
<td>1</td>
<td>Any sub-model should be reviewed in the same manner as the primary model that uses the sub-model’s output as input. Depending on the result of item A.2.b, the importance of this item may be decreased.</td>
</tr>
<tr>
<td>A.3.a</td>
<td>Determine if premium, exposure, loss, or expense data were adjusted (e.g., on-leveled, developed, trended, adjusted for catastrophe experience, or capped). If so, how? Do the adjustments vary for different segments of the data? If so, identify the segments and how the data was adjusted.</td>
<td>2</td>
<td>The rating plan or indications underlying the rating plan may provide special treatment of large losses and non-modeled large loss events. If such treatments exist, the company should provide an explanation how they were handled. These treatments need to be identified and the company/regulator needs to determine whether model data needs to be adjusted. For example, should large bodily injury (BI) liability losses in the case of personal automobile insurance be excluded, or should large non-catastrophe wind/hail claims in home insurance be excluded from the model’s training, test and validation data? Look for anomalies in the data that should be addressed. For example, is there an extreme loss event in the data? If other processes were used to load rates for specific loss events, how is the impact of those losses considered? Examples of losses that can contribute to anomalies in the data are large losses or flood, hurricane, or severe convective storm losses for personal automobile comprehensive or home insurance. Premium should be brought to current rate level if the target variable is calculated with a premium metric, such as loss ratio. Premium can be brought to current rate level with the extension of exposures method or the parallelogram method. Note that the premium must be on-leveled at a granular variable level for each variable included in the new model if the parallelogram method is used. Statewide on-level factors by coverage are typically sufficient for statewide rate indication development but not sufficient for models that determine rates by variable level.</td>
</tr>
<tr>
<td>A.3.b</td>
<td>Identify adjustments that were made to aggregated data (e.g., transformations, binning and/or categorizations). If any, identify the name of the characteristic/variable and obtain a description of the adjustment.</td>
<td>1</td>
<td>Pre-modeling binning may be unnecessary in a random forest model. The tree model will naturally segment numerical values in the splitting process of the trees. However, if the insurer does bin variables before modeling, the reason should be understood.</td>
</tr>
</tbody>
</table>
Ask for aggregated data (one dataset of pre-adjusted/scrubbed data and one dataset of post-adjusted/scrubbed data) that allows the regulator to focus on the univariate distributions and compare raw data to adjusted/binned/transformed/etc. data.

This is most relevant for variables that have been “scrubbed” or adjusted.

Though most regulators may never ask for aggregated data and do not plan to rebuild any models, a regulator may ask for this aggregated data or subsets of it.

It would be useful to the regulator if the percentage of exposures and premium for missing information from the model data by category are provided. This data can be displayed in either graphical or tabular formats.
### 3. Data Management and Preparation

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>A.3.d</td>
<td>Determine how missing data was handled.</td>
<td>1</td>
<td>This is most relevant for variables that have been “scrubbed” or adjusted. The regulator should be aware of assumptions the modeler made in handling missing, null, or “not available” values in the data. For example, it would be helpful to the reviewer if the modeler were to provide a statement as to whether there is any systemic reason for missing data. If adjustments or recoding of values were made, they should be explained. It may also be useful to the regulator if the percentage of exposures and premium for missing information from the model data are provided. This data can be displayed in either graphical or tabular formats. The modeler should describe the way the tree fitting process handled missing values. The modeler should specify if missing values are treated before running the tree model or if they are allowed to be handled by the tree model.</td>
</tr>
<tr>
<td>A.3.e</td>
<td>If duplicate records exist, determine how they were handled.</td>
<td>1</td>
<td>Look for a discussion of how outliers were handled. If necessary, the regulator may want to investigate further by getting a list (with description) of the types of outliers and determine what adjustments were made to each type of outlier. To understand the filer’s response, the regulator should ask for the filer’s materiality standard.</td>
</tr>
<tr>
<td>A.3.f</td>
<td>Determine if there were any material outliers identified and subsequently adjusted during the scrubbing process.</td>
<td>3</td>
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### 4. Data Organization

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<tr>
<td>A.4.a</td>
<td>Obtain documentation on the methods used to compile and organize data, including procedures to merge data from different sources or filter data based on particular characteristics and a description of any preliminary analyses, data checks, and logical tests performed on the data and the results of those tests.</td>
<td>2</td>
<td>This should explain how data from separate sources was merged and/or how subsets of policies, based on selected characteristics, are filtered to be included in the data underlying the model and the rationale for that filtering.</td>
</tr>
<tr>
<td>A.4.b</td>
<td>Obtain documentation on the insurer’s process for reviewing the appropriateness, reasonableness, consistency, and comprehensiveness of the data, including a discussion of the rational relationship the data has to the predicted variable.</td>
<td>2</td>
<td>An example is when by-peril or by-coverage modeling is performed; the documentation should be for each peril/coverage and make rational sense. For example, if “murder” or “theft” data are used to predict the wind peril, the company should provide support and a rational explanation for their use.</td>
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<tr>
<td>A.4.c</td>
<td>Identify material findings the company had during its data review and obtain an explanation of any potential material limitations, defects, bias, or unresolved concerns found or believed to exist in the data. If issues or limitations in the data influenced modeling analysis and/or results, obtain a description of those concerns and an explanation how modeling analysis was adjusted and/or results were impacted.</td>
<td>1</td>
<td>“None” or “N/A” may be an appropriate response.</td>
</tr>
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</table>
### B. BUILDING THE MODEL

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td><strong>1. High-Level Narrative for Building the Model</strong></td>
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<tr>
<td>B.1.a</td>
<td>Identify the type of model underlying the rate filing (e.g., Random Forest, GLM,</td>
<td>1</td>
<td>It is important to understand if the model in question is a Random Forest and, therefore, these information elements are applicable; or if it is some other model type, in which case other reasonable review approaches may be considered. There should be an explanation of why the model (using the variables included in it) is appropriate for the line of business. If by-peril or by-coverage modeling is used, the explanation should be by-peril/by-coverage. <strong>Note:</strong> If the model is not a Random Forest, the information elements in this white paper may not apply in their entirety.</td>
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<td>decision tree, Bayesian GLM, gradient-boosting machine, neural network, etc.)</td>
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<tr>
<td>B.1.b</td>
<td>Identify the software used for model development. Obtain the name of the software</td>
<td>3</td>
<td>Changes in software from one model version to the next may explain if such changes, over time, contribute to changes in the modeled results. The company should provide the name of the third-party vendor and a “contact” in the event the regulator has questions. The “contact” can be an intermediary at the insurer (e.g., a filing specialist) who can place the regulator in direct contact with the appropriate SME at the vendor. Open-source software/programs used in model development should be identified by name and version the same as if from a vendor.</td>
</tr>
<tr>
<td></td>
<td>vendor/developer, software product, and a software version reference used in model</td>
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<td></td>
<td>development.</td>
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<tr>
<td>B.1.c</td>
<td>Obtain a description how the available data was divided between model training, test, and/or validation datasets. The description should include an explanation why the selected approach was deemed most appropriate, whether the company made any further subdivisions of available data, and reasons for the subdivisions (e.g., a portion separated from training data to support testing of components during model building). Determine if the validation data was accessed before model training was completed and, if so, obtain an explanation of why that came to occur. Obtain a discussion of whether the model was rebuilt using all the data or if it was only based on the training data.</td>
<td>1</td>
<td>The reviewer should be aware that modelers may break their data into three or just two datasets. Although the term “training” is used with little ambiguity, “test” and “validation” are terms that are sometimes interchanged, or the word “validation” may not be used at all. The reviewer should note whether a company employed cross-validation techniques instead of a training/test/validation dataset approach. If cross-validation techniques were used, the reviewer should request a description of how cross-validation was done and confirm that the final model was not built on any particular subset of the data, but rather the full dataset. The discussion of training, test, and/or validation datasets is a separate discussion from the % of observations (rows of data) or % of features (columns of data) used within each tree. These splits are based on hyperparameters and are commented on in other sections.</td>
</tr>
<tr>
<td>B.1.d</td>
<td>Obtain a brief description of the development process, from initial concept to final model and filed rating plan.</td>
<td>1</td>
<td>The narrative should have the same scope as the filing.</td>
</tr>
<tr>
<td>B.1.e</td>
<td>Obtain a narrative on whether loss ratio, pure premium, or frequency/severity analyses were performed and, if separate frequency/severity modeling was performed, how pure premiums were determined.</td>
<td>1</td>
<td>A clear description of the target variable is key to understanding the purpose of the model. It may also prove useful to obtain a sample calculation of the target variable in Excel format, starting with the “raw” data for a policy, or a small sample of policies, depending on the complexity of the target variable calculation.</td>
</tr>
<tr>
<td>B.1.f</td>
<td>Identify the model’s target variable.</td>
<td>1</td>
<td>Candidate variables are the variables used as input to the modeling process. Certain variables may not end up used in the final model if none of the component trees of the model split on the variable. The narrative regarding the candidate variable selection process may address matters such as the criteria upon which variables were selected or omitted, identification of the number of preliminary variables considered in developing the model versus the number of variables that remained, and any statutory or regulatory limitations that were taken into account when making</td>
</tr>
<tr>
<td>B.1.g</td>
<td>Obtain a description of the candidate variable selection process prior to the model building.</td>
<td>1</td>
<td></td>
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the decisions regarding candidate variable selection. The modeler should comment on the use of automated feature selection algorithms to choose candidate predictor variables and explain how potential overfitting that can arise from these techniques was addressed.
### B.1.h

In conjunction with variable selection, obtain a narrative on how the company determined the granularity of the rating variables during model development.

**Comments**

3. The narrative should include discussion of how credibility was considered in the process of determining the level of granularity of the variables selected. Minimum data volume constraints can be applied to a tree based model, such that the trees will not create a split that would result in terminal nodes with volume below a set amount. The modeler should comment on how the threshold was chosen.

### B.1.i

Determine if model input data was segmented in any way (e.g., by-coverage, by-peril, or by-form basis). If so, obtain a description of data segmentation and the reasons for data segmentation.

**Comments**

1. The regulator would use this to follow the logic of the modeling process.

### B.1.j

If adjustments to the model were made based on credibility considerations, obtain an explanation of the credibility considerations and how the adjustments were applied.

**Comments**

2. If there was no minimum data volume threshold applied to the trees, or if the threshold was very small, obtain an explanation of any post modeling adjustments the modeler made to address the credibility considerations and how the adjustments were applied.

## 2. Medium-Level Narrative for Building the Model

### B.2.a

At crucial points in model development, if selections were made among alternatives regarding model assumptions, techniques, or hyperparameters, obtain a narrative on the judgment used to make those selections.

**Comments**

2. Evaluate the addition or removal of variables and the model fitting. It is not necessary for the company to discuss each iteration of adding and subtracting variables, but the regulator should gain a general understanding of how these adjustments were done, including any statistical improvement measures relied upon.

### B.2.b

If post-model adjustments were made to the data and the model was rerun, obtain an explanation on the details and the rationale for those adjustments.
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<tr>
<td>B.2.d</td>
<td>Identify which distribution was used for the model (e.g., Regression based on Poisson, Gamma, Logistic, or Tweedie are common choices). Obtain an explanation of why the distribution was chosen. Certain distribution assumptions will involve numerical parameters, for example regression with a Tweedie assumed distribution will have a p power value. Obtain the specific numerical parameters associated with the distribution.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>B.2.e</td>
<td>Obtain a narrative on how the predictions from the component trees are combined to arrive at a final model prediction.</td>
<td>2</td>
<td>Tree based methods combine predictions from multiple component trees and aggregate them into a final prediction for each observation. Common methods for combining random forest model predictions include the arithmetic or geometric mean of all the component trees.</td>
</tr>
<tr>
<td>B.2.f</td>
<td>If there were data situations in which weights were used, obtain an explanation of how and why they were used.</td>
<td>3</td>
<td>Investigate whether identical records were combined to build the model.</td>
</tr>
<tr>
<td>New B.3.1</td>
<td>Obtain the number of component trees comprising the Random Forest model. Obtain a narrative on how this number was chosen.</td>
<td>1</td>
<td>Random Forest models should contain enough trees to reduce error to an acceptable level. Random forest models should balance this with the concept of parsimony. A model with fewer trees that achieves relatively similar reduction in error is preferable to a model with more trees. Checking the error on a test dataset or out of bag error for different numbers of trees</td>
</tr>
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can reveal at what value the error on test data starts to level off.

Modelers might rely on early stopping rules within modeling software to arrive at the final number of trees. The narrative on the number of trees should discuss the stopping criterion, which defines what condition is met when the model stopped adding more trees.

| New B.3.2 | Obtain the sampling parameters that apply to both the percent of observations used in each component tree and the number of features tested for each split within each tree. Obtain a narrative on how the sampling parameters were selected. | 1 | Random forest models often sample both the observations (typically rows of modeling data) with replacement and sample the features (typically columns of modeling data) This means that each tree has a bootstrapped dataset.

The company should discuss the bagging fraction (aka sample size) applied to observations (typically rows of data). This is often expressed as a percent. For example: perhaps each tree is based on a bootstrapped sample which is 50% of the original dataset.

The company should discuss the number of features considered at each split. This is often expressed as an integer. A common choice for the number of features is equal to roughly the square root of the total number of candidate variables. For example: perhaps each split is based on 10 randomly selected features (typically columns of data) when there are 100 candidate variables. |

| New B.3.3 | Obtain the maximum depth that applies to the component trees in the model. Obtain a narrative on how this number was chosen. | 1 | The depth of a tree is the number of splits that are allowed to occur between the root node and the terminal nodes. This number can be set explicitly in modeling software or may be implicitly set if the company applies a splitting constraint, such as a minimum observations per node. Maximum tree depths of 8 or higher are considered extremely high. |
### Section

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<tr>
<td><strong>3. Predictor Variables</strong></td>
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<tr>
<td>B.3.a</td>
<td>Obtain a complete data dictionary, including the names, types, definitions, and rationales for each variable.</td>
<td>1</td>
</tr>
<tr>
<td>B.3.b</td>
<td>Obtain a list of predictor variables considered but not used in the final model, and the rationale for their removal.</td>
<td>4</td>
</tr>
<tr>
<td>B.3.c</td>
<td>Obtain a correlation matrix for all predictor variables included in the model and sub-model(s).</td>
<td>3</td>
</tr>
<tr>
<td>B.3.d</td>
<td>Obtain plots describing the relationship between each predictor variable and the target variable. Obtain a rational explanation for the observed relationship between each predictor variable and the target variable (frequency, severity, loss costs, expenses, or any element or characteristic being predicted).</td>
<td>1</td>
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<tr>
<td>B.3.e</td>
<td>If the modeler made use of one or more dimensionality reduction techniques, such as a principal component analysis (PCA), obtain a narrative about that process, an explanation why that technique was chosen, and a description of the step-by-step process used to transform observations (usually correlated) into a set of linearly uncorrelated variables. In each instance, obtain a list of the pre-transformation and post-transformation variable names, as well as an explanation of how the results of the dimensionality reduction technique was used within the model.</td>
<td>2</td>
</tr>
<tr>
<td>New B.3.f</td>
<td>Obtain variable importance plots. Obtain a description of how variable importance was calculated.</td>
<td>1</td>
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4. Adjusting Data, Model Validation, and Goodness-of-Fit Measures

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| B.4.a   | Obtain a description of the methods used to assess the statistical significance/goodness-of-fit of the model to validation data, such as lift charts and statistical tests. Compare the model’s projected results to historical actual results and verify that modeled results are reasonably similar to actual results from validation data. | 1 | For models that are built using multistate data, validation data for some segments of risk is likely to have low credibility in individual states. Nevertheless, some regulators require model validation on state-only data, especially when analysis using state-only data contradicts the countrywide results. State-only data might be more applicable but could also be impacted by low credibility for some segments of risk.  
**Note:** It may be useful to consider geographic stability measures for territories within the state. |
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<tr>
<td>B.4.e</td>
<td>Obtain evidence that the model fits the training data well by variable and for the overall model.</td>
<td>2</td>
<td>The regulator should ask for the company to provide exhibits or plots that show the fitted average makes sense when compared to the observed average for variables of interest. Regulators would ideally review this comparison for every variable, but time constraints may limit the focus to just variables of interest. Variables of interest should include those with a low importance measure according to diagnostic tests, variables without an intuitive relationship to loss, or variables that may be a proxy for a protected class attribute.</td>
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<tr>
<td>B.4.g</td>
<td>Obtain a description how the model was tested for stability over time.</td>
<td>2</td>
<td>Evaluate the build/test/validation datasets for potential time-sensitive model distortions (e.g., a winter storm in year 3 of 5 can distort the model in both the testing and validation datasets). Obsolescence over time is a model risk (e.g., old data for a variable or a variable itself may no longer be relevant). If a model being introduced now is based on losses from years ago, the reviewer should be interested in knowing whether that model would be predictive in the proposed context. Validation using recent data from the proposed context might be requested. Obsolescence is a risk even for a new model based on recent and relevant loss data. The reviewer may want to inquire as to the following: What steps, if any, were taken during modeling to prevent or delay obsolescence? What controls exist to measure the rate of obsolescence? What is the plan and timeline for updating and ultimately replacing the model? The reviewer should also consider that as newer technologies enter the market (e.g., personal automobile) their impact may change claim activity over time (e.g., lower frequency of loss). So, it is not necessarily a bad thing that the results are not stable over time.</td>
</tr>
<tr>
<td>B.4.h</td>
<td>Obtain a narrative on how potential concerns with overfitting were addressed.</td>
<td>2</td>
<td>Tree based models such as Random Forest models are notorious for over-fitting. The company should provide a narrative on how overfitting was addressed. The company should provide lift charts on training data and testing data that is separate from the training data.</td>
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<tr>
<td>B.4.i</td>
<td>Obtain support demonstrating that the Random Forest assumptions are appropriate.</td>
<td>3</td>
<td>A visual review of plots of actual errors is usually sufficient. The reviewer should look for a conceptual narrative covering these topics: How does this particular Random Forest work? Why did the rate filer do what it did? Why employ this design instead of alternatives? Why choose this particular distribution function and this particular link function? A company response may be at a fairly high level and reference industry practices. If the reviewer determines that the model makes no assumptions that are considered to be unreasonable, the importance of this item may be reduced.</td>
</tr>
<tr>
<td>B.4.j</td>
<td>Obtain 5-10 sample records with corresponding output from the model for those records.</td>
<td>2</td>
<td>The company should provide 5-10 sample records with corresponding input variable values, the prediction from each component tree in the model, and the final ensemble model prediction. The company should describe how the final model prediction aggregates the individual tree model predictions.</td>
</tr>
<tr>
<td>New B.4.k</td>
<td>Obtain a deviance analysis by number of trees</td>
<td>2</td>
<td>The company should provide a plot showing that the deviance of the overall model decreases after each iteration (each additional tree)</td>
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5. “Old Model” Versus “New Model”

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<tr>
<td>B.5.a</td>
<td>Obtain an explanation of why this model is an improvement to the current rating plan. If it replaces a previous model, find out why it is better than the one it is replacing; determine how the company reached that conclusion and identify metrics relied on in reaching that conclusion. Look for an explanation of any changes in calculations, assumptions, parameters, and data used to build this model from the previous model.</td>
<td>2</td>
<td>The regulator should expect to see improvement in the new class plan’s predictive ability or other sufficient reason for the change.</td>
</tr>
<tr>
<td>B.5.b</td>
<td>Determine if two Gini coefficients were compared and obtain a narrative on the conclusion drawn from this comparison.</td>
<td>3</td>
<td>This information element requests a comparison of the Lorenz curve and Gini coefficient from the prior model to the Gini coefficient of proposed model. It is expected that there should be improvement in the Gini coefficient. A higher Gini coefficient indicates greater differentiation produced by the model and how well the model fits that data. This is relevant when one model is being updated or replaced. The regulator should expect to see improvement in the new class plan’s predictive ability. One example of a comparison might be sufficient. Note: This comparison is not applicable to initial model introduction. Reviewer can look to CAS monograph, “Generalized Linear Models for Insurance Rating.”</td>
</tr>
<tr>
<td>B.5.c</td>
<td>Determine if double-lift charts were analyzed and obtain a narrative on the conclusion drawn from this analysis.</td>
<td>3</td>
<td>One example of a comparison might be sufficient. <strong>Note</strong>: “Not applicable” is an acceptable response.</td>
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<tr>
<td>B.5.d</td>
<td>If replacing an existing model, obtain a list of any predictor variables used in the old model that are not used in the new model as candidate variables. Obtain an explanation of why these variables were dropped from the new model. Obtain a list of all new predictor variables in the new model that were not in the prior old model.</td>
<td>2</td>
<td>It is useful to differentiate between old and new variables, so the regulator can prioritize more time on variables not yet reviewed.</td>
</tr>
<tr>
<td>6. Modeler Software</td>
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<tr>
<td>B.6.a</td>
<td>Request access to SMEs (e.g., modelers) who led the project, compiled the data, and/or built the model.</td>
<td>4</td>
<td>The filing should contain a contact that can put the regulator in touch with appropriate SMEs and key contributors to the model development to discuss the model.</td>
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### C. THE FILED RATING PLAN

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<tr>
<td>1. General Impact of Model on Rating Algorithm</td>
<td>In the actuarial memorandum or explanatory memorandum, for each model and sub-model (including external models), look for a narrative that explains each model and its role (i.e., how it was used) in the rating system.</td>
<td>1</td>
<td>The “role of the model” relates to how the model integrates into the rating plan as a whole and where the effects of the model are manifested within the various components of the rating plan. This is not intended as an overarching statement of the model’s goal, but rather a description of how specifically the model is used. This item is particularly important, if the role of the model cannot be immediately discerned by the reviewer from a quick review of the rate and/or rule pages. (Importance is dependent on state requirements and ease of identification by the first layer of review and escalation to the appropriate review staff.)</td>
</tr>
<tr>
<td>C.1.a</td>
<td>Obtain an explanation of how the model was used to adjust the filed rating algorithm.</td>
<td>1</td>
<td>The regulator should consider asking for an explanation of how the model was used to adjust the rating algorithm.</td>
</tr>
<tr>
<td>C.1.c</td>
<td>Obtain a complete list of characteristics/variables used in the proposed rating plan, including those used as input to the model (including sub-models and composite variables) and all other characteristics/variables (not input to the model) used to calculate a premium. For each characteristic/variable, determine if it is only input to the model, whether it is only a separate univariate rating characteristic, or whether it is both input to the model and a separate univariate rating characteristic. The list should include transparent descriptions (in plain language) of each listed characteristic/variable.</td>
<td>1</td>
<td>Examples of variables used as inputs to the model and used as separate univariate rating characteristics might be criteria used to determine a rating tier or household composite characteristic.</td>
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| 2. Relevance of Variables and Relationship to Risk of Loss | C.2.a Obtain a narrative regarding how the characteristics/rating variables included in the filed rating plan relate to the risk of insurance loss (or expense) for the type of insurance product being priced. | 2 | The narrative should include a discussion of the relevance each characteristic/rating variable has on consumer behavior that would lead to a difference in risk of loss (or expense). The narrative should include a rational relationship to cost, and model visualization plots (such as partial dependence plots, accumulated local effects plots, or Shapley plots) should be consistent with the expected direction of the relationship. 
**Note:** This explanation would not be needed if the connection between variables and risk of loss (or expense) has already been illustrated. |
| 3. Comparison of Model Outputs to Current and Selected Rating Factors | C.3.b Obtain documentation and support for all calculations, judgments, or adjustments that connect the model’s indicated values to the selected rates filed in the rating plan. | 1 | The documentation should include explanations for the necessity of any such adjustments and each significant difference between the model’s indicated values and the selected values. This applies even to models that produce scores, tiers, or ranges of values for which indications can be derived. 
**Note:** This information is especially important if differences between model-indicated values and selected values are material and/or impact one consumer population more than another. |
| C.3.c For each characteristic/variable used as both input to the model (including sub-models and composite variables) and as a separate univariate rating characteristic, obtain a narrative regarding how each characteristic/variable was tempered or adjusted to account for possible overlap or redundancy in what the characteristic/variable measures. | 2 | The insurer should address this possibility or other considerations; e.g., tier placement models often use risk characteristics/variables that are also used elsewhere in the rating plan. 
One way to do this would be to model the loss ratios resulting from a process that already uses univariate rating variables. Then the model/composite variables would be attempting to explain the residuals. |
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<tr>
<td>4. A</td>
<td>Determine what, if any, consideration was given to the credibility of the output data.</td>
<td>2</td>
<td>The regulator should determine at what level of granularity credibility is applied. If modeling was by-coverage, by-form, or by-peril, the company should explain how these were handled when there was not enough credible data by coverage, form, or peril model. The company should comment on the minimum data volume requirement at each node before splitting.</td>
</tr>
<tr>
<td>4. B</td>
<td>If the rating plan is less granular than the model, obtain an explanation of why.</td>
<td>2</td>
<td>This is applicable if the company had to combine modeled output in order to reduce the granularity of the rating plan.</td>
</tr>
<tr>
<td>4. C</td>
<td>If the rating plan is more granular than the model, obtain an explanation of why.</td>
<td>2</td>
<td>A more granular rating plan may imply that the company had to extrapolate certain rating treatments, especially at the tails of a distribution of attributes, in a manner not specified by the model indications. It may be necessary to extrapolate due to data availability or other considerations.</td>
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<td>5.</td>
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<tr>
<td>5. A</td>
<td>Obtain a narrative regarding adjustments made to model output (e.g., transformations, binning and/or categorizations). If adjustments were made, obtain the name of the characteristic/variable and a description of the adjustment.</td>
<td>2</td>
<td>If rating tiers or other intermediate rating categories are created from model output, the rate and/or rule pages should present these rating tiers or categories. The company should provide an explanation of how model output was translated into these rating tiers or intermediate rating categories.</td>
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<td>6.</td>
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<tr>
<td>6. A</td>
<td>Obtain aggregated state-specific, book-of-business-specific univariate historical experience data, separately for each year included in the model, consisting of loss ratio or pure premium relativities and the data underlying those calculations for each category of model output(s) proposed to be used within the rating plan. For each data element, obtain an explanation of whether it is raw or adjusted and, if the latter, obtain a detailed explanation for the adjustments.</td>
<td>4</td>
<td>For example, were losses developed/undeveloped, trended/untrended, capped/uncapped, etc.? Univariate indications should not necessarily be used to override more sophisticated multivariate indications. However, they do provide additional context and may serve as a useful reference.</td>
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### 7. Consumer Impacts

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<tr>
<td>C.7.a</td>
<td>Obtain a listing of the top five rating variables that contribute the most to large swings in renewal premium, both as increases and decreases, as well as the top five rating variables with the largest spread of impact for both new and renewal business.</td>
<td>4</td>
<td>These rating variables may represent changes to rating factors, be newly introduced to the rating plan, or have been removed from the rating plan.</td>
</tr>
<tr>
<td>C.7.b</td>
<td>Determine if the company performed sensitivity testing to identify significant changes in premium due to small or incremental change in a single risk characteristic. If such testing was performed, obtain a narrative that discusses the testing and provides the results of that testing.</td>
<td>3</td>
<td>One way to see sensitivity is to analyze a graph of each risk characteristic’s/variable’s average fitted model prediction. Look for significant variation between the average fitted model predictions for adjacent rating variable levels and evaluate if such variation is reasonable and credible.</td>
</tr>
<tr>
<td>C.7.c</td>
<td>For the proposed filing, obtain the impacts on renewal business and describe the process used by management, if any, to mitigate those impacts.</td>
<td>2</td>
<td>Some mitigation efforts may substantially weaken the connection between premium and expected loss and expense and, hence, may be viewed as unfairly discriminatory by some states.</td>
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<td>C.7.d</td>
<td>Obtain a rate disruption/dislocation analysis, demonstrating the distribution of percentage and/or dollar impacts on renewal business (created by rerating the current book of business) and sufficient information to explain the disruptions to individual consumers.</td>
<td>2</td>
<td>The analysis should include the largest dollar and percentage impacts arising from the filing, including the impacts arising specifically from the adoption of the model or changes to the model as they translate into the proposed rating plan. While the default request would typically be for the distribution/dislocation of impacts at the overall filing level, the regulator may need to delve into the more granular variable-specific effects of rate changes if there is concern about particular variables having extreme or disproportionate impacts, or significant impacts that have otherwise yet to be substantiated. See Appendix D for an example of a disruption analysis.</td>
</tr>
<tr>
<td>C.7.e</td>
<td>Obtain exposure distributions for the model’s output variables and show the effects of rate changes at granular and summary levels, including the overall impact on the book of business.</td>
<td>3</td>
<td>See Appendix D for an example of an exposure distribution.</td>
</tr>
<tr>
<td>C.7.f</td>
<td>Identify policy characteristics, used as input to a model or sub-model, that remain “static” over a policy’s lifetime versus those that will be updated periodically. Obtain a narrative on how the company handles policy characteristics that are listed as “static,” yet change over time.</td>
<td>3</td>
<td>Some examples of “static” policy characteristics are prior carrier tenure, prior carrier type, prior liability limits, claim history over past X years, or lapse of coverage. These are specific policy characteristics usually set at the time new business is written, used to create an insurance score or to place the business in a rating/underwriting tier, and often fixed for the life of the policy. The reviewer should be aware, and possibly concerned, how the company treats an insured over time when the insured’s risk profile based on “static” variables changes over time but the rate charged, based on a new business insurance score or tier assignment, no longer reflect the insured’s true and current risk profile. A few examples of “non-static” policy characteristics are age of driver, driving record, and credit information (FCRA-related). These are updated automatically by the company on a periodic basis, usually at renewal, with or without the policyholder explicitly informing the company.</td>
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<tr>
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<td>C.7.g</td>
<td>Obtain a means to calculate the rate charged a consumer.</td>
<td>3</td>
<td>The filed rating plan should contain enough information for a regulator to be able to validate policy premium. However, for a complex model or rating plan, a score or premium calculator via Excel or similar means would be ideal, but this could be elicited on a case-by-case basis. The ability to calculate the rate charged could allow the regulator to perform sensitivity testing when there are small changes to a risk characteristic/variable. <strong>Note:</strong> This information may be proprietary. For the rating plan, the rate order of calculation rule may be sufficient. However, it may not be feasible for a regulator to get all the input data necessary to reproduce a model’s output. Credit and telematics models are examples of model types where model output would be readily available, but the input data would not be readily available to the regulator.</td>
</tr>
<tr>
<td>C.7.h</td>
<td>In the filed rating plan, be aware of any non-insurance data used as input to the model (customer-provided or other). In order to respond to consumer inquiries, it may be necessary to inquire as to how consumers can verify their data and correct errors.</td>
<td>1</td>
<td>If the data is from a third-party source, the company should provide information on the source. Depending on the nature of the data, it may need to be documented with an overview of who owns it. The topic of consumer verification may also need to be addressed, including how consumers can verify their data and correct errors.</td>
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</table>

**8. Accurate Translation of Model into a Rating Plan**

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<thead>
<tr>
<th>Section</th>
<th>Information Element</th>
<th>Level of Importance to Regulator’s Review</th>
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<tbody>
<tr>
<td>C.8.a</td>
<td>Obtain sufficient information to understand how the model outputs are used within the rating system and to verify that the rating plan’s manual, in fact, reflects the model output and any adjustments made to the model output.</td>
<td>1</td>
<td>The regulator can review the rating plan’s manual to see that modeled output is properly reflected in the manual’s rules, rates, factors, etc.</td>
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<tr>
<td>Section</td>
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<tr>
<td>9. Efficient and Effective Review of Rate Filing</td>
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<tr>
<td>C.9.a</td>
<td>Establish procedures to efficiently review rate filings and models contained therein.</td>
<td>1</td>
<td>“Speed to market” is an important competitive concept for insurers. Although the regulator needs to understand the rate filing before accepting the rate filing, the regulator should not request information that does not increase his/her understanding of the rate filing. The regulator should review the state’s rate filing review process and procedures to ensure that they are fair and efficient.</td>
</tr>
<tr>
<td>C.9.b</td>
<td>Be knowledgeable of state laws and regulations in order to determine if the proposed rating plan (and models) are compliant with state laws and/or regulations.</td>
<td>1</td>
<td>This is a primary duty of state insurance regulators. The regulator should be knowledgeable of state laws and regulations and apply them to a rate filing fairly and efficiently. The regulator should pay special attention to prohibitions of unfair discrimination.</td>
</tr>
<tr>
<td>C.9.c</td>
<td>Be knowledgeable of state laws and regulations in order to determine if any information contained in the rate filing (and models) should be treated as confidential.</td>
<td>1</td>
<td>The regulator should be knowledgeable of state laws and regulations regarding confidentiality of rate filing information and apply them to a rate filing fairly and efficiently. Confidentiality of proprietary information is key to innovation and competitive markets.</td>
</tr>
<tr>
<td>C.10.d</td>
<td>Obtain complete documentation of all component trees and how the individual predictions are aggregated together into a final prediction.</td>
<td>1</td>
<td>The company should provide either tree diagrams for each component tree or comprehensive if-else statements that would replicate the logic of the trees. The company should state how the individual component tree predictions are combined into a final prediction.</td>
</tr>
</tbody>
</table>
New Glossary Terms:

**Accumulated Local Effects Plots:** A type of interpretability plot. Accumulated Local Effects plots calculate smaller, incremental changes in the feature effects. ALE shows the expected and centered effects of a variable.

**Bagged Trees:** An ensemble of trees model where each tree is based on a “bootstrap aggregated” sample.

**Branch:** A connection on a decision tree between a parent node and a child node. A relationship based on a predictor variable is checked at each node, determining which branch applies.

**Candidate Variables:** The variables specified by the modeler to be used within the full model. The random variable selection by a random forest means that component trees might only use a subset of these variables in each tree.

**Child node:** The node below a parent node. The child node is the result of a split that occurs based on a predictor variable. The node above the child node, which is where the split occurred resulting in the creation of the child nodes, is called the parent node. There is 1 parent node for every child node. The root node is the only node which is not a child node.

**Component Tree:** An individual tree within an ensemble of trees based method such as random forest or gradient boosting machine.

**Deviance:** A measure of model fit. Deviance is based on the difference between the log-likelihood of the saturated model and the log-likelihood of the proposed model being evaluated. Smaller values of deviance demonstrate that a model’s predictions fit closer to actual. Deviance on training data will always decrease as model complexity increases.

**Hyperparameter:** A model hyperparameter is a model setting specified by the modeler that is external to the model and whose value cannot be estimated from data.

**Node:** A point on a decision tree. Nodes are either root nodes (the top node), leaf nodes (a terminal node at which point no further splitting occurs), or an internal node which appears in the middle of the tree while splitting is still taking place.

**Out-of-Bag Error:** Error calculated for observations based on the trees that did not include them in the set of training observations. Out-of-Bag Error is calculable when bootstrapping is used to generate different datasets for each component tree in an ensemble tree method.

**Parent node:** The node above a child node. The parent node is where a split occurs based on a predictor variable. The nodes below the parent node, which are a direct result of the parent node’s split, are called child nodes. There are typically 2 child nodes for every parent node. Terminal nodes can not be parent nodes.

**Partial Dependence Plots:** A type of interpretability plot. The partial dependence plot computes the marginal effect of a given variable on the prediction.

**Pruning:** The process of scaling back a tree to reduce it’s complexity. This results in trees with fewer branches and terminal nodes appearing higher on the tree. Pruning is more common on models built on
a single decision tree rather than on ensemble models such as random forests or Gradient Boosting Machines.

**Random Forest**: An ensemble of trees model where each tree is based on a bootstrap aggregated sample and each split is based on a random sample of the candidate variables.

**Root node**: The first (top) node in a decision tree. This node contains the entire set of data used by the tree as no splits have occurred yet.

**Shapley Additive Explanation Plots**: A type of interpretability plot. Shapley plots investigate the effect of including a variable in the model by the order in which it is added. The Shapley value represents the amount the variable of interest contributes to the prediction.

**Splitting**: The process of dividing a node into two or more sub-nodes, starting from the root node. Splitting occurs at every node up until the terminal (leaf) nodes when the stopping criterion is met.

**Stopping Criterion**: A criterion applied to the splitting process that informs the node when it is ineligible to split any further. Volume of data is often used as a stopping criterion, such that each leaf node is based on at least a pre-determined amount of data.

**Terminal Node**: An end node containing no child nodes, because the node has met the stopping criterion. The terminal node is associated with a prediction for one of the component trees. The terminal node is also known as a “leaf” node, the resulting endpoint of a decision tree.

**Tree Based Model**: Models that can be represented as a decision tree or a collection of decision trees.

**Tree Depth**: The maximum number of splits between the root node and a leaf node for a tree.

**Variable Importance**: A measure of how the variables (aka features) contribute to the overall model. There are multiple ways to measure variable importance.

https://naiconline.sharepoint.com/w:/r/sites/NAICSupportStaffHub/Member%20Meetings/Fall%202021/TF/CasAct/New%20Glossary%20Terms.docx?d=w0087e0f55cc540be89c24c97583d53b&csf=1&web=1&e=NLa5Y9
Casualty Practice Council (CPC) Update

- **Comment Letters**
  - Response to Federal Insurance Office (FIO) on availability and affordability of cyber insurance
  - Response to FIO on climate-related insurance financial risk in the insurance sector
- **Auto**
  - Consumer Cost of Automobile insurance
  - Wildfire Paper Update (December)
  - Cyber Toolkit (Expansion in early January)
  - Consumer Surveys and COVID-21
- **DE&I Efforts**
  - Presentation to NAIC Special (EX) Committee on Race and Insurance Workstream 3
  - Colorado Department of Insurance Comment Letter (December)
  - Causation-Correlation Issue Brief (Early January)
  - Protected Class Data Issue Brief (Early January)
  - Medical Professional Liab. Issue Brief on COVID-19 impact
  - Wildfire Paper Update (December)

Questions?

Contact: Rob Fischer, Casualty Policy Analyst, fischer@actuary.org

Committee on Property and Liability Financial Reporting (COPLFR) Update

- **Recent Activities**
  - Comments on annual statements and premiums and losses to the Blanks Working Group and CASTF
  - 2021 Seminar on Effective P/C Loss Reserve Opinions: Tools for the Appointed Actuary (Dec. 6 and 7)
  - Upcoming events
  - Release of 2021 Practice Note on SAOs on P/C Loss Reserves (December)
  - P/C Loss Reserve Law Manual (December or early January) – thank you for your help!
  - Risk Transfer Practice Note Update (Q1 2022)

https://naiconline.sharepoint.com/b:/sites/NAICSupportStaffHub/Member%20Meetings/Fall%202021/TF/CasAct/Academy%20Presentation%20to%20CASTF%2012.7.21_Final%20(reduced).pdf?csf=1&web=1&ct=1&c=AhGpNw
Newly formed research council
- Focus on Covid, climate and cyber

Disparate impact
- 4 papers to be published in Jan. 2022

Social inflation
- Final draft of Schedule P analysis received
- Text analysis of claims data nearing completion

Technology survey final draft complete
Cannabis research w/CIA
CASCOR IFRS 17
Wildfire geospatial modeling Q1 2022
Wildfire mitigation Q1/Q2 2022
Professional Education


Recent and Future PE Events

- Casualty Loss Reserve Seminar
- 2021 In Focus Virtual Seminar: Bridging the Gap: Technical Analysis vs Business Strategy for Tomorrow’s Culturally Empowered Actuary
- 2021 Annual Meeting hybrid virtual and in-person
- Python virtual workshops to be repeated in 2022
- Live Python workshop planned for March 2022

https://naiconline.sharepoint.com/:b:/r/sites/NAICSupportStaffHub/Member%20Meetings/Fall%202021/TF/CasAct/CAS%20Research%20Report.pdf?csf=1&web=1&e=iqxF6w
SURPLUS LINES (E) TASK FORCE

Surplus Lines (C) Task Force Nov. 29, 2021, Minutes ................................................................. 8-154
Surplus Lines (C) Working Group Oct. 21, 2021, Minutes (Attachment One) .................................. 8-156
NAIC Standard Form Trust Agreement for Alien Excess or Surplus Lines Insurers (Attachment One-A) 8-157
Surplus Lines (C) Working Group Sept. 22, 2021, Minutes (Attachment Two) ................................. 8-171
Comment Letter (Attachment Two-A) ............................................................................................. 8-173
Andrea Best Comment Letter (Attachment Two-B) ........................................................................ 8-174
Proposed Friendly Amendment to Section 2.1 of the NAIC Standard Form Trust Agreement for Alien Excess or Surplus Lines Insurers (Attachment Three) ......................................................... 8-178
The Surplus Lines (C) Task Force met Nov. 29, 2021. The following Task Force members participated: James J. Donelon, Chair, Stewart Guerin and Tom Travis (LA); Larry D. Deiter, Vice Chair (SD); Lori K. Wing-Heier represented by Sian Ng-Ashcraft (AK); Jim L. Ridling represented by Jimmy Gunn (AL); Ricardo Lara represented by Libio Latimer (CA); Michael Conway represented by Rolf Kaumann (CO); Karima M. Woods represented by Robert Baron (MD); Troy Downing (MT); Mike Causey represented by Fred Fuller (NC); Russell Toal represented by Ursula Almada (NM); Barbara D. Richardson (NV); and Mike Kreidler represented by Jeff Baughman (WA); and Jeff Rude represented by Danie Capps (WY). Also participating was Robert Wake (ME).

1. **Adopted its Summer National Meeting Minutes**

Director Deiter made a motion, seconded by Mr. Baughman, to adopt the Task Force’s Aug. 5 minutes (see NAIC Proceedings – Fall 2021, Surplus Lines (C) Task Force). The motion passed unanimously.

2. **Adopted the Report of the Surplus Lines (C) Working Group**

Mr. Guerin reported that since the Summer National Meeting, the Surplus Lines (C) Working Group met Sept. 22 to address two administrative tasks. He stated that the Working Group discussed amendments to the NAIC Standard Form Trust Agreement for Alien Excess or Surplus Lines Insurers. Mr. Guerin stated that after discussion of several amendments, the Working Group re-exposed the document for a 14-day public comment period ending Oct. 6. The Working Group conducted an e-vote that concluded Oct. 21 to adopt the amendments to the NAIC Standard Form Trust Agreement for Alien Excess or Surplus Lines Insurers.

Mr. Kaumann made a motion, seconded by Mr. Fuller, to adopt the report of the Surplus Lines (C) Working Group, including its Oct. 21 (Attachment One) and Sept. 22 (Attachment Two) minutes. The motion passed unanimously.

Following the report, Robert Wake (ME) presented a few friendly amendments to the NAIC Standard Form Trust Agreement for Alien Excess or Surplus Lines Insurers.

Mr. Kaumann made a motion, seconded by Mr. Baughman, to adopt the amendments to the NAIC Standard Form Trust Agreement for Alien Excess or Surplus Lines Insurers (Attachment Three). The motion passed unanimously.

Mr. Guerin concluded that the second administrative task covered during the Working Group’s Sept. 22 meeting covered the adoption of modifications to the NAIC Quarterly Listing of Alien Insurers.

Commissioner Donelon addressed Mr. Guerin’s comments regarding Clark Fitz-Hugh (International Sureties Ltd.), who proposed the use of surety bonds as a means to fund collateral within the required trust funds that secure the solvency of insurers on the Quarterly Listing of Alien Insurers. Commissioner Donelon asked Mr. Fitz-Hugh to present his proposal. However, Mr. Fitz-Hugh was not in attendance. Commissioner Donelon asked for comments on the matter, and Director Deiter indicated that he has concerns with the use of surety bonds to fund the trusts as they are not admitted assets. Commissioner Donelon commented that his opinion aligns with Director Deiter. Mr. Latimer commented that California has a preference to maintain consistency between the surplus lines and reinsurance trust fund collateral requirements. Further, Mr. Latimer commented that there are concerns regarding the uncertainty regarding potential collectability. Mr. Wake commented that there are certain conditions that are necessary to fund a trust and a surety bond is not considered evergreen.

Director Deiter made a motion, seconded by Mr. Baughman, to table any further consideration regarding the use of surety bonds as a means to fund collateral within the required trust funds that secure the solvency of insurers on the Quarterly Listing of Alien Insurers. The motion passed unanimously.
3. Received an Update from the Model #870 Drafting Group

Mr. Travis said that the drafting group for the Nonadmitted Insurance Model Act (#870) consisted of various participants from Colorado, Illinois, Louisiana, Texas, and Washington. He indicated that since the Summer National Meeting, the drafting group met three times: Nov. 4, Oct. 20, and Sept. 28. He stated that the drafting group discussed specific sections of the Model #870 while working through a revision-marked version. He said that once the drafting group has made it through its initial review of the model, it will integrate comments received and reconvene in open session to cover the revised draft. He concluded by indicating that the drafting group anticipates presenting a draft of the model to the Task Force during the first quarter of 2022.

4. Heard an Update on Surplus Lines Industry Results

Andy Daleo said that at year-end 2020, the Quarterly Listing of Alien Insurers consisted of 87 Lloyd’s syndicates and 75 non-U.S. companies for a total of 162 entities, an increase of four entities over the prior year. He stated that in comparison, U.S. domestic surplus lines insurers totaled 297. He indicated that during 2020, non-U.S. based entities (syndicates and companies) collectively wrote $18.6 billion in direct U.S. surplus lines premiums, a 10.3% increase over the prior year. In comparison, domestic insurers wrote $47.5 billion in surplus lines premiums in 2020, a 17.9% increase from the prior year. Mr. Daleo stated that in 2020, non-U.S. insurer surplus lines premiums accounted for 28.1% of total U.S. surplus lines exposure, slightly lower than 29.5% in 2019 and 30.6% in 2018. He summarized that as of Dec. 31, 2020, the non-U.S. entities recorded an aggregate $21.1 billion in gross loss, loss adjustment expenses (LAEs), and incurred but not recorded (IBBR) reserves. He stated that as of June 30, 2021, the gross reserves were partially secured by nearly $5.2 billion in individual U.S. trust fund assets.

Mr. Daleo indicated that the U.S. nonadmitted market wrote $731 million in cyber direct premiums. In comparison, non-U.S. surplus lines insurers wrote $1.3 billion in cyber direct premiums written; 86% was written within the Lloyd’s market, with the majority written as stand-alone coverage opposed to within a package policy. He stated that there were approximately 600,000 nonadmitted U.S. and non-U.S. cyber policies in force, and 24,697 nonadmitted U.S. and non-U.S. claims were reported during 2020 with total direct loss payments of approximately $804 million.

Mr. Daleo said that 2020 was the first full year of private flood data collected. He indicated that the U.S. nonadmitted market wrote roughly $247 million in private flood direct premiums written. In comparison, non-U.S. surplus lines insurers wrote $847 million in private flood direct premiums written; 73% was written within the Lloyd’s market. He concluded that there were approximately 346,000 nonadmitted U.S. and non-U.S. private flood policies in force, with 6,474 claims reported during 2020 with total direct loss payments of approximately $143 million.

Having no further business, the Surplus Lines (C) Task Force adjourned.
The Surplus Lines (C) Working Group of the Surplus Lines (C) Task Force conducted an e-vote that concluded Oct. 21, 2021. The following Working Group members participated: Eli Snowbarger, Vice Chair (OK); David Phifer (AK); Michelle Lo (CA); Rolf Kaumann (CO); James A. McCarthy (MA); William Leach (NJ); Amy Garcia (TX); and Steve Drutz (WA).

1. **Adopted the NAIC Standard Form – Trust Agreement for Alien Excess or Surplus Lines Insurers**

The Working Group conducted an e-vote to consider adoption of the modifications to the NAIC Standard Form – Trust Agreement for Alien Excess or Surplus Lines Insurers (Attachment One-A). The motion passed with a majority of the members in favor of adoption.

Having no further business, the Surplus Lines (C) Working Group adjourned.
This Agreement, dated ________________, effective as of _________________ between ________________, organized and existing under the ___________________, its country of domicile and having its head office at ___________________________ (“Company”), and ________________, a (banking corporation/national banking association) organized and existing under the laws of _______________________ (“Trustee”); having its principal offices at ___________________________.

WITNESSETH:

WHEREAS the Company is engaged in the insurance business in its country of domicile and has or will have Policyholders in the United States (U.S.) of America as a result of writing insurance on an excess or surplus lines basis on risks therein; and

WHEREAS the Company desires to establish a trust fund in the United States U.S. as security for said Policyholders and Third-Party Claimants and to qualify as an eligible or approved excess or surplus lines insurer therein; and

WHEREAS, the Trustee is willing to act as Trustee of such trust fund; and

WHEREAS, the Trustee agrees to administer such trust fund principally from its office in the City of _____________________________ and the State of ________________.

NOW, THEREFORE, the Company has transferred to the Trustee cash in U.S. currency, Letters of Credit, Readily Marketable Securities, or any combination thereof, valued at a total of not less than the Trust Fund Minimum Amount as defined in Paragraph 2.7 of this Agreement on the date hereof, receipt of which the Trustee hereby acknowledges and agrees to hold in trust for the uses and on the conditions hereinafter set forth:

ARTICLE 1
DEFINITIONS

The following terms used herein shall, unless the context otherwise requires, have the following meanings:

1.1 “AMERICAN United StatesUNITED STATES U.S. POLICY” means any contract or policy of insurance issued or any agreement to insure made by the Company pursuant to the excess or surplus lines laws of any state, district, territory, commonwealth or possession of the United States U.S., in which the Company is not licensed to do an insurance business, provided that such Policies shall not include reinsurance or life insurance.

1.2 “CLAIM” means either or both of the following:

(a) a claim against the Company by a Policyholder, as defined in paragraph 1.9, or Third-Party Claimant for a loss under an American United States U.S. Policy excluding punitive or exemplary damages
awarded to or against a Policyholder and also excluding any extracontractual obligations not expressly covered by the American United States U.S. Policy ("Loss") or;

(b) a claim against the Company by a Policyholder for the return of unearned premium ("Unearned Premium") under an American United States U.S. Policy.

1.3 "DOMICILIARY COMMISSIONER" shall mean the Chief Regulatory Officer for Insurance in any state, territory, district, commonwealth or possession of the United States U.S. in which the Trust Fund is principally administered as identified on page one of this Agreement.

1.4 "EFFECTIVE DATE" shall mean the date as of which this Agreement is effective as specified on page one of this Agreement.

1.5 "IID" shall mean the International Insurers Department of the National Association of Insurance Commissioners ("NAIC").

1.6 "LETTER OF CREDIT" means a clean, unconditional, irrevocable Letter of Credit issued or confirmed by a Qualified United States U.S. Financial Institution.

1.7 "MATURED CLAIM" means a Claim which is enforceable against the Trust Fund as provided for in Paragraph 2.3 of this Agreement.

1.8 "NON-DOMICILIARY COMMISSIONER" shall mean the Chief Regulatory Officer for Insurance other than the Domiciliary Commissioner in any state, territory, district, commonwealth or possession of the United States U.S. in which the Company has Policyholders and who has provided the Trustee with written notice that he or she requires any notification required to be made to the Domiciliary Commissioner pursuant to this agreement.

1.9 "POLICYHOLDER" for the purposes of this Agreement, shall mean the holder of an American United States U.S. Policy that is a resident of or doing business in the United States U.S., and any other persons or associations who are assignees, pledgees, or mortgagees named therein.

1.10 "QUALIFIED UNITED STATES U.S. FINANCIAL INSTITUTION" means an institution that:

(a) Is organized and licensed or (or in the case of a U.S. branch office of a foreign banking organization, licensed) licensed under the laws of the United States U.S. or any state thereof; and,

— (b) — A national bank, state bank, or trust company which is adequately capitalized and qualified to accept securities as determined by the standards adopted by the U.S. banking regulators and regulated by state banking laws or a member of the Federal Reserve system; and

Is regulated, supervised and examined by U.S. federal or state authorities having regulatory authority over banks and trust companies; and

— (c) — Has been determined by the Securities Valuation Office of the NAIC as an acceptable financial institution; and

— (d) — Has been granted authority to operate with trust powers, if such qualified United States U.S. financial institution is to act as the fiduciary of the trust.
1.11 “READILY MARKETABLE SECURITIES” means debt or equity securities for which a public market exists and that is readily marketable on a regulated United States U.S. national security exchange, or principal regional security exchanges or those determined by the Securities Valuation Office of the NAIC to warrant an NAIC designation of 1 or 2.

1.12 “RECEIVER” shall mean for purposes of this Agreement, the Domiciliary Commissioner or such other person as may be appointed by a court of competent jurisdiction or designated by the statute of a state, territory, district, commonwealth or possession of the United States U.S. having jurisdiction over the conservation, rehabilitation or liquidation of the insurer.

1.13 “THIRD PARTY CLAIMANT” is one not a party to the insurance contract but having a final judgment against the Company for claims arising from an American United States U.S. Policy.

1.14 “TO TRANSMIT” or “TRANSMITTED” shall mean to send by telex, teletype, facsimile, modem or other similar means of electronic communication.

1.15 “TRUST FUND” or “TRUST” means the cash, readily marketable securities and letters of credit, or any combination thereof, in the actual and sole possession of the Trustee and held under the provisions of this Agreement.

1.16 “U.S. REPRESENTATIVE” shall mean the individual or firm designated by the Company or its successor in interest to act on behalf of the company.

**ARTICLE 2**

**THE TRUST**

2.1 **Duration of Trust Fund.** The Trust Fund shall be irrevocable and remain in full force and effect for a period of at least five years and may be until terminated following notification of intent to terminate the trust by the Company to the Trustee, the passage of a 90-day period from the receipt of notification to the trustee, and only upon the occurrence execution of any any of the following events:

(a) The passage of five (5) years from the date of written notice to the Trustee of the termination of the Trust. The Trustee and the NAIC IID and all Non-Domiciliary Commissioners receive from the Domiciliary Commissioner or from the Company written confirmation that the Domiciliary Commissioner has determined that all claims attributable to the period while the Company was eligible and listed on the NAIC Quarterly Listing of Alien Insurers have been satisfied and that no outstanding liabilities remain with respect to United States U.S. insurance policies in accordance with 2.14(a) of this Agreement. Insurers with exposure to “occurrence” policies are not eligible for this option.

(b) The expiration of a sixty (60) 90 days period after the Company has sent written notice to the Trustee and the NAIC IID by certified mail return receipt requested that it: (i) has become qualified and licensed insurer or eligible surplus lines insurer to conduct an insurance business in all States where it has direct insurance in force; or

   (cii) has entered into an assumption and assignment agreement transferring all liability with respect to all risks covered by this Trust Fund to an insurer licensed to do an insurance business in such states or an insurer listed by the IID assumption reinsurance agreement between the Company and an
accredited, certified, or reciprocal reinsurer(s), or an assumption reinsurance or assignment agreement between the Company and a U.S. authorized insurer(s) or accredited reinsurer eligible surplus lines insurer(s), or an insurer(s) currently approved on the Quarterly Listing of Alien Insurers, pursuant to which the claimant has a direct claim against the authorized or eligible insurer(s) or accredited reinsurer(s), provided, however, that any such assuming insurer or reinsurer shall have capital and surplus in excess of the minimum capital and surplus required for inclusion on the Quarterly Listing of Alien Insurers or (2) an insurer currently approved on the Quarterly Listing of Alien Insurers. Such written notice submitted to the Trustee by the Company shall include a list of all states in which the Company has American U.S. Policies in force as certified by the Company or U.S. representative.

The Trustee shall notify the IID and the Insurance Commissioners of said States in writing of its receipt of a notice as provided for in Subparagraphs (a), (b), or (c) of this paragraph within thirty (30) days of receipt of such notice from the Company.

2.2 **Priority of Payments Out of Trust Fund.** The Trust Fund shall be exclusively available first for the payment of all expenditures and fees under Paragraph 3.7 of this Agreement including legal fees and expenses actually incurred by or on behalf of the Trustee in connection with its administration, preservation or conservation of the Trust ("Trustee Priority Claims"); provided, however, that this amount shall not exceed $250,000 or 10% of the value of the Trust, whichever is less. Any amount in excess of the amount necessary to satisfy Trustee Priority Claims shall be available for the payment of Matured Claims, provided, however, that Losses shall always take priority over Unearned Premium in the payment of Claims so that the Trustee shall pay all Matured Claims for Losses in full prior to payment of any part of a Matured Claim for Unearned Premium. The Trustee shall pay a Matured Claim for Unearned Premium after receipt of a Claim for Losses which has not yet become a Matured Claim for any reason.

2.3 **When Claims Become Enforceable Against the Trust.** Subject to the payment of Trustee Priority Claims and to the priority of Losses over Unearned Premium, a Claim against the Company shall be enforceable against the Trust Fund when all of the following five conditions have been satisfied:

(a) The Policyholder or Third Party Claimant has obtained a judgment against the Company in any court of competent jurisdiction within the United States of America or has obtained a binding arbitration award in respect of the Company’s liability under an American U.S. Policy;

(b) Such judgment has become final in the sense that the particular litigation has been concluded, either through failure to appeal within the time permitted therefor or through final disposition of any appeal or appeals that may be taken, the word “appeal” being used herein to include any similar procedure for review permitted by applicable law;

(c) The service upon the Trustee of a certified copy of said judgment, together with such proof as to its finality as the Trustee may reasonably request;

(d) Certified written statements from the Policyholder, Third Party Claimant or their legal counsel stating, without qualification other than with respect to the passage of the time period described in Paragraph 2.3(e) hereof, that the Claim does not include exemplary or punitive damages, what part of the Claim, if any, is for Unearned Premium and that the Policyholder or Third Party Claimant has complied with all of the provisions set forth in Subparagraphs (a), (b), (c) and (d) of this paragraph; and
(e) The expiration of a period of thirty (30) days from the date of the service upon the Trustee of said certified copy of said judgment and all of said proofs without such judgment having been satisfied; provided, however, that in the event that the termination date of the Trust is less than thirty (30) days following such date of service, the expiration of the period of time equal to the amount of time left before the day before the termination date of the Trust.

A Claim which has satisfied each of the above five conditions shall be deemed to be a Matured Claim. The Trustee shall determine that the above conditions have been met on the basis of the evidence specified above and shall be held harmless in relying upon such evidence in its determination. Such determination shall be conclusive and binding upon all parties. Any Matured Claim shall, subject to Article 4, be paid by the Trustee by check mailed to the address of the Policyholder or Third Party Claimant solely out of the Trust Fund then in its actual and sole possession, without regard to the rights of any other Policyholder, unless the judgment shall be with respect to a Matured Claim for return of Unearned Premium in which case payment by the Trustee shall be made in accordance with the priorities stated above in Paragraph 2.2. The Trustee shall promptly notify the Company in writing of the receipt of a Claim which has been determined by the Trustee to meet conditions (a) through (d) of this paragraph and of the amount thereof. If a Matured Claim would, if paid, reduce the Trust Fund below the Trust Fund Minimum Amount as defined in Paragraph 2.7, or, if the Trustee has received notice that the Company is declared or deemed insolvent as set forth in Paragraph 4.1, then Article 4 shall govern the distribution of the Trust Fund. A Matured Claim which, if paid, would reduce the amount of the Trust Fund below the Trust Fund Minimum Amount shall only be paid in accordance with the provisions of Article 4 of this Agreement. The Trustee shall notify the IID, the Domiciliary Commissioner and the Non-Domiciliary Commissioner within ten (10) days of the Trustee’s receipt of any Matured Claim that would reduce the Trust Fund below the Trust Fund Minimum Amount as set forth in Paragraph 2.7. In determining whether payment of a Matured Claim would reduce the amount of the Trust Fund below the Trust Fund Minimum Amount, the Trustee shall rely upon the value of the Trust Fund as established at its most recent valuation as provided for in Paragraph 2.13 of this Agreement.

2.4 Limitations of Policyholder’s Source of Recovery. No Policyholder or Third Party Claimant shall have any right of any nature or description under this Agreement to seek to enforce a Claim or otherwise bring an action against the Trustee in respect of any assets of the Trustee or of any assets other than those in the Trust Fund. No Policyholder or Third Party Claimant, even after its Claim has become a Matured Claim, may require an accounting from the Trustee or inquire into the administration of the Trust, question any of the Trustee’s acts or omissions or otherwise enforce this Agreement, the sole right of such Policyholder or Third Party Claimant under this Agreement being to receive the amount of its Claim after it has become a Matured Claim from the assets then in the Trust Fund and available for such payment under this Agreement.

2.5 Sale of Trust Assets. Unless otherwise directed in writing by the Company, the Trustee shall retain the specific assets of the Trust Fund. Subject to the terms of this Agreement, at the time a Matured Claim becomes payable by the Trustee from the Trust Fund, payment shall be effected in accordance with the Company’s written instructions or, if no such instructions are received by the Trustee at least ten (10) days prior to the expiration of the time period set forth in Paragraph 2.3(e), then as follows: (i) first from any cash in the Trust Fund; (ii) then, from the proceeds of the sale by the Trustee of any or all of the Readily Marketable Securities or other investments (other than Letters of Credit) in the Trust Fund; (iii) then, any other assets or other property in the Trust Fund (other than the Letters of Credit); (iv) then, from drawings against any Letters of Credit. Subject only to the provisions set forth in the previous sentence, the Trustee in its sole discretion, may sell all or part of the Trust Fund, in any order it elects, needed to effect timely payment of any Matured Claims. The Trustee shall not be liable, except as provided by paragraph 3.11,
for any loss incurred in the sale of assets or for its selection of the assets to be sold, and shall only be
obligated to sell such assets at the market price then available to the Trustee.

2.6 Management of Trust Fund.
The responsibility for making investments of the Trust Fund shall, for the duration of the trust, repose
with the Company and unless and until otherwise directed by the Company in writing, the Trustee shall
not be required to take any action in regard to investments and property held in the Trust other than to
collect the interest and dividends or other sums payable thereon. Unless otherwise requested in writing by
the Company, and subject only to the provisions of Paragraph 2.5, the Trustee shall retain any and all
assets of the Trust held by it from time to time hereunder, notwithstanding that the same may not be
recognized as legal investments for trust funds under the laws of the state where the Trust Fund is
administered or other applicable law.

The Trustee shall deposit the assets of the Trust Fund, except to the extent the Trust Fund consists of
Letters of Credit, or any part thereof, in one or more such banks (which may include the Trustee) or trust
companies in the United States U.S. of America, or invest and reinvest the Trust Fund, except to the extent
the Trust Fund consists of Letters of Credit, or any part thereof, in any such stocks, bonds and securities
as the Company shall direct in writing, notwithstanding that such investments may not be recognized by
the laws of the state where the Trust Fund is administered or other applicable law as legal investments for
trust funds.

The Domiciliary Commissioner and the Chief Regulatory Officer for Insurance in any other state,
territory, district, commonwealth or possession of the United States U.S. where the Company is eligible
for excess or surplus lines shall have the right to review the assets in the trust to determine whether such
assets are acceptable.

Nothing herein contained is intended to relieve the Company from furnishing investments in the Trust
Fund of the quality required by the Surplus Lines or Excess Lines Laws of all states where the Trust Fund
is required as a condition of the Company’s eligibility. Each investment instruction from the Company
shall be a representation by the Company that the investments specified therein meet such conditions and
the conditions imposed by the definitions set forth in this Agreement. The Trustee shall also make or
change any deposits and sell and dispose of any negotiable assets of the Trust, other than Letters of Credit,
by and with the direction in writing of the Company. The Trustee shall be under no duty to give any
investment advice to any person in connection with the Trust Fund but shall always, provided the Trustee
itself shall have received actual notice thereof, notify the Company as to any rights to conversion,
subscription, voting or other rights pertaining to any investments held in the Trust Fund and of any default
in the payment of principal or interest. The Company shall have the full, unqualified right to vote and
execute consents and to exercise any and all proprietary rights, not inconsistent with this Trust Agreement,
with respect to any of the property forming a part of the Trust Fund. All interest, dividends and other
income resulting from the investment of the property in the Trust Fund (subject to the Company’s
obligation to maintain the Trust Fund Minimum Amount and to the Trustee’s interests provided herein)
shall be the property of the Company. To the extent the Company shall be entitled to receive such income,
Trustee shall collect and pay it to the Company, upon the Company’s written instructions, not more
frequently than monthly, provided, however, that the Trustee shall have no obligation with respect to the
payment of income by the issuer of any security.

2.7 Trust Fund Minimum Amount and Quality. The Company, either directly or through its U.S.
representative, shall provide the Trustee with written notice of the minimum amount which the Company
is required by law to maintain in the Trust Fund (“Trust Fund Minimum Amount”). The Company may
amend the Trust Fund Minimum Amount from time to time by providing the Trustee with advance written notice thereof. In no event, however, may the Trust Fund Minimum Amount be less than the amount determined by the funding provisions contained within Section V. B(i) of the IID Plan of Operation or its successor provision. The maintenance of the trust fund minimum amount shall continue until it is terminated per the provisions of 2.1 (a), (b), or (c).

If the Company is transacting business in California, the Trust Fund Minimum Amount must consist of cash or readily marketable securities acceptable to the California Insurance Commissioner which are authorized pursuant to Sections 1170 to 1182, inclusive, of the California Insurance Code, and are listed on a regulated United States national or principal regional security exchange, or letters of credit acceptable to the California Insurance Commissioner and issued by a qualified United States financial institution.

If the Company is not transacting business in California, the Trust Fund Minimum Amount must consist of cash, readily marketable securities or letters of credit issued by a qualified United States financial institution.

Trust fund amounts in excess of the Trust Fund Minimum Amount shall consist of cash, securities, letters of credit or investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in the state where the trust is principally administered.

2.8 **Letters of Credit.** In the event that the assets of the Trust Fund consist in whole or in part of a Letter of Credit (which Letter of Credit may be issued by the Trustee or an affiliate in its commercial and not its trust capacity) and said Letter of Credit shall bear a termination date prior to any stated or noticed termination date of the Trust, shall be evergreen until the termination of the Trustee shall, in the absence of notice at least thirty (30) days in advance of any termination of the Letter of Credit that the Letter of Credit will be renewed or extended, draw down and convert such Letter of Credit to cash and hold the same as assets of the Trust Fund pursuant to the terms hereof.

2.9 **Contributions to the Trust Fund.** The Company may make further contributions to the Trust Fund from time to time which further contributions shall be subject to the terms and conditions hereof.

2.10 **Withdrawal of Excess Funds.** From time to time the Company may direct the Trustee in writing to pay over to the Company any funds in excess of the Trust Fund Minimum Amount set forth in Paragraph 2.7.

2.11 **Trustee’s Authority to Hold Investments.** Legal title to the assets of the trust shall be vested in the Trustee for the benefit of the Company’s American United States U.S. Policyholders and Third Party Claimants in accordance with the provisions of this Trust. Trustee may hold any investments or other assets thereunder in the name of a nominee. The term “hold” shall include Trustee’s authority to deposit any part or all of the aforesaid property, which consists of securities in registered or unregistered form, at a Federal Reserve Bank under federal book entry procedure, a depository trust company or other centralized securities depository system, whether now or hereafter organized (one or all herein called “CSDS”). All securities in registered form are to be registered in the name of a nominee of Trustee or CSDS.

2.12 **Assets of the Trust.** Trustee shall be under no duty or obligation to require the Company to make any transfers or payments of additional assets to the Trust and it shall be conclusively presumed that any and all such transfers or payments to Trustee have been properly made.
2.13 Trustee to Certify Trust Assets.
   (a) Whenever reasonably required by the Company, but not less often than annually and not more often than quarterly, Trustee shall prepare and submit to the Company a statement of the assets in the Trust and such other information as may be agreed upon between the Company and the Trustee.

   (b) Trustee shall promptly certify the existence of the trust fund and the assets and their market valuation on the effective date of this instrument and quarterly thereafter, to the IID and the Domiciliary Commissioner. Such notification shall be made within thirty (30) days after the effective date of the end of each calendar quarter.

In addition, Trustee shall certify the existence and most recent value of the Trust Fund whenever so directed by IID, the Company, its U.S. representative, the Domiciliary Commissioner or any Non-Domiciliary Commissioner. Whenever the Trustee in the performance of its duties thereunder shall be required to value the assets of the Trust Fund, it may employ an agent for such valuation and the Company shall reimburse Trustee for any costs or expenses of valuations performed either by the Trustee or such agent. In the absence of the filing in writing with the Trustee by the Company of exceptions to any such statement within sixty (60) days, approval of such statement shall be deemed to have been given; and in such case or upon written approval, the Trustee shall be released, relieved and discharged with respect to all matters set forth in such statement as though such account had been settled in a court of competent jurisdiction in a proceeding where all parties having a beneficial or regulatory interest in the Trust were parties.

2.14 Trustee’s Duties Upon Termination of Trust Fund.
   (a) In the event of termination in accordance with Paragraph 2.1 (a) through (c), the Company shall appoint either a qualified, certified public accountant or a qualified actuary with the consent of the Trustee, which consent shall not be unreasonably withheld, as auditor and an independent audit shall be made as of the date of such termination of the Trust Fund and the Company’s estimate of the outstanding liability, if any, of the Company for incurred and unpaid losses (both reported and unreported) and Unearned Premium on American United StatesU.S. Policies issued during the term of the Trust and up to and including the date of termination. The Company shall present to the Trustee such audit report together with a true and correct copy of the auditor’s practicing certificate or equivalent document issued by the authority governing the licensing or conduct of the auditor. If the auditor’s practicing certificate or equivalent document is unavailable, then the Trustee, upon the request of the Company, shall submit a request for the written approval of the auditor from the Domiciliary Commissioner. Approval of the auditor shall be deemed given if the Domiciliary Commissioner does not object to such auditor in writing to the Company and the trustee within 90 days from the date of delivery of such request. The auditor shall upon the completion of such audit, and from time to time thereafter, at the request of the Trustee, issue a report to the Trustee expressing an opinion on the amount of any such outstanding liability at the date of such termination or at such later date specified in such report. The Trustee shall be protected in acting or relying upon any report of said auditor and shall have the right to retain such assets in the Trust Fund as may be necessary, in the Trustee’s sole discretion, and the Trustee shall pay or cause to be paid therefrom the amount of any such Losses in the manner provided in Paragraph 2.3. Upon the termination of the Trust and the payment of any fees and expenses of the Trustee provided for thereunder due and owing, the Trustee shall transfer, pay over and deliver to the Company the income and principal of the Trust’s assets then in its actual and sole possession, or the balance thereof then remaining if Losses are to be paid according to the report of the auditor, and such payment, transfer and delivery shall constitute a full, final and sufficient release, discharge and acquittance to the Trustee in respect thereof.
b) No officer of the Trustee shall recognize the audit report of either a certified public accountant or a qualified actuary, nor accept any annual audited financial report if such officer has actual knowledge that such audit report was prepared in whole or in part by any natural person who: (i) has been convicted of fraud, bribery, a violation of the Racketeering, Influenced and Corrupt Organizations Act, 18 U.S.C. Sections 1961-1968, or any dishonest conduct or practices under federal or state law; (ii) has been found to have violated the insurance laws of any state with respect to any previous reports submitted in connection with the aftermath of a trust established for excess or surplus lines eligibility purposes; or (iii) has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed.

2.15 [Optional at the choice of the Company and Trustee] Company May Waive Conditions for Claims Payments. With respect to assets in excess of the Trust Fund Minimum Amount as defined in Paragraph 2.7, the Company may approve the Trustee’s payment of any Claim by waiving any or all of the conditions specified in Subparagraphs (a) through (e) of Paragraph 2.3 and directing the Trustee in writing to pay such approved Claim out of the Trust Fund whereupon the Trustee shall forthwith satisfy said Claim out of the Trust Fund without (i) regard to the rights of any other Policyholder and any obligations other than the observance of the priorities of Paragraph 2.2 and of the exceptions set forth in the last subparagraph of Paragraph 2.3; (ii) inquiring into or ascertaining the validity of such Claim or the propriety of such direction; or (iii) seeing to the application of such payment. Nothing herein, however, should be construed to permit the Company to order, or the Trustee to make, payment pursuant to this section if the Trustee is in receipt of a notice of insolvency as referenced in Paragraph 4.2 or if such payment would reduce the trust fund below the Trust Fund Minimum Amount set forth in paragraph 2.7.

ARTICLE 3
THE TRUSTEE

3.1 Trustee’s Qualification. Trustee shall always meet the requirements of Subparagraphs (a),(b), (c)and (d) of Paragraph 1.10.

3.2 Trustee’s Duties and Liability. Trustee’s duties and responsibilities shall be governed by applicable law and the terms of this Agreement.

The Trustee shall not be liable for any loss to the Trust Fund other than losses caused by its own negligence or willful misconduct. The Company agrees to indemnify and hold harmless the Trustee from and against any and all claims, damages, losses or other payments of any nature whatsoever arising out of the Trustee’s performance or nonperformance thereunder, unless such claims, losses, damages or other payments arise as a result of the Trustee’s own negligence or willful misconduct.

3.3 Trustee May Rely on Certain Writings. The Trustee shall be entitled to rely upon, be protected, held harmless and deemed to have exercised reasonable due care, if the Trustee relies upon any writing believed by it in good faith to be genuine and to have been signed (whether facsimile or otherwise) or coded or purported to be signed or coded and transmitted, sent or delivered by the proper parties.

3.4 What Constitutes Conclusive Proof for Trustee. If the Trustee deems it necessary or desirable that a matter be proven prior to taking or omitting any action thereunder, such matter, unless other evidence in respect thereof be herein specifically prescribed, may be deemed to be conclusively proven by a statement purported to be executed in the name of the Company or by any of its agents or U.S. representatives designated by it as such in writing to the Trustee and delivered to the Trustee for any such action or omission on its faith thereof; but the Trustee, in its discretion, may instead accept or require such other or
additional evidence on the matter as it may deem reasonable, provided that in the event the effect of the action would be to terminate the Trust, the Trustee may rely only on a statement or certification of officers or agents of the Company duly authorized for this purpose.

3.5 What Constitutes Proper Execution for Trustee. Except as otherwise expressly provided in this Agreement, any writing to be furnished by the Company shall be sufficiently executed if signed in the Company’s name by such of its officers or other agents or U.S. representative as it may designate in writing to the Trustee, which designation shall continue in effect until changed by subsequent written notice received by the Trustee. With respect to the authority conferred on it, the Trustee may rely on any writing of any such officers or agents.

3.6 Trustee’s Reliance on Opinions of its Counsel. The Trustee may consult with counsel selected by it and may rely on said counsel’s opinion as complete authority in respect of any action taken or omitted by the Trustee in good faith in accordance with said opinion and the Trustee shall be deemed to have exercised reasonable due care in reliance thereon.

3.7 Trustee’s Fees and Expenses. The fees of the Trustee for administering the Trust shall be mutually agreed upon from time to time between the Company and the Trustee.

The fees and all expenses of Trustee, including its counsel fees and expenses and other disbursements incurred in administering, preserving or conserving the Trust, shall be, and the Company hereby irrevocably grants to Trustee, a first priority security interest in and a lien no greater than the lesser of: (i) $250,000 of the Trust Fund Minimum Amount as defined in Paragraph 2.7 of this Agreement or, (ii) 10% of the value of the Trust if the value falls below the Trust Fund Minimum Amount specified in Paragraph 2.7. Nothing herein shall limit the right of the Trustee to assert a priority claim in any amount against amounts in excess of the Trust Fund Minimum Amount pursuant to Paragraph 4.5. All amounts to which the Trustee is entitled by reason of this paragraph shall be Trustee Priority Claims for purposes of Paragraph 2.2. Nothing in this Agreement shall be construed as requiring that the Trustee’s fees and expenses be satisfied solely from the corpus of the Trust Fund.

3.8 Maintenance and Inspection of Trustee’s Records. The Trustee shall keep complete records of the administration of the Trust which may be examined at any time, with reasonable advance notice, by the Domiciliary Commissioner or any Non-Domiciliary Commissioner. Any persons duly authorized by the Company in writing may examine during normal business hours upon ten (10) days written notice to the Trustee. The Company agrees to reimburse the Trustee for any reasonable expenses incurred by the Trustee as a result of any such examination.

3.9 Trustee’s Resignation or Removal; Appointment of Successor. Notwithstanding Paragraph 2.1 hereof, the Trustee may resign at any time by sending its notice of resignation by notifying certified mail return receipt requested, to the Company’s last known address and to the Domiciliary Commissioner, all Non-Domiciliary Commissioners, and the IID to take effect on the date specified in such notice, but not less than sixty (60) days after the date of such mailing or personal delivery thereof if not mailed, unless the Company shall accept shorter notice as adequate. Trustee or any Successor Trustee may be removed by the Company by sending written notice of such removal by certified mail return receipt requested, to such the Trustee’s last known address and to the domiciliary Commissioner, all non-domiciliary Commissioners, and the IID, to take effect on the date specified in such notice but not less than sixty (60) days after the date of such notification mailing or personal delivery thereof if not mailed, unless Trustee accepts shorter notice as adequate; provided that no such removal shall become effective without Trustee’s
consent until all sums due to it thereunder for its fees and expenses including legal fees and expenses have been paid to it.

The Trust Fund shall be retained by the Trustee who is resigning or who has been removed until payment of its fees and expenses as provided in Paragraph 3.7 and its Successor Trustee has accepted its appointment, at which time the Trustee shall transfer, pay and deliver to the Successor Trustee the assets comprising the Trust Fund as they may be then constituted. If a Successor Trustee has not accepted appointment and the Trustee wishes to be relieved of responsibility thereunder, the Trustee may tender the Trust Fund assets to the Domiciliary Commissioner and, if the Domiciliary Commissioner declines to accept responsibility for Trust Fund assets, the Trustee may deposit the Trust Fund with a court of proper jurisdiction and with regard to such action shall be responsible only for giving notice to the Domiciliary Commissioner, all Non-Domiciliary Commissioners, the IID, the Company and such Policyholders which have notified the Trustee in writing that they have an actual or potential claim against the assets of the Trust Fund. When Funds are accepted by the Domiciliary Commissioner or paid into court, the Trustee’s sole remaining responsibility shall be to render a final accounting of the Trust. Copies of the required notice or resignation or removal required by this Paragraph shall also be sent communicated by certified mail, return receipt requested, to the IID, the domiciliary Commissioner, and all Non-Domiciliary Commissioners.

3.10 Trustee’s Assets. No provision of this Agreement shall require the Trustee to expend or risk its own funds or to otherwise incur any financial liability in the performance of any of its duties thereunder or in the exercise of its rights including, but not limited to, prosecuting, defending or otherwise enforcing any claims by or against the Trust Fund unless and until it has been indemnified for any fees and expenses likely to be incurred thereby.

3.11 Trustee’s Liability. The Trustee shall not be liable for any of its actions or omissions thereunder (including any actions taken in accordance with Article 4), except for its own negligence or willful misconduct. If the Trust Fund is funded, in whole or in part, by a letter of credit issued by the Trustee or by an affiliate of the Trustee, the failure of the Trustee to draw against the letter of credit in circumstances where such draw would be required by this Agreement shall be deemed to be negligence and/or willful misconduct for purposes of this paragraph.

ARTICLE 4
INSOLVENCY

4.1 Insolvency of Trust Fund. The Trust Fund shall be deemed insolvent upon the happening of the earlier of the following events:

(a) The Trustee actually receives written notice from the Company, the Company’s U.S. representative, the insurance regulatory authority in the Company’s jurisdiction of domicile, the domiciliary Commissioner, any Non-Domiciliary Commissioner or the IID, that the Company has been declared insolvent in its country of domicile; or

(b) The expiration of sixty (60) days after the value of the Trust Fund as shown by the most recent valuation of the Trust Fund as provided for in Paragraph 2.13 of this Agreement (i) was reduced below the Trust Fund Minimum Amount as specified in accordance with Paragraph 2.7 or (ii) would be so reduced by the payment of a Matured Claim, whichever of the events described in (i) and (ii) occurs first. If said minimum has been replenished within said sixty (60) day period by or on behalf of the Company to offset any such reduction, notice thereof shall be given by the Trustee to the IID as provided
below, and the insolvency shall be deemed cured. Promptly after such actual or anticipated reduction of the value of the Trust Fund, the Trustee shall send notice to the Company of the actual or anticipated reduction and a copy of such notice by certified mail return receipt requested, to the Domiciliary Commissioner, all Non-Domiciliary Commissioners, and the IID.

4.2 Notice of Insolvency.

(a) If declared insolvent in its country of domicile, the Company shall promptly (i) transmit send a written notice of this event and (ii) send a certified copy of such declaration by certified mail return receipt requested to the Company’s U.S. representative, the trustee, the domiciliary commissioner, all non-Domiciliary Commissioners and the IID.

(b) If the Trust Fund is deemed insolvent as defined in Paragraph 4.1, the Trustee shall promptly transmit send a written notice of this event by certified mail return receipt requested to the Company, its U.S. representative, the Domiciliary Commissioner, all Non-Domiciliary Commissioners and the IID.

4.3 Transfer of Trust Assets to Domiciliary Commissioner in Event of Insolvency. In the event that the Trust becomes insolvent as specified in Paragraph 4.1 and notwithstanding the provisions of this Article 4 or of any other provision in this Agreement, the Trustee shall comply with an order of the Domiciliary Commissioner or a U.S. court of competent jurisdiction directing the Trustee to transfer to the Domiciliary Commissioner or other designated Receiver all of the assets of the Trust Fund except those assets which are necessary to satisfy the Trustee’s Priority Claims as determined in Articles 2.2 and 3.7. The Domiciliary Commissioner or other designated Receiver shall distribute assets transferred from the Trust in compliance with applicable state law.

Compliance with such an order shall relieve the Trustee of all further duties, obligations and liabilities of any kind or description under this Agreement. Nothing in this paragraph shall be construed as relieving the Trustee of any liability under this Agreement for any acts or omissions which occurred prior to the date on which the Trustee transfers the assets of the Trust Fund to the domiciliary Commissioner.

4.4 One Year Waiting Period After Insolvency. Except in cases where Trust assets have been transferred to the Domiciliary Commissioner as provided for in paragraph 4.3 and unless otherwise ordered by a court of competent jurisdiction, no Claims, other than the Trustee’s Priority Claims, shall be paid out of the Trust Fund during the 12 month period (“Waiting Period”) commencing on the date the Trustee receives written notice that the Company was declared insolvent in its country of domicile as set forth in Paragraph 4.1(a) or the date the Trustee is required to transmit send a notice to the Company pursuant to Paragraph 4.1(b), unless the insolvency has been cured within the sixty (60) day period as provided for in Paragraph 4.1(b), whichever occurs first.

Matured Claims, whether arising prior to or during the Waiting Period, may be filed throughout said period by certified mail return receipt requested.

4.5 Final Distribution of Trust Fund Assets By Trustee. As soon as practicable after the end of the Waiting Period specified in Paragraph 4.4, the Trustee shall distribute the balance of the Trust Fund in accordance with state law.

Trustee Priority Claims shall first be paid out of any amount in the Trust Fund in excess of the Trust Fund Minimum Amount. The Trust Fund Minimum Amount and any amount in excess of the Trust Fund
Minimum Amount not needed to satisfy Trustee Priority Claims shall then be distributed among the claimants with Matured Claims.

Such prorated distribution shall be in the ratio which the value of each such Matured Claim bears to such balance.

Any assets remaining in the Trust Fund after all matured claims have been paid in full shall be used to satisfy any outstanding and unpaid Trustee Priority Claims.

Any remaining assets shall be transferred by the Trustee to the Company or its successor in interest.

In performing its duties thereunder the Trustee may retain any person to act on its behalf or assist it as it deems necessary and shall pay the necessary and reasonable compensation and expense of such person thereunder out of the Trust Fund.

ARTICLE 5
MISCELLANEOUS

5.1 Governing Law. This agreement shall be governed by, and construed and enforced in accordance with, the laws of the United States jurisdiction in which the Trust Fund is principally administered as specified on page one of this Agreement.

5.2 Survival of Prior Obligations. Commencing on the Effective Date, this Agreement shall be binding upon the parties hereto and their successors and assigns and shall supersede such prior agreements, except for continuing obligations created by any prior agreements between the parties on the subject matter hereof as to matters arising prior to the Effective Date.

5.3 Procedure to Be Followed in Amending this Agreement.

(a) All amendments to this Agreement shall be in writing and signed by the Company and the Trustee. The Trustee shall have discretion either to give or withhold its consent thereunder and its decision to give or withhold its consent shall be binding and conclusive upon all persons and parties, and in no event shall it incur any liability for any decision made by it thereunder in good faith.

(b) Notwithstanding the provisions of Paragraph (a) of this section, no amendment shall become effective without the IID’s prior written consent.

(c) The company shall give written notice of any proposed amendment to all Domiciliary and Non-Domiciliary Commissioners together with a copy of the proposed amendment. If no Non-Domiciliary Commissioner disapproves the proposed amendment within thirty (30) days of receipt of the notice, the amendment shall be effective on the date specified by the Domiciliary Commissioner.

5.4 Notice. The Company shall provide the Trustee with the names and mailing addresses of the manager of the IID, the Domiciliary Commissioner, all Non-Domiciliary Commissioners and the Company’s U.S. representative, and shall update this list from time to time as may be necessary to keep the information in the list current. In providing the Notices required under any provision of this Agreement, Trustee may rely upon this list and in doing so shall be protected, held harmless and deemed to have exercised all reasonable due care.
5.5 **Partial Invalidity Does Not Invalidate Entire Agreement.** If any provision of this Agreement is held invalid or unenforceable, the balance of this Agreement shall be construed and enforced as if such provision had not been inserted herein.

5.6 **Interpretation.** The use herein of one gender shall be deemed to include the other and the singular the plural, as the context may require.

5.7 **Headings and References.** The headings herein are for reference only and not for defining any provisions hereof. Reference to this Agreement shall include its amendments, if any. All articles, paragraphs and subparagraphs as well as their subdivisions and abbreviations cited herein refer to this Agreement and its amendments, if any.

5.8 **Counterparts.** This Agreement may be executed in any number of counterparts, each of which when signed by the Company and the Trustee, shall be deemed to be an original.

IN WITNESS WHEREOF, the Company and the Trustee have caused this Agreement to be duly executed and their corporate seals affixed hereto.

Executed at __________________________________________________

[Seal] ___________________________ on ___________________________

Attest: ___________________________ By ___________________________

[Name and Title]  [Name and Title]

Executed at __________________________________________________

[Seal] ___________________________ on ___________________________

Attest: ___________________________ By ___________________________

[Name and Title]  [Name and Title]

[Notarizations]
The Surplus Lines (C) Working Group of the Surplus Lines (C) Task Force met Sept. 22, 2021. The following Working Group members participated: Stewart Guerin, Chair (LA); Eli Snowbarger, Vice Chair (OK); David Phifer (AK); Michelle Lo (CA); Rolf Kaumann (CO); Robert Ballard (FL); Scott Sanders (GA); Marcy Savage (IL); James A. McCarthy (MA); Jose Joseph and Joana Lucashuk (NY); Amy Garcia (TX); and Steve Drutz (WA).

1. **Heard Comments on the Modifications to the Trust Agreement**

Mr. Guerin referenced call materials that included a re-draft of the NAIC Standard Form – Trust Agreement for Alien Excess or Surplus Lines Insurers (Trust Agreement) and several comment letters. He introduced the comment letter contributors, who were asked to summarize their comments.

Ms. Lo indicated that she has no objections to removing the California provision in Section 2.7 of the Trust Agreement since the removal would not affect the department’s authority established in its statutes. Mr. Guerin commented that the re-draft of the Trust Agreement reflects that deletion.

Ms. Lucashuk summarized several minor technical edits to the Trust Agreement that clarify and improve the consistency throughout the document. Mr. Guerin agreed with the edits proposed by Ms. Lucashuk and indicated that these edits were not yet reflected in the re-drafted Trust Agreement. He indicated that these edits would be reflected in the Trust Agreement when re-exposed.

Andrea T. Best (McDermott Will & Emery LLP—MWE) indicated that MWE is generally in favor of the proposal to eliminate the current five-year notice period for termination of the trust. She summarized several recommendations for the new language proposed to Section 2.1 of the Trust Agreement. First, she suggested clarifying the role of the Domiciliary Commissioner by removing the language that indicates the Domiciliary Commissioner determines outstanding U.S. liabilities, as it conflicts with the requirement in Section 2.14 that requires a qualified actuary or accountant to prepare an independent audit of any outstanding liabilities. Second, regarding the termination of a trust by the transfer of liabilities, she proposed expanding the list of transferees to include accredited reinsurers and U.S. surplus lines insurers. Lastly, she suggested that the occurrence policy language be eliminated, given that an independent auditor is required to confirm that there are no U.S. liabilities before a trust is terminated. Mr. Guerin indicated that all of Ms. Best’s comments have been incorporated in the re-draft of the Trust Agreement.

Mr. Kaumann made a motion, seconded by Ms. Lo, to incorporate all the comments (Attachment Two-A), including Ms. Lucashuk’s edits into the re-draft of the Trust Agreement, and solicit comments during an exposure period of 14 calendar days. The motion passed unanimously.

2. **Adopted Revisions to the Quarterly Listing of Alien Insurers**

Mr. Guerin summarized one comment received from Ms. Best regarding the Quarterly Listing of Alien Insurers to maintain a listing of trust banks and contacts. He commented that NAIC staff already maintain this listing for reference. Following no additional discussion, the chair requested a motion to adopt the Quarterly Listing of Alien Insurers as presented.

Mr. Phifer made a motion, seconded by Mr. Joseph, to adopt the revisions to the Quarterly Listing of Alien Insurers (Attachment Two-B). The motion passed unanimously.

3. **Discussed Other Matters**

Clark Fitz-Hugh (International Sureties) requested that the Working Group consider the potential use of surety bonds to fund the trust securing the writings of alien insurers on the Quarterly Listing of Alien Insurers. He summarized various reasons to support the inclusion of surety bonds, such as being rated by the same rating companies as banks and regulated by state insurance departments. He also indicated that surety bonds are designed to serve the same purpose as a letter of credit, and the wording of surety bonds and letter of credits match exactly. He further indicated that surety bonds were created to be an
alternative to banks, because they make the credit process easier and less onerous for applicants. He emphasized that surety bonds are used throughout the U.S. and guarantee various transactions from one party to another, such as payments of judgements, payment of construction loan defaults, and workers’ compensation claims. He suggested that the utilization of surety bonds as trust funding devices could be permitted on a limited use basis, perhaps to secure those insurers that require only a minimum trust fund balance.

Thomas M. Dawson (MWE) commented that he endorses the use of surety bonds on behalf of several of his clients. He also indicated that if the Working Group were to proceed with allowing surety bonds as a device to fund the trust, the Trust Agreement would need to be updated to accommodate the surety bond option.

Mr. Guerin suggested that the use of surety bonds as a trust funding device would be more appropriate for the Surplus Lines (C) Task Force, given it is a policy issue. Therefore, he proposed that he present this issue in his summary report to the Task Force during the next meeting.

Having no further business, the Surplus Lines (C) Working Group adjourned.
Hi Bree,

At the Working Group’s July 7th conference call, Thomas Dawson from McDermott Will & Emery raised an issue over the California Requirement paragraph within Section 2.7 of the NAIC Trust Agreement Form. That paragraph mandates the trust fund’s composition for insurers transacting (nonadmitted) business in California. Thomas indicated that the NRRA preempts the California Requirement; and the mandated composition of the trust fund should only apply to insurers who wish to be on the California’s LASLI list.

While waiting to see how he could establish the NRRA preemption case, we want to inform you that we wouldn’t have any issue removing the California Requirement paragraph from the NAIC Trust Agreement Form since the removal wouldn’t affect the authority we have in our statutes. California can continue to enforce the trust fund requirements at the initial LASLI application review stage and during the subsequent renewal periods.

Thank you for your consideration.

Regards,
Michelle

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Bree Wilson  
National Association of Insurance Commissioners  
International Insurers Department  
1100 Walnut Street, Suite 1500  
Kansas City, Missouri 64106-2197  

6 August 2021  

Dear Ms. Wilson,  

We are writing with respect to the NAIC International Insurers Department’s (“IID”) proposed draft changes to the Standard Form Trust Agreement for Alien Excess or Surplus Lines Insurers (“SFTA”), and the proposed changes to the Quarterly Listing of Alien Insurers. As you know, we are privileged to represent twenty-five (25) insurers that currently appear on the Quarterly Listing. We are not writing on behalf of any particular client, and the views expressed below are our own. Further to our comments on the Surplus Lines Working Group call on July 7th, we are pleased to provide the following written comments on the proposed drafts.  

Surplus Lines Trust Agreement  

1. Trust termination  

We are in favour of the NAIC’s proposal to eliminate the current 5-year notice period for termination of the trust and the substitution of a 90-day notice period instead. Most of our comments on the SFTA concern the proposed new procedure for termination, specifically:  

a. Domiciliary regulator required to determine no outstanding U.S. liabilities  

Under Section 2.1 of the SFTA, it is proposed that the domiciliary regulator of the trust must determine that “all claims attributable to the period while the Company was eligible and listed on the NAIC Quarterly Listing of Alien Insurers have been satisfied and that no outstanding liabilities remain with respect to U.S. insurance policies.”  

It is not clear how this determination by the domiciliary regulator is intended to work with the requirement that currently appears in Section 2.14 of the SFTA, which requires a qualified actuary or accountant (acceptable to the trustee bank) to prepare an independent audit of any outstanding liabilities. Such audit opinion is currently submitted only to the trustee bank; the domiciliary commissioner of the trust typically has no involvement in termination of the trust other than to receive notice of termination. The proposed change of requiring the domiciliary commissioner to determine that no U.S. liabilities remain would mark a significant deviation from longstanding practice that has the potential to introduce considerable uncertainty and potential delay to the trust termination process.
To the best of our knowledge, the current process of requiring the insurer to obtain an independent audit opinion confirming no remaining surplus lines liabilities and submit the opinion to the trustee bank has worked smoothly over many years, and we are not aware of any claimants that have been disadvantaged by this process. Therefore our preference would be to retain the status quo and not introduce a requirement for the domiciliary regulator of the trust to determine that no U.S. liabilities remain.

b. Transferring liabilities to another insurer

We welcome the NAIC’s proposal to allow insurers to terminate the trust on 90 days’ notice not just by transferring liabilities to U.S. admitted insurers or other insurers on the Quarterly Listing, but also by transferring liabilities to an accredited reinsurer. This change would give insurers a wider variety of options to transfer their liabilities to other re/insurers that are subject to regulatory oversight and have assets in the U.S. for the benefit of U.S. policyholders.

We would suggest that the Working Group may also wish to consider allowing insurers to terminate their SFTA by transferring liabilities to U.S. surplus lines insurers. Currently, the SFTA only permits transfers to other alien surplus lines insurers on the Quarterly Listing, or to U.S. insurers that are admitted in all states. As you well know, U.S. surplus lines insurers are subject to regulatory oversight by their domestic state regulator and must submit the same statutory financial statements and are subject to the same minimum capital and solvency requirements as admitted insurers in their domiciliary state. It would seem to us that U.S. policyholders would be equally well protected if an insurer on the Quarterly Listing were to transfer its surplus lines liabilities to a U.S. surplus lines insurer, perhaps limited to those insurers that would meet the IID’s minimum capital and surplus standards.

c. Occurrence policies

It is proposed that the 90 days’ termination option described above would not be available to insurers that have written occurrence policies. Therefore, an insurer that wrote a single occurrence policy many years ago would be barred from terminating the trust forever, no matter how old the occurrence policy or how confident the company or a qualified actuary or auditor is that no policy liabilities remained.

If, under Section 2.14 an independent auditor must confirm that no U.S. liabilities remain before the trustee bank would be able to terminate the trust, then it would not appear to be necessary to bar all insurers that wrote occurrence policies from terminating their trusts. Therefore, we would be in favour of eliminating this proposed exception prohibiting termination of the trust for insurers that wrote occurrence policies.
d. Assumption reinsurance

Currently, insurers are permitted to terminate the trust by transferring liabilities to another licensed or NAIC-listed carrier via an “assumption and assignment agreement.” The draft SFTA would instead allow insurers to transfer liabilities via an “assumption reinsurance agreement.” As we noted on the July 7th Surplus Lines Working Group call, while this was a positive addition for those companies who wish to transfer liabilities by way of reinsurance, it would seem to eliminate the well-trodden path of terminating a trust by transferring liabilities to another NAIC-listed carrier using a mechanism such as a Part VII transfer under English law, which of course is not a reinsurance arrangement. We appreciate the NAIC agreeing with our comment on the call and we understand that the previous language permitting transfer of liabilities by way of an assumption and assignment agreement will be re-inserted, in addition to the new option of using assumption reinsurance.

2. Investments

Section 2.7 of the SFTA requires listed insurers “doing business” in California to abide by California’s rules with respect to permitted investments. This is a provision that has been in the SFTA since the early 1990’s. In our view such a state-specific provision (like any similar provision that would obligate compliance with state-specific investment rules) is now subject to challenge based on the provisions of the federal Nonadmitted and Reinsurance Reform Act (“NRRA”). The NRRA’s command that no state can deny surplus lines eligibility to an IID-listed insurer is undercut at the very least to the extent that any state’s local eligibility requirements, investment-related or otherwise, could be imposed on IID-listed carriers. We would suggest that this provision should be removed from the SFTA as it pertains to IID-listed insurers.

Should California or any other state wish to impose such investment requirements, or other financial/solvency-related requirements, upon insurers that choose to maintain or obtain a place on the state’s voluntary listing of surplus lines insurers (the LASLI for California), then states are free to do so through their own statutes, regulations, or application requirements for their voluntary lists. Indeed, California and New York have done just that by enacting statutes imposing higher minimum capital and surplus standards for surplus lines insurers appearing on their state lists.

Quarterly Listing

Finally, the NAIC has proposed to eliminate all financial information from the Quarterly Listing of Alien Insurers. Specifically, the trust fund minimum amount and balance, identity of the trustee bank, and the company’s total assets and surplus, will be deleted and only the country of domicile and US representative contact information will remain. We understand this is due to concerns that brokers and insureds might be using the information on the Quarterly Listing to choose one insurer over another, which of course has never been the intent of the list.
We note that the list of trustee banks and contact information for the banks has always been useful for new applicants for the Quarterly Listing, as well as insurers who might be looking to change their trustee bank. Not all banks are familiar with the SFTA and therefore it is helpful to know which ones have experience acting as trustees for other insurers. To that end, while we understand that the NAIC no longer wishes to publish this information, we would appreciate if the NAIC could privately maintain a list of the trustee banks and make it available upon request to new applicants or companies already on the IID List.

***

We are grateful to the NAIC and the Working Group for the opportunity to provide these comments. We would be pleased to discuss any of our comments at your convenience, and we thank you in advance for your kind consideration.

Yours sincerely,

Andrea T. Best

cc: Andy Daleo, NAIC
    Thomas M. Dawson, McDermott Will & Emery LLP
Proposed Friendly Amendment to 2.1, Updated November 3, 2021

2.1 Duration of Trust Fund. The Trust Fund shall be irrevocable and remain in full force and effect until terminated 90 days after notification by the Company to the Trustee and the IID of intent to terminate the trust, based upon any of the following grounds for termination:

(a) The Trustee and the NAIC IID have received written confirmation from the Company that all claims attributable to the period while the Company was eligible and listed on the NAIC Quarterly Listing of Alien Insurers have been satisfied and that no outstanding liabilities remain with respect to U.S. insurance policies, based on an independent audit conducted in the manner prescribed in 2.14(a) of this Agreement.

(b) The Company has become licensed to conduct insurance business in all States where it has direct insurance in force, or has redomesticated to a U.S. jurisdiction and is an eligible U.S. surplus lines insurer in all States where it has direct insurance in force and is not licensed; or

(c) An assumption reinsurance agreement has been executed by the Company and an accredited, certified, or reciprocal reinsurer(s), or an assumption reinsurance or assignment agreement has been executed by the Company and a U.S. authorized insurer(s) or eligible surplus lines insurer(s), or an insurer(s) currently approved on the Quarterly Listing of Alien Insurers, pursuant to which the claimant has a direct claim against the authorized or eligible insurer(s) or accredited reinsurer(s), provided, however, that any such assuming insurer or reinsurer shall have capital and surplus in excess of the minimum capital and surplus required for inclusion on the Quarterly Listing of Alien Insurers.
TITLE INSURANCE (C) TASK FORCE

Title Insurance (C) Task Force Nov. 16, 2021, Minutes .................................................................8-180
Title Insurance (C) Task Force Oct. 19, 2021, Minutes (Attachment One)........................................8-185
The Title Insurance (C) Task Force met Nov. 16, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Michelle Brugh Rafeld (OH); David Altmaier, Vice Chair, represented by Anoush Brangaccio (FL); Lori K. Wing-Heier represented by Katie Hegland (AK); Peni Itula Sapini Teo represented by Elizabeth Perri (AS); Karima M. Woods represented by Angela King (DC); Colin M. Hayashida represented by Martha Im (HI); Vicki Schmidt represented by James Norman (KS); James J. Donelon represented by Warren Byrd (LA); Grace Arnold represented by Paul Hanson (MN); Chlora Lindley-Myers represented by Marjorie Thompson (MO); Troy Downing represented by Sharon Richetti (MT); Mike Causey represented by Timothy Johnson (NC); Marlene Caride represented by Randall Currier (NJ); Russell Toal and Mark Marquez (NM); Barbara D. Richardson (NV); Jessica K. Altman represented by Michael McKenney (PA); Larry D. Deiter represented by Maggie Dell (SD); Scott A. White represented by Mike Beavers (VA); and Michael S. Pieciak represented by Kevin Gaffney (VT). Also participating was: Michael Walker (WA).

1. **Adopted its Oct. 19 Minutes**

The Task Force met Oct. 19 and took the following action: 1) adopted its Summer National Meeting minutes; 2) discussed its 2022 proposed charges; 3) heard a presentation on Demotech’s *Regional Title Underwriter Escrow Theft and Defalcation Prevention Measures Report*; and 4) heard a presentation on the American Land Title Association’s (ALTA’s) new forms of Commitment, Owner’s Policy, and Loan Policy, effective July 1.

Mr. Byrd made a motion, seconded by Mr. McKenney, to adopt the Task Force’s Oct. 19 minutes (Attachment One). The motion passed unanimously.

2. **Adopted its 2022 Proposed Charges**

Ms. Rafeld stated that the Task Force vetted recommendations for its 2022 proposed charges during its Oct. 19 meeting. State insurance regulators and interested parties were asked to submit additional comments and suggestions to NAIC staff by Nov. 1. No additional comments were received. The Task Force exposed a redlined version of the 2022 proposed charges with all suggestions taken into consideration on Nov. 5, with comments due by Nov. 12. No additional comments were received.

The revisions to the 2022 proposed charges are as follows:

The **Title Insurance (C) Task Force** will:

1. **Discuss and/or monitor issues and developments occurring impacting in** the title insurance industry, and provide support and expertise to other NAIC committees, task forces and/or working groups, or outside entities, as appropriate.

2. **Review and assist various regulatory bodies in combating fraudulent and/or unfair real estate settlement activities.** Such efforts could include working with the Antifraud (D) Task Force and other NAIC committees, task forces and/or working groups to combat mortgage fraud and mitigating title agent defalcations through the promotion of closing protection letters (CPLs) and other remedies. **Report results at each national meeting.**

3. **Consult with the Consumer Financial Protection Bureau (CFPB) and other agencies responsible for information; education; and disclosure for mortgage lending, closing and settlement services about the role of title insurance in the real estate transaction process.**

4. **Consider the effectiveness of changes in financial reporting by title insurance companies, and identify further improvements and clarifications to blanks, instructions, Statement of Statutory Accounting Principles (SSAPs), solvency tools, and other matters, as necessary.** Coordinate efforts with the Statutory Accounting Principles (E) Working Group.

5. **Revise the Title Insurance Consumer Shopping Tool Template to include questions and answers about title insurance related fraud topics, including but not limited to, CPLs and wire fraud.**

6. **Evaluate the effectiveness of CPLs including but not limited to, intent, to ensure compliance with state regulation and requirements, consumer protections offered and excluded, and potential alternatives for coverage.**

7. **Explore short-term and long-term issues and solutions from the pandemic.**
The last sentence of the second charge was struck, as the Task Force does not work with other regulatory bodies or committees at a frequency where it would need to report at each meeting held. The fourth charge was removed, as it is an outdated charge that has been completed, and the need for similar work can still be done under the first charge if need be. The fifth charge was removed, as the Title Insurance Consumer Shopping Tool was updated to include information about wire fraud and adopted by the Property and Casualty Insurance (C) Committee during the Summer National Meeting. The seventh charge was removed, as the Task Force has sufficiently covered the impact the pandemic has had on the title industry this year. The remainder of the modifications were made in an effort to clarify the intent of the charge.

Birny Birnbaum (Center for Economic Justice—CEJ) stated that he would like the Task Force to add the following to its 2022 proposed charges: 1) review the effectiveness of current rate regulation practices to protect title insurance consumers from excessive rates and charges and, if needed, recommend needed changes in regulatory practices to protect consumers from excessive title insurance rates and charges; and 2) develop a model bulletin prohibiting the inclusion of pre-dispute mandatory arbitration provisions in title insurance policies. The first suggested charge has to do with addressing the excessive profit of the title insurance industry over the last several years. The second suggested charge involves title insurers’ inclusion of pre-dispute mandatory arbitration provisions in their policies. This has been found to be an unfair practice, but the title industry seems to be including them. Mr. Birnbaum stated that ALTA’s presentation slides include its policies’ mandatory arbitration provisions provided for under Condition 14, Arbitration (described under agenda item 4).

Peter Kochenburger (University of Connecticut School of Law) stated that since the NAIC approved the model bulletin prohibiting the use of pre-dispute mandatory arbitration clauses, the evidence demonstrating that these provisions are anti-consumer has only grown. He provided the link to the bulletin in the chat (https://content.naic.org/sites/default/files/inline-files/legal_bulletin_arb_clauses_choice_of_law_provisions_personal_lines_ins_bulletin.pdf).

Mr. Byrd stated that Louisiana has a provision that prevents having a provision in any policy contract that would take away the ability of a party to seek readress in the court. As such, Louisiana would likely not approve such language in the title insurance contract if it were submitted. He stated that he is curious if other states have the same prohibition and whether that may give some viability to Mr. Birnbaum’s discussion.

Mr. Beavers stated that he would like more time to review Mr. Birnbaum’s suggested additions to the 2022 proposed charges before voting on them.

Aaron Brandenburg (NAIC) stated that he would recommend that the Task Force adopt the 2022 proposed charges without the additional two charges suggested by Mr. Birnbaum. Mr. Birnbaum could then provide these suggested revisions in a comment letter following the Task Force’s exposure of its 2022 proposed charges under the Property and Casualty Insurance (C) Committee. This would keep the Fall National Meeting timeline intact for progressing adopted charges for 2022 from the task force level to the parent committee level.

Ms. Rafeld stated that Mr. Brandenburg’s suggestion is preferable, given the approaching holiday. She instructed the NAIC to distribute Mr. Birnbaum’s proposed addition to the 2022 proposed charges to the Task Force for consideration before the Property and Casualty Insurance (C) Committee meeting.

Mr. Byrd made a motion, seconded by Ms. Richetti, to adopt the Task Force’s 2022 proposed charges (see NAIC Proceedings – Fall 2021, Property and Casualty Insurance (C) Committee, Attachment Six). The motion passed unanimously.

3. Heard a Presentation on How the Robust Housing Market Drove Historic Title Industry Performance

Ann Modica and Kourtnie Beckwith (AM Best) provided an overview of how current economic factors, housing market trends, monetary policy, real estate trends and issues, and insurtech startups impacted U.S. title insurers’ performance.

The Best’s Market Segment Report, “Robust Housing Market Drives Historic Title Performance,” found that the title industry’s net income rose by 18% to $1.5 billion in 2020. Net underwriting income has improved in each of the last four years, including a substantial 39.6% year-over-year (YOO) increase in 2020 to $1.7 billion, largely due to premium growth. Additionally, the combined ratio of 90.6 in 2020 represented the ninth consecutive year the ratio has been below 100. This title industry’s strong performance reflects how economic and market conditions have helped title insurers thrive despite the upheaval caused by the pandemic. AM Best revised its market segment outlook for the title insurance industry to stable from negative in early 2021 because of the resilience shown by the industry. Despite the ongoing COVID-19 challenges, the real estate market rebounded strongly in the third quarter of 2020 and continues to show strong growth. Historically low interest rates, shifting demographics, and consumer demand for homes remain the main drivers underpinning the strong housing market in 2021. Title insurers’
continued strong results through the first three quarters of 2021 reflect the support of the housing market by extraordinary U.S. monetary policy.

Residential and commercial property refinancing have driven the increase in title insurance premium over the last several years, including thus far in 2021. A severe lack of housing inventory, particularly for more affordable housing, has been a major factor in driving up prices. Title premiums are expected to continue to grow since title premiums are charged as a percentage of home price value, and high demand for new and existing homes is driving more transactions at higher value. The smaller portion of title premium driven by low new home inventory relative to demand and home price appreciation remain the two main obstacles that prospective new homeowners and home title insurance customers must navigate. Additionally, as the economy recovers and inflation potentially becomes more of a concern, the Federal Reserve is expected to raise central bank rates as early as 2022.

The onset of COVID-19 has prompted a shift toward digital real estate transactions to meet the social distancing needs of buyers, lenders, and sellers. To date, 38 states have enacted some form of permanent remote online notarization (RON) law. Benefits of RON include: 1) closings for vacation homes or second homes in different states are more convenient; 2) homebuyers will not be limited to lenders that are close in proximity, which could increase competition through deals with more favorable terms; 3) online closings are significantly less expensive for lenders, without the need to produce significant amounts of paper documents; and 4) online closings can be scheduled and held quicker than in-person closings.

A handful of startups have entered the title insurance industry, focused on making the process of buying a policy easier, cheaper, and more transparent. Because title insurance is so expense-driven, digital transformations focused on lowering company expense ratios by reducing personnel costs and the costs of title searches would be particularly valuable. With digital or e-mortgages that centralize the real estate transaction for all stakeholders involved, integrating technological advances to augment the title insurance process can be vital to the future of the industry. Artificial intelligence (AI) and smartphone apps can shorten the time needed to perform title searches. Apps that connect the customer with title underwriters directly not only streamline the application process for the customer, but also lighten the related expense load for the insurer.

Ms. Rafeld asked if AM Best had looked at what the title industry would look like in the near future or next year with the potential for the housing boom to slow down.

Ms. Beckwith stated that it is anticipated that the housing market will remain consistent through 2022 but start to return to pre-pandemic levels in 2023.

Mr. Byrd asked if costs that are paid by the seller outside of what loss costs the insurance pays would be captured in the expense ratio.

Ms. Beckwith stated that the expense ratio would not reflect mitigation done prior to the policy’s issue to ensure a clean title. Steve Gottheim (ALTA) stated that if it is something captured at closing, it will not be captured in the expense ratio.

4. Heard a Presentation on Changes to ALTA’s Homeowners Policy and Endorsements

Mr. Gottheim, Mary Payne Thomas (Stewart Title), and Dan Buchanan (First American Title) provided an overview of key changes to the homeowners policy of title insurance and ALTA endorsements. These changes include:

Owner’s Information Sheet, Table of Contents, and Owner’s Coverage Statement
- The Owner’s Information Sheet and Table of Contents have been removed. The policy now begins with the statement that the policy is valid if issued electronically. This includes instruction for submitting a claim.
- Non-substantive revisions to improve readability and clarity were made to the Owner’s Coverage Statement. This includes the term “actual loss” being revised to “loss or damage.”

Covered Risks
- Covered Risk 6 (previously 5) no longer given post-policy effect.
- Covered Risk 7 (previously 6) no longer gives post-policy effect.
- Coverage for the enforcement of governmental police power has been expanded to include forfeiture, regulatory, and national security powers, and it incorporates the defined term “Enforcement Notice.”
- Coverage for surface damage arising from subsurface extraction has an expanded list of subsurface materials.
- The defined term “Discriminatory Covenant” is now used in Covered Risk 26, which provides coverage for any attempted enforcement.
• New Covered Risk for matters arising after Date of Policy but prior to recording of the deed.

New Exclusions from Coverage
• Exclusion 9: Any lien on Your Title for real estate taxes or assessments imposed or collected by a governmental authority that becomes due and payable after the Date of Policy. Exclusion 9 does not modify or limit the coverage provided under Coverage Risk 8a or 27.
• Exclusion 10: Any discrepancy in the quantity of the area, square footage, or acreage of the Land or of any improvement to the Land.

Condition 1, Definitions
• New defined terms: Amount of Insurance, Covenant, Date of Policy, Discriminatory Covenant, Enforcement Notice, Insured, Municipal, and State.
• As with the Owner’s Policy and Loan Policy, the definitions of “Land” and “Public Records” have been revised.

Condition 2, Continuation of Coverage
• Revisions were made to clarify the scope of continued coverage.
• Condition 2.a now includes the addition of continued coverage for a named Insured who acquires the Title of another Insured.

Condition 6, Contract of Indemnity, Determination, and Extent of Liability
• As with the Owner’s Policy and Loan Policy, the Homeowners Policy now includes a provision making clear that the policy is contract of indemnity and not an abstract or representation of the condition of the Title.
• The phrase “actual loss” has been replaced with a more precise measure of loss and provisions for determining the date on which the loss is calculated.
• As done in the Owner’s Policy and Loan Policy, the Amount of Insurance is now increased by 15%, rather than 10%, if we are unsuccessful in pursuing an effort to establish the Title as insured, and the policy now provides the Insured the ability to elect alternative dates for calculating loss.
• The Homeowners Policy includes rental reimbursement and relocation of personal property when a covered claim renders the property unusable. The distance for transportation of personal property has been increased from 25 miles to 50 miles.

Condition 12, Choice of Law and Choice of Forum
• This Condition uses the new defined term “State” and makes it clear that the state law and courts of the state where the property is located apply to the policy.

Condition 13, Class Action
• This Condition is based on the unique nature of each property and real estate transaction, and it prohibits class proceedings with respect to the policy.

Condition 14, Arbitration
• This policy now includes the same arbitration provision as the Owner’s Policy and Loan Policy, where arbitration must be a mutual decision where the Amount of Insurance is over $2 million. The prior version of the policy provided that either the Insured or the company could require binding arbitration (if permitted under state law).

Schedule B, Exceptions from Coverage
• The preamble to Schedule B now begins with a statement repudiating discriminatory covenants and deleting any from the documents referenced in Schedule B. This preamble uses the new defined term “Discriminatory Covenant.”

New Endorsements
• ALTA 34.1 is very similar to the existing ALTA 34 but designed to facilitate a more precise description of the insured risk.
• ALTA 47 Series endorsements were created to address the choice of law and related issues related to the U.S. Supreme Court decision in McGirt v. Oklahoma when using the “pre-2021” policies.

Revised Endorsements
• Thirty existing endorsements were revised as part of the 2021 forms package.
• Most of these revisions were to incorporate terms that are now defined within the new policy forms.
• Some endorsement revisions were to address the applicable law issues that might arise when property is within a Native American reservation.

Mr. Byrd asked if there are any thresholds to the discrepancy in quantity of the area square footage of acreage under Exclusion 10. He asked if it is the intent of the change to indicate that there is no treatment difference between there being a 50% or 2% difference in the acreage. He also asked if there is anything that would prevent the parties themselves from deciding whether to go to mediation or non-binding arbitration under Condition 14, Arbitration.

Mr. Buchanan stated that this is the intent. The legal description of the property and its boundaries are what is insured. There are a lot of old legal descriptions that say, “consisting of 20 acres more or less,” and the actual acreage or improvements to it are not verified. The exclusion was created for efficiency. Condition 14, Arbitration only addresses arbitration, not mediation. In general, most companies prefer mediation.

Ms. Rafeld asked if there had been any feedback from state insurance regulators since the new forms were rolled out in July of this year.

Mr. Buchanan stated that he is not aware of feedback received. First American Title has been spending a lot of time on reformatting and restructuring its forms, so it is just beginning of the form filing process. The California Land Title Association (CLTA) has filed the entire package in California, and it was all accepted for filing with no feedback.

Ms. Thomas stated that Stewart Title has had several form filings approved, and most of the feedback from states have been in the form of clarification questions. One jurisdiction had a question on the arbitration provision, which Stewart Title excludes prior to the filing for states that do not allow them.

Having no further business, the Title Insurance (C) Task Force adjourned.
Title Insurance (C) Task Force
Virtual Meeting
October 19, 2021

The Title Insurance (C) Task Force met Oct. 19, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Michelle Brugh Rafeld (OH); David Altmaier, Vice Chair, represented by Anoush Brangaccio (FL); Lori K. Wing-Heier represented by Sian Ng-Ashcraft (AK); Karima M. Woods represented by Angela King (DC); Colin M. Hayashida represented by Paul Yuen (HI); James J. Donelon represented by Warren Byrd (LA); Grace Arnold represented by Paul Hanson (MN); Chlora Lindley-Myers represented by Marjorie Thompson (MO); Troy Downing (MT); Mike Causey represented by Timothy Johnson (NC); Marlene Caride represented by Randall Currier (NJ); Russell Toal and Mark Marquez (NM); Barbara D. Richardson represented by Maggie Dell (SD); Scott A. White represented by Kevin Gaffney (VT). Also participating were: Jennifer Welch (DE); and Michael Walker (WA).

1. Adopted its Summer National Meeting Minutes

The Task Force met July 13 and took the following action: 1) adopted its June 7 minutes; 2) adopted revisions to the Title Insurance Consumer Shopping Tool Template (Shopping Tool); and 3) heard a presentation on business email compromises.

Mr. Byrd made a motion, seconded by Mr. Currier, to adopt the Task Force’s July 13 minutes (see NAIC Proceedings – Summer 2021, Title Insurance (C) Task Force). The motion passed unanimously.

2. Discuss it 2022 Proposed Charges

Ms. Rafeld recommended removing the Task Force’s fourth charge to “consider the effectiveness of changes in financial reporting by title insurance companies, and identify further improvements and clarifications to blanks, instructions, Statement of Statutory Accounting Principles (SSAPs), solvency tools, and other matters, as necessary. Coordinate efforts with the Statutory Accounting Principles (E) Working Group.” This charge has been included in the list of charges for some time, as it was tied to work being done by the Title Insurance Financial Reporting (C) Working Group, which was disbanded once it completed this task. There are no requests for assistance at this time from the Statutory Accounting Principles (E) Working Group, and any future requests can be handled under the first charge. Ms. Rafeld also recommended removing the fifth charge to “revise the Title Insurance Consumer Shopping Tool Template to include questions and answers about title insurance-related fraud topics, including but not limited to, [closing protection letters] CPLs and wire fraud.” The Task Force updated the Shopping Tool to include information about wire fraud, and it was adopted by the Property and Casualty Insurance (C) Committee during the Summer National Meeting. In addition, based upon all the presentations held over the past year regarding the impact the pandemic has had on the title industry, Ms. Rafeld recommended removing the seventh charge to “explore short-term and long-term issues and solutions from the pandemic.” She stated that Ohio had a consumer from Florida contact them about just realizing his title insurance carrier had been liquidated more than a decade ago. Unfortunately, Ohio does not have a guaranty association, so there was nowhere for this consumer to turn. There may be the need for the Task Force to create some type of guideline or best practice stating that policyholders should be notified that they no longer have coverage in the rare case that an underwriter liquidates as well as what their next steps should be if they have a claim. The Task Force may want to also consider looking into whether guaranty associations should be a best practice.

Mr. Byrd stated his support for removing the fourth, fifth, and seventh charges. He stated that he would like to be educated on why some states do not have title guaranty associations.

Birny Birnbaum (Center for Economic Justice—CEJ) stated that the Life and Health Insurance Guaranty Association Model Act (§520) specifically excludes title insurance. He believes this is an important issue to look into. At the time of the financial crisis, one of the largest title insurers was failing and was ultimately purchased by another title insurer. Had it failed, it would have created significant problems for consumers and the banks who rely upon title insurance to protect their loans. The issue extends not just to informing the consumers, but lenders too. However, there have been failures covered by the Texas guaranty fund.

Steve Gottheim (American Land Title Association—ALTA) stated that the Task Force set up a Working Group at one time to look into guaranty funds. The financial difficulty of the title company that struggled during the financial crisis was due to some
of their investments, not its insurance. As stated previously, the insurance was purchased by another licensed insurer, which is common practice. ALTA can connect consumers inquiring about their liquidated insurer to where they need to make a claim or how they should request additional information on getting a new policy.

Aaron Day (Texas Land Title Association—TLTA) stated that Texas has a complex system, and its guaranty fund is completely consumer-funded. The underwriters front the immediate needs through assessments, and those assessments are recouped by the underwriter through a subsequent fee. There is also an independent board whose members are appointed by the Texas Department of Insurance (DOI) and consist of public members, industry members, and staff.

Ronald J. Blitenthal (Old Republic Title) stated that he would send NAIC staff a copy of the January 2013 minutes he has of the Task Force’s prior Working Group that looked into guaranty fund issues.

Ms. Rafeld asked that additional comments or revision suggestions for the Task Force’s 2022 proposed charges be emailed to NAIC staff. The Task Force will review comments to the proposed charges for potential adoption on its Nov. 16 call.

3. **Heard a Presentation on Demotech’s Regional Title Underwriter Escrow Theft and Defalcation Prevention Measures Report**

Joseph L. Petrelli Jr., Paul Osborne, and Douglas Powell (Demotech) discussed Demotech’s observed and reported impacts of defalcations and escrow theft on the title industry. Demotech requests title underwriters for which it assigns Financial Stability Ratings to submit information on their current agent review process, defalcation prevention procedures, and any other mitigation procedures. Each title underwriter is requested to submit a questionnaire, detailed summary, and any additional supporting documentation. Demotech recently released its latest aggregated results of 40 regional underwriters for 2020. The results are largely consistent with 2019, with only four defalcations for title underwriters writing 2.6 million policies that year. This indicates that the processes and procedures currently in place are mitigating defalcation activity.

Mr. Currier asked what the highest amount was on the summary results for 2020. Mr. Powell stated that the total amount was $817 million in 2020. In 2019, claims were $2 million for two claims. Given the number of transactions, the mitigation measures put in place by title insurers seem to be doing a good job.

4. **Heard a Presentation on ALTA’s New Policy Forms**

Mr. Gottheim, Mary Payne Thomas (Stewart Title), and Dan Buchanan (First American Title) provided an overview of ALTA’s new forms of Commitment, Owner’s Policy, and Loan Policy, effective July 1, 2021.

The changes align the updated language of the 2016 Commitment to the Policy Forms, moving some exceptions that became commonplace to the jacket as Exclusions. They also make punctuation and grammatical refinements, revise amendments based on how courts have treated the prior policy language and add language for some new coverages and exclusions for both the insured and insurer. More specifically, the changes include: 1) the coverages of the electronic policy/signature endorsement are now included in the Policy Jacket; 2) there is now clarification on the treatment of the Perishable Agricultural Commodities Act (PACA) exception; 3) the term “insured” is defined to allow coverage under the Owner’s Policy to continue when the Land is conveyed to an affiliate, even when money changes hands; 4) Remote Online Notarization (RON) is now part of the covered risk, as traditional in-person notarization is; 5) the “Enforcement Notice” term is introduced, defining a document that is a lien but governmental in nature; 6) the Loan Policy’s Covered Risk adds language to clarify and confirm for lenders that the coverage is for certain enumerated components of the Indebtedness; 6) Covered Risk on Mechanics Liens now confirms that the coverage relates to services and equipment in addition to labor and materials; 7) the new forms reference “voidable transfer” instead of “fraudulent transfer” to be consistent with the Uniform Voidable Transactions Act (UVTA); 8) the Transaction Identification Data is now formatted into Schedule A of the new policies for consistency; 9) standard exceptions to illegal covenants in Schedule B were created; and 10) a new Condition is added that gives an insured a choice of valuing a loss at either the date a notice of claim was received by the company or the date of a foreclosure sale. This addresses prior confusion created under the old policies’ lack of specificity on when a loss should be valued, which led to several legal disputes during the great recession.

Ms. Rafeld stated that the comparisons between the old and new policies on ALTA’s website are very helpful.

Mr. Currier stated that he believes it would be helpful if ALTA presented at a deeper level on changes to its endorsements during the Task Force’s Nov. 16 meeting. Ms. Rafeld stated that she would invite ALTA to present during the meeting. She
stated that the Task Force would also hear a presentation from AM Best on how the housing market has driven title industry performance.

Having no further business, the Title Insurance (C) Task Force adjourned.
WORKERS’ COMPENSATION (C) TASK FORCE

The Workers’ Compensation (C) Task Force did not meet at the Fall National Meeting.
MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE

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The Market Regulation and Consumer Affairs (D) Committee met in San Diego, CA, Dec. 15, 2021. The following Committee members participated: Barbara D. Richardson, Chair (NV); Sharon P. Clark, Vice Chair, represented by Ron Kreiter (KY); Alan McClain (AR); Evan G. Daniels (AZ); Trinidad Navarro (DE); Dana Popish Severinghaus (IL); Chlora Lindley-Myers (MO); Edward M. Deleon Guerrero (MP); Troy Downing represented by Bob Biskupiak (MT); Jon Godfread (ND); Carter Lawrence (TN); Jonathan T. Pike (UT); and Michael S. Pieciak represented by Kevin Gaffney (VT). Also participating were: Damion Hughes (CO); Cynthia Amann (MO); Larry D. Deiter (SD); Mike Kreidler and John Haworth (WA); and Rebecca Rebholz (WI).

1. **Adopted its Summer National Meeting Minutes**

   Commissioner Clark made a motion, seconded by Commissioner Godfread, to adopt the Committee’s Aug. 16 minutes (see *NAIC Proceedings – Summer 2021, Market Regulation and Consumer Affairs (D) Committee*). The motion passed unanimously.

2. **Adopted its 2022 Proposed Charges**

   Commissioner Richardson said the Committee’s charges were circulated to Committee members, interested state insurance regulators, and interested parties on Nov. 22 and posted on the NAIC website. Since Nov. 22, the Market Information Systems (D) Task Force held a conference call and was not able to finish its review of the report drafted by the Market Information Systems Research and Development (D) Working Group. Because of this, Commissioner Richardson said the Task Force held an e-vote and added back the 2021 charge to “[d]evelop recommendations for the incorporation of artificial intelligence (AI) abilities in NAIC Market Information Systems for use in market analysis. Complete by the 2022 Summer National Meeting.” The wording of the 2021 charge did not change, and only the completion date was changed to the 2022 Summer National Meeting.

   Commissioner Pike made a motion, seconded by Commissioner Lawrence, to adopt the Committee’s 2022 proposed charges (see *NAIC Proceedings – Fall 2021, Executive (EX) Committee and Plenary, Attachment Three*). The motion pass unanimously.

3. **Adopted Revisions to the Market Regulation Handbook**

   Commissioner Richardson said the next three agenda items are to consider adoption of a new title in-force standardized data request (SDR), a new title claims SDR, revisions to Chapter 24—Conducting the Health Examinations of the Market Regulation Handbook (Handbook), and revisions to Chapter 25—Conducting the Medicare Supplement Examination of the Handbook.

   Mr. Hughes said the Market Conduct Examination Guidelines (D) Working Group began discussing a new title insurance in-force policy SDR and a new title insurance claims SDR at its March 30 meeting. Comments were received on the draft SDRs from Colorado, Nebraska, Rhode Island, the Center for Economic Justice (CEJ), and the American Land Title Association (ALTA). The Working Group adopted changes to Chapter 24 to include the review of quality-of-care complaints for examination standard 4, which focuses on quality assessment and improvement. The Working Group adopted revisions to Chapter 25 to provide more specific cross-references to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651).

   Commissioner Godfread made a motion, seconded by Director Lindley-Myers, to adopt the new title in-force SDR (Attachment One), the new title claims SDR (Attachment Two), and revisions to Chapter 24 (Attachment Three) and Chapter 25 (Attachment Four) of the Handbook. The motion passed unanimously.

4. **Adopted its Task Force and Working Group Reports**

   Commissioner Richardson said the Privacy Protections (D) Working Group adopted a “Report on Consumer Data Privacy Protections,” and the adoption of the Task Force and Working Group reports will include the receipt of the “Report on Consumer Data Privacy Protections.”
a. **Antifraud (D) Task Force**

Commissioner Navarro said the Antifraud (D) Task Force met Nov. 12 and adopted its Oct. 27 and Summer National Meeting minutes. The Antifraud Education Enhancement (D) Working Group worked with NAIC staff on an investigator safety training webinar delivered on Dec. 2. The Antifraud Technology (D) Working Group identified subject matter experts (SMEs) to continue working on an Antifraud Plan template to potentially be used by insurance companies. Commissioner Navarro said another draft will be circulated in the first quarter of 2022. He said the Improper Marketing of Health Insurance (D) Working Group continued to meet monthly in regulator-to-regulator session. The Working Group held its first open meeting on Dec. 11, which included hearing presentations from the Alliance of Health Care Sharing Ministries, America’s Health Insurance Plans (AHIP), and Out2Enroll regarding their efforts to fight against the improper marketing of health insurance.

b. **Market Information Systems (D) Task Force**

Commissioner Kreidler said the Market Information Systems (D) Task Force met Nov. 23 and adopted the report of the Market Information Systems Research and Development (D) Working Group. The Working Group continues to monitor and oversee the prioritization of the Uniform System Enhancement Requests (USERs). It is also in the process of completing the 2021 Market Information Systems (MIS) data analysis metrics.

Commissioner Kreidler said most of the Task Force meeting was dedicated to consideration of the Working Group’s recommendations regarding incorporation of artificial intelligence (AI) abilities in NAIC MIS. The recommendations of the Working Group were in fulfillment of the Task Force’s charge to develop these recommendations. There were five recommendations in the report: 1) evaluate currently available market analysis data and assess its quality; 2) adopt a more rigorously statistical approach to identify the predictive power of market scoring systems and integrate data into a single overall analysis; 3) incorporate promising AI modes of analyses, as well as traditional statistical modeling; 4) assess ways AI can improve the efficiency of qualitative analysis and facilitate pattern recognition across larger volumes of textual evidence; and 5) explore potential data sources suitable for AI techniques. Consumer representatives were generally supportive of the recommendation and suggested a new charge to begin exploring the types of data needed to implement more robust statistical methods, including AI. Commissioner Kreidler said some Task Force members were concerned that there was no NAIC staff feedback on the cost and time required to implement the recommendations and prioritize competing priorities. Additionally, there was concern of overlap with the charges being considered for the new Innovation, Cybersecurity, and Technology (H) Committee. Commissioner Kreidler said the Task Force did not vote on the recommendations and will have further discussions in 2022.

c. **Producer Licensing (D) Task Force**

Director Deiter said the Producer Licensing (D) Task Force met Nov. 29. He said the Producer Licensing Uniformity (D) Working Group provided the Task Force with the results of its survey regarding what the Working Group members recommend as the appropriate producer licensing standard for pet insurance. Seven Working Group members suggested that the current Uniform Licensing Standards, which treats pet insurance as a non-core limited line is the appropriate licensing standard, seven Working Group members suggested that the major lines of authority of property/casualty (P/C) should be required, one Working Group member suggested that pet insurance should become a core limited line, and one Working Group suggested that a license for any major line of authority should be required. Since the survey was completed prior to the Property and Casualty Insurance (C) Committee adopting the Pet Insurance Model Act, which includes a training requirement for insurance producers who want to sell, solicit, or negotiate Pet Insurance, Director Deiter said the Task Force will review this issue in more detail after the NAIC members consider adoption of the Pet Insurance Model Act.

Director Deiter said he Task Force discussed the draft procedures for amending the NAIC Producer Licensing Applications, which are being developed to ensure that the consideration of changes to the uniform applications support the NAIC members’ goal of providing stable, uniform applications and encourage the use of electronic technology for licensing. The Task Force will circulate a revised draft, and it plans to consider adoption of the procedures during the first quarter of 2022. Once the procedures are adopted, Director Deiter said the Task Force will review the proposed amendments to the Producer Licensing Applications, which the Task Force and the Committee adopted in 2018. The Executive (EX) Committee and Plenary did not consider adoption of these amendments, and the amendments will be reviewed within the framework of the adopted procedures.

Director Deiter said the Task Force received comments from the American Council of Life Insurers (ACLI) on diversity, equity, and inclusion (DE&I), and its request for the Task Force to provide further consideration on how the 1033 waiver process and the presence of unnecessary pre-licensing education mandates may be unnecessary barriers to individuals seeking an insurance producer license.
In response to the referral from the Special (EX) Committee on Race and Insurance, Director Deiter said the Task Force discussed the elimination of cultural bias in producer licensing examinations, which included a review of preliminary feedback from two examination vendors on their internal training and industry standards for examination fairness. The Task Force is still seeking input from another examination vendor and will compile the responses in a report to the Special Committee.

Director Deiter said the Task Force received a report from the National Insurance Producer Registry (NIPR) Board of Directors. October marked the 25th anniversary for NIPR, and NIPR is on track to have its highest transaction volume and revenue year with a forecast of processing more than $1 billion in fees for state insurance departments. NIPR continues to implement the contact change request application for business entities and recently implemented a chat feature for customers.

Finally, the Task Force discussed how states could address errors or misstatements on producer licensing applications, which were completed by third-party authorized submitters.

d. **Market Conduct Examination Guidelines (D) Working Group**

Mr. Hughes said the Market Conduct Examination Guidelines (D) Working Group met Nov. 4, Oct. 7, and Sept. 2. He said the Working Group adopted a new title in-force SDR, a new title claims SDR, and revisions to Chapters 24 and 25 of the Handbook. He said the Working Group discussed revisions to Chapter 21—Conducting the Property and Casualty Examination regarding provisions from the Real Property Lender-Placed Insurance Model Act (#631) and Chapter 20—General Examination Standards regarding provisions in the Insurance Holding Company System Regulatory Act (#440). He said the Working Group received updates from state SMEs reviewing the following models potentially affecting the Handbook: Suitability in Annuity Transactions Model Regulation (#275), Corporate Governance Annual Disclosure Model Act (#305), and Corporate Governance Annual Disclosure Model Regulation (#306). He said the Working Group received some additional background from Tim Mullen (NAIC) on the Working Group’s charge regarding group supervision of market conduct risks.

Mr. Hughes said the Working Group has been asked to coordinate with the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group to update the mental health parity-related chapter of the Handbook to ensure it reflects the current mental health parity compliance requirements set forth in federal guidance enacted in December 2020. He said the two working groups would be addressing this issue in 2022.

e. **Market Analysis Procedures (D) Working Group**

Mr. Haworth said the Market Analysis Procedures (D) Working Group met Nov. 18 and continued its discussion of the market analysis training needs of state insurance regulators. He said the Working Group is developing standard scorecard ratios in response to the Committee’s adoption of the Short-Term Limited-Duration (STLD) and Travel Insurance Market Conduct Annual Statement (MCAS) blanks. He said draft ratios have been developed for both lines of business, and the Working Group should have the final draft ready by the 2022 Spring National Meeting. He said the Working Group began a discussion about the current market analysis tools that may be eliminated in the NAIC’s i-Site+. Many of the tools are being replaced with enhanced tools being developed as part of the State Ahead project to develop self-service dashboards. Mr. Haworth said the Working Group will provide its expertise to the Market Information Systems Research and Development (D) Working Group regarding the final decision to replace these tools. Finally, the Working Group discussed the definitions of “surrender” and “replacement” for the purposes of the Annuity MCAS Data Call and Definitions. A clarification will be drafted for the Frequently Asked Questions (FAQ) document.

f. **Market Conduct Annual Statement Blanks (D) Working Group**

Ms. Rebholz said the Market Conduct Annual Statement Blanks (D) Working Group met Nov. 22 and exposed two changes to the current Homeowner and Auto MCAS blanks. The Working Group exposed revisions to the definition of “lawsuit” and the placement of the lawsuit data elements in the MCAS blanks. Ms. Rebholz said this will allow for the distinction between claims-related lawsuits and non-claims-related lawsuits. The Working Group also exposed an interrogatory question for capturing information on third-party vendors who provide data and algorithms used in the digital claims process. Ms. Rebholz said the Working Group will consider adoption of these changes in the first quarter of 2022. She said the Working Group received an update on the Life MCAS draft edits for accelerated underwriting (AU) as the Working Group continues to coordinate the development of a definition for AU with the definition that will be adopted by the Accelerated Underwriting (A) Working Group. She said the Working Group’s “Other Health” SMEs will be led by Mary Kay Rodriguez (WI).
g. Privacy Protections (D) Working Group

Ms. Amann said the Working Group met Dec. 11, Nov. 22, Oct. 25, Oct. 11, Sept. 27, Sept. 13, and Aug. 30. During its Aug. 30 meeting, the Working Group heard an update on state privacy legislation and California Proposition 24 and circulated the first exposure draft of the privacy policy statement with comments of interested parties incorporated into the draft. Ms. Amann said the Working Group changed the policy statement to a report so as not to infer the Working Group was making statements on behalf of the NAIC members.

During the Sept. 13 meeting, Ms. Amann said the Working Group discussed the consumer right to opt-out of data sharing and reviewed the comments of AHIP, the Blue Cross Blue Shield Association (BCBSA), and the Coalition of Health Companies. She said the use of the term right was used for ease of language, and the term right should be considered as an area for future discussion. During the Sept. 27 meeting, Ms. Amann said the Working Group continued its discussion regarding a consumer’s right to opt-out of information sharing and reviewed the nine principles for consumer data privacy in insurance submitted by Harry Ting (Health Consumer Advocate).

During the Oct. 11 meeting, Ms. Amann said the Working Group received an update on state privacy legislation and discussed a consumer’s right to correct information. During the Oct. 25 meeting, she said the Working Group reviewed a data privacy legislation chart and a consumer’s right to delete information. During the Nov. 22 meeting, she said the Working Group heard an update on state privacy legislation and discussed a consumer’s right to data portability, a consumer’s right to restrict the use of data, and consumer ownership of data. She said the Working Group also reviewed the final exposure draft of the privacy report. Ms. Amann said the Working Group met Dec. 11 and restated that the term right should be considered an area for future consideration, and the policy statement was changed to be a Working Group report to eliminate any reference the Working Group was making to a statement on behalf of the NAIC members. She concluded her report and requested that the Committee receive the Working Group’s final exposure “Report on Consumer Data Privacy,” which includes the following: 1) a summary of consumer privacy protections provided by the Health Information Privacy Model Act (#55), the NAIC Insurance Information and Privacy Protection Model Act (#670), and the Privacy of Consumer Financial and Health Information Regulation (#672); 2) a summary of the General Data Protection Regulation (GDPR) and recently adopted state consumer privacy protection laws; 3) a summary of the Working Group’s discussion on data transparency, consumer control of data, consumer access to data, data accuracy, and data ownership and portability; and 4) a recommendation that Model #670 and Model #672 be revised to modernize their applicability to the current technology-based insurance market. Commissioner Godfread said the report is a significant undertaking and a significant step forward for these discussions.

Commissioner Godfread made a motion, seconded by Commissioner Lawrence, to adopt the following reports, including the receipt but not the adoption of the “Report on Consumer Data Privacy Protections” (Attachment Five): 1) Antifraud (D) Task Force; 2) Market Information Systems (D) Task Force; 3) Producer Licensing (D) Task Force; 4) Market Conduct Examination Guidelines (D) Working Group (Attachment Six); 5) Market Analysis Procedures (D) Working Group (Attachment Seven); 6) Market Conduct Annual Statement Blanks (D) Working Group (Attachment Eight); and 8) Privacy Protections (D) Working Group (Attachment Nine). The motion passed unanimously.

5. Discussed Other Matters

Birny Birnbaum (CEJ) said he was not recognized prior to the adoption of charges and would like to propose two charges for the Committee to consider. The first is for the Committee to review the use of dark patterns, which prompt consumers to purchase products they did not want and disclose personal information. Mr. Birnbaum said state insurance regulators must understand how dark patterns work and how the rapid deployment of digital interfaces is transforming how consumers and insurers interact. He urged the Committee to adopt a charge to explore the use of manipulative and deceptive practices in digital insurance interfaces, including applications and disclosures (dark patterns), and he recommend any changes needed in training for market regulation staff and any changes needed in regulatory guidance to insurers. Mr. Birnbaum said when the Market Conduct Annual Statement effort was launched as a pilot project over 15 years ago, state insurance regulators opted to use market conduct examination authority to facilitate the data collection. The result was that individual MCAS submissions were treated as confidential. Mr. Birnbaum said there is no reason why individual company MCAS data is confidential, but there are good reasons to make the submissions public information. He suggested that the Committee adopt a charge to explore benefits and costs of public access to individual company MCAS submissions and methods of MCAS data collection that would permit public access.

Having no further business, the Market Regulation and Consumer Affairs (D) Committee adjourned.
POLICY IN FORCE STANDARDIZED DATA REQUEST
Title Line of Business

Contents: This file should be downloaded from the company system(s) and contain one record for each title policy issued in [applicable state] at any time during the examination period.

For any fields where there are multiple entries, please repeat field as necessary.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the issuance and/or underwriting of title policies in [applicable state] within the scope of the examination.

- Cross-reference with the claims data file to validate the completeness of the in force file; and
- Cross-reference to state(s) licensing information to ensure proper agent licensure.

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<td>N</td>
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<tr>
<td>LoanAmt</td>
<td>150</td>
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<td>2</td>
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<td>CommitDt</td>
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<td>Date commitment issued [MM/DD/YYYY]</td>
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<td></td>
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<tr>
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<tr>
<td>PolIssDt</td>
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<td>Date policy issued/delivered to insured [MM/DD/YYYY]</td>
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<tr>
<td>Field Name</td>
<td>Start</td>
<td>Length</td>
<td>Type</td>
<td>Decimals</td>
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</tr>
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<td>------------</td>
<td>-------</td>
<td>--------</td>
<td>------</td>
<td>----------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td>DRecDt</td>
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<td>10</td>
<td>D</td>
<td>10</td>
<td>Date deed is recorded [MM/DD/YYYY]</td>
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<tr>
<td>DPrsDt</td>
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<td>10</td>
<td>Date deed was presented for recording [MM/DD/YYYY]</td>
</tr>
<tr>
<td>DisbDt</td>
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<td>10</td>
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<td>10</td>
<td>Disbursement date [MM/DD/YYYY]</td>
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<td></td>
<td>Middle name of agent</td>
</tr>
<tr>
<td>AgLast</td>
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<td></td>
<td>Last name of agent (or agency name, if applicable)</td>
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<tr>
<td>AgStat</td>
<td>292</td>
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<td>A</td>
<td></td>
<td>Status of agent, CSR or agency appointment (active, inactive, terminated, etc.)</td>
</tr>
<tr>
<td>AgAddr</td>
<td>307</td>
<td>25</td>
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<td></td>
<td>Agent’s, CSR’s or agency’s street address</td>
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<tr>
<td>AgCity</td>
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<td></td>
<td>Agent’s, CSR’s or agency’s city</td>
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<td>AgSt</td>
<td>357</td>
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<td>A</td>
<td></td>
<td>Agent’s, CSR’s or agency’s state abbreviation</td>
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<tr>
<td>PrZip</td>
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<td>9</td>
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<td>Agent’s, CSR’s or agency’s ZIP code</td>
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<tr>
<td>BasePrem</td>
<td>368</td>
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<td>Base premium charged for the policy per company filed rates as defined by [Insert statutory citation here]</td>
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<td>EndorLst</td>
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<td>List endorsements attached to the policy Please provide a list to explain any codes used</td>
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<td>EndorPrm</td>
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<td>Type of policy discount (Employee, military, charitable organization, etc.) If codes are used, provide a list of codes along with their meanings</td>
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<td>DiscAmt</td>
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<td>Amount of premium retained by the agent or agency</td>
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<td>CPLetter</td>
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<td>Closing protection letter (Y/N)</td>
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<td>N</td>
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<td>Title service charges</td>
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<td>ClosChgs</td>
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<td>N</td>
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<td>Closing charges</td>
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<td>A</td>
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<td>City of subject property</td>
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<td>A</td>
<td></td>
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<td>PropZip</td>
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<td>A</td>
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<td>Field Name</td>
<td>Start</td>
<td>Length</td>
<td>Type</td>
<td>Decimals</td>
<td>Description</td>
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<td>-------</td>
<td>--------</td>
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<td>-------------</td>
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<td>A</td>
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<td>County of subject property</td>
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<td>SellName</td>
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<td>Name of seller of subject property</td>
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<tr>
<td>RealEst</td>
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<td>Subject property a new construction (Y/N)</td>
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<td></td>
<td>End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.</td>
</tr>
</tbody>
</table>
CLAIMS STANDARDIZED DATA REQUEST
Title Line of Business

Contents: This file should be downloaded from company system(s) and contain one record for each claim transaction (i.e. paid/denied/pending/closed w/o payment) that the company processed within the scope of the examination. Include all claims open during the examination period. Do not include expense payments to vendors.

Uses: Data will be used to determine if the company follows appropriate procedures with respect to the handling of Title claims within the scope of the examination.
- Cross-reference to annual statement claims data (amount) to ensure completeness of exam data submitted.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Start</th>
<th>Length</th>
<th>Type</th>
<th>Decimals</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>TAgency</td>
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<td>Title agency name</td>
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<td>TUnder</td>
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<td>A</td>
<td></td>
<td>Underwriting title insurer</td>
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<td>CoCode</td>
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<td>NAIC company code</td>
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<td>A</td>
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<td>ClmPre</td>
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<td>Claim number prefix (Blank if NONE)</td>
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<td>ClmSuf</td>
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<td>A</td>
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<td>PolTyp</td>
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<td>A</td>
<td></td>
<td>Type of policy (Presumably an alphabetic character such as O (Owner), M (Mortgagee), L (Lender), S (Simultaneous), H (Hold Open) Please provide a list to explain any codes used</td>
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<td>A</td>
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<td>Full name of lender insured by policy (if applicable)</td>
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<tr>
<td>OwnFirst</td>
<td>203</td>
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<td>A</td>
<td></td>
<td>First name of owner insured by policy (if applicable)</td>
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<td>A</td>
<td></td>
<td>Middle initial of owner insured by policy (if applicable)</td>
</tr>
<tr>
<td>OwnLast</td>
<td>219</td>
<td>20</td>
<td>A</td>
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<td>Last name of owner insured by policy (if applicable)</td>
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<td>RcvdDt</td>
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<td>D</td>
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<td>First notice of loss [MM/DD/YYYY]</td>
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<td>ClmOpnDt</td>
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<td>Date claim opened [MM/DD/YYYY]</td>
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<td>ClmAckDt</td>
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<td>D</td>
<td></td>
<td>Date company or its producer acknowledged the claim [MM/DD/YYYY]</td>
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<tr>
<td>NtcInvDt</td>
<td>269</td>
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<td>D</td>
<td></td>
<td>Date of written notice to insured/claimant regarding incomplete investigation [MM/DD/YYYY]</td>
</tr>
<tr>
<td>ResEstDt</td>
<td>279</td>
<td>10</td>
<td>D</td>
<td></td>
<td>Date reserves established for claim, if applicable [MM/DD/YYYY]</td>
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<tr>
<td>AggResAm</td>
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<td>10</td>
<td>N</td>
<td>2</td>
<td>Aggregate amount of reserves established for claim</td>
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<tr>
<td>AggClmEx</td>
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<td>2</td>
<td>Aggregate amount of claim expenses (litigation, research fees, etc.)</td>
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<td>A</td>
<td></td>
<td>Claim litigated? (Y/N)</td>
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<td>Field Name</td>
<td>Start</td>
<td>Length</td>
<td>Type</td>
<td>Decimals</td>
<td>Description</td>
</tr>
<tr>
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<td>-------</td>
<td>--------</td>
<td>------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>OutCnsl</td>
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<td>1</td>
<td>A</td>
<td></td>
<td>Claim referred to outside counsel (Y/N)</td>
</tr>
<tr>
<td>RefDt</td>
<td>311</td>
<td>10</td>
<td>D</td>
<td></td>
<td>Date referred for legal counsel [MM/DD/YYYY]</td>
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<tr>
<td>Arbt</td>
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<td>A</td>
<td></td>
<td>Claim arbitrated? (Y/N)</td>
</tr>
<tr>
<td>ClmStat</td>
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<td>A</td>
<td></td>
<td>Claim status P = Paid, D = Denied, N = Pending, H = Partial Payment, C = Closed Without Payment, R = Rescinded, T = Title Cleared</td>
</tr>
<tr>
<td>ClmPdDt</td>
<td>323</td>
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<td>D</td>
<td></td>
<td>Claim paid date [MM/DD/YYYY]</td>
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<td>2</td>
<td>Claim payment amount</td>
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<td>ClmDnyDt</td>
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<td>10</td>
<td>D</td>
<td></td>
<td>Date claim was denied [MM/DD/YYYY]</td>
</tr>
<tr>
<td>ClmClDt</td>
<td>353</td>
<td>10</td>
<td>D</td>
<td></td>
<td>Date claim closed [MM/DD/YYYY]</td>
</tr>
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<td>EndRec</td>
<td>363</td>
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<td>A</td>
<td></td>
<td>End of record marker. Please place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.</td>
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</tbody>
</table>
STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

<table>
<thead>
<tr>
<th>Standard 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>The health carrier reports to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the health carrier to terminate or suspend contractual arrangements with the provider.</td>
</tr>
</tbody>
</table>

Apply to: All health carriers with managed care plans

Priority: Essential

Documents to Be Reviewed

- Applicable statutes, rules and regulations
- Quality assessment and improvement policies and procedures
- Reports made to the licensing authority
- Terminated and suspended provider contract files
- Quality of Care complaints

Others Reviewed

- __________________________
- __________________________

NAIC Model References

*Quality Assessment and Improvement Model Act (#71), Section 5*
*Health Maintenance Organization Model Act (#430)*

Review Procedures and Criteria

Determine that policies and procedures address reporting requirements.

Ascertain whether applicable terminated and suspended contract files reflect compliance with reporting requirements. Examiners should note that some terminated and suspended contracts will involve issues that are not necessary to report.
A. Operations/Management

1. Purpose

The Operations/Management portion of the examination is designed to provide a view of what the entity is and how it operates. Normally, it is not based on sampling techniques; it is more concerned with structure. This review is not intended to duplicate financial examination review, but is important in providing the market conduct examiner with an understanding of the examined entity. Many troubled insurance companies have become so because management has not been structured to recognize and address the problems that can arise in the insurance industry. In addition to the general categories, examiners should also review Section J Provider Credentialing (Medicare Select carriers only) of this chapter.

a. Provider Credentialing

Examiners should determine that a Medicare Select carrier has established documented verification programs to ensure that participating health care professionals meet minimum specific professional qualifications, both initially and on an ongoing basis.

Additional introductory material is located in Chapter 20—General Examination Standards.
STANDARDS
OPERATIONS/MANAGEMENT

Standard 1
The Medicare Select carrier’s plan of operation complies with applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Plan of operations

_____ Information to enrollees

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ ________________________________

_____ ________________________________

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Ascertain that the plan of operation has been filed with the insurance commissioner.

Review the plan of operation for compliance with applicable statutes, rules and regulations.
## STANDARDS
### OPERATIONS/MANAGEMENT

<table>
<thead>
<tr>
<th>Standard 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The entity reports to the insurance department on an annual basis, each resident of the state for whom the entity has more than one Medicare supplement policy or certificate in force.</td>
</tr>
</tbody>
</table>

**Apply to:** All Medicare supplement carriers  
**Priority:** Essential

### Documents to be Reviewed
- Reporting Medicare supplement policies form  
- Records of issued Medicare supplement policies/certificates  
- Applicable statutes, rules and regulations  

**Others Reviewed**
-  
-  

### NAIC Model References

*Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 9.2 and 22*

### Review Procedures and Criteria

Ascertain that the reporting Medicare supplement policies form has been filed with the insurance commissioner.

Review policy and certificate records to ascertain whether multiple sales of policies or certificates to individual enrollees have been made.

Review the reporting Medicare supplement policies form and compare with multiple sales findings during the examination to ensure that the entity has accurately reported multiple sales.

Verify plans after Jan. 1, 2020 are in compliance with Section 9.2 of Model # 651.

Verify the Benefit Chart of Medicare Supplement Plans Sold on or after Jan. 1, 2020 is correct pursuant to Model #651.

Verify the information provided by the carrier on Plan F or High Deductible F is correct pursuant to Model #651, for plans issued on or after Jan. 1, 2020.

Verify the information provided by the carrier on Plan G or High Deductible G is correct pursuant to Model #651, for plans issued on or after Jan. 1, 2020.
### STANDARDS
**OPERATIONS/MANAGEMENT**

<table>
<thead>
<tr>
<th>Standard 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>The entity does not provide producer compensation that encourages replacement sales.</td>
</tr>
</tbody>
</table>

**Apply to:** All Medicare supplement carriers

**Priority:** Essential

**Documents to be Reviewed**

- Producer manuals
- Producer compensation agreements
- Applicable statutes, rules and regulations

**Others Reviewed**

- _________________________________________
- _________________________________________

**NAIC Model References**

*Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 16*

**Review Procedures and Criteria**

Review procedures, producer compensation agreements and producer manuals to ascertain whether the entity’s standards for producer compensation are in compliance with applicable statutes, rules and regulations concerning replacement sales.
B. Complaint Handling

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

C. Marketing and Sales

1. Purpose

The marketing and sales portion of the examination is designed to evaluate the representations made by the entity about its product(s). Typically, it is not based on sampling techniques, but sampling may be used as a review tool. The areas to be considered in this kind of review include all documented, verbal and electronic advertising and sales materials. The entity’s website that informs about Medicare supplement availability and/or benefits, would be considered advertising and should be reviewed for accuracy.

2. Techniques

This area of review should include all advertising and sales material, including Internet advertising, and all producer sales training materials to determine compliance with applicable statutes, rules and regulations. Information from other jurisdictions may be reviewed, if appropriate. The examiner may contact policyholders, producers and others to verify the accuracy of the information provided or to obtain additional information. The examiner should be familiar with outlines of coverage and replacement regulations. Policyholder records are a good source for detection of multiple issues of Medicare supplement policies. Suitability should be considered in reviewing the entity’s sales and marketing practices.

The entity must have procedures in place to establish and at all times maintain a system of control over the content, form and method of dissemination of its advertisements. All advertisements maintained by, or for, and authorized by the entity are the responsibility of the entity.

The same statutes, rules and regulations (such as the Unfair Trade Practices Act (#880)) that apply to conventional advertising also apply to Internet advertising. When the examiner is reviewing an entity’s Internet advertisements, it is important to also review the safeguards implemented by the entity.

All advertisements are required to be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently clear to avoid deception. The advertisement must not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive must be determined when reviewing the overall impression that the advertisement reasonably may be expected to create upon a person of average education or intelligence with the segment of the public to which the advertisement is directed.

Ensure that the entity actively offers all its Medicare supplement products to eligible individuals. The company should not engage in marketing practices such as discriminatory commission levels or references to health conditions that discourage individuals with less favorable risk characteristics from seeking or obtaining coverage.

Determine whether producer training materials require the producer to report all sales of Medicare supplement policies and/or certificates.

Ascertain that the entity has procedures for distributing to producers and other company personnel any bulletins issued by state or federal regulators.
Ensure that the entity prohibits the sale of Medicare supplement policies or certificates to people enrolled in a Medicare Advantage or private fee-for-service plans.

Ensure that the entity prohibits the sale of a Medicare supplement policy/certificate to an individual already covered under such a policy, unless the new policy/certificate is a replacement policy/certificate.

Ensure that producer commission schedules do not encourage replacement sales or sales of more than one Medicare supplement policy/certificate to an individual, or discourage eligible individuals with unfavorable risk characteristics.

Ensure that the entity offers to all eligible individuals all the Medicare supplement products it sells.

Determine whether individuals in the state have been eligible for guaranteed issue (was previously hyphenated, changed to guaranteed issue without a hyphen) because of termination of Medicare business by managed care organizations, and review company practices with respect to eligible individuals.

Determine whether individuals in the state have been eligible for guaranteed issue for other situations as described in NAIC Model References Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 12.

Review entity communications to company personnel, producers and applicants about open enrollment and guaranteed-issue rights.

3. Tests and Standards

The marketing and sales review includes, but is not limited to, the following standards addressing various aspects of the marketing and sales function. The sequence of the standards listed here does not indicate the priority of the standard.
STANDARDS  
MARKETING AND SALES

<table>
<thead>
<tr>
<th>Standard 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Entity rules concerning replacement are in compliance with applicable statutes, rules and regulations.</strong></td>
</tr>
</tbody>
</table>

**Apply to:** All Medicare supplement products

**Priority:** Essential

**Documents to be Reviewed**

- ____ Bulletins, newsletters and memos
- ____ Replacement register
- ____ Underwriting guidelines and files
- ____ Replacement comparison forms (if external replacement)
- ____ Applicable statutes, rules and regulations

**Others Reviewed**

- ____ _________________________________________
- ____ _________________________________________

**NAIC Model References**

*Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651)*

**Review Procedures and Criteria**

Review replacement register to see if it is cross-indexed by producer and entity to determine if the entity has been targeted for replacements by a producer (internal or external).

Ensure that the application or other form asks whether the policy or certificate is intended to replace or add to any coverage currently in force.

Ensure that the application or other form asks all the questions required by state law to be asked.

Determine if the entity permits multiple sales of Medicare supplement policies to the same person.

Using a random selection of policyholders, have the entity run a policyholder/certificateholder history to identify the number of policies or certificates sold to those individuals.

Determine if underwriting guidelines place limitations on multiple sales; i.e. limits on coverage, determination of suitability, detection of predatory sales practices, etc.

Ensure that the entity, when determining whether a sale involves replacement, furnishes to the applicant prior to policy/certificate issue, or at the time of issue in the case of a direct response sale, the required notice concerning replacement of Medicare supplement coverage, obtains the signatures required by state law, and maintains one copy of the signed notice on file.

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Determine whether marketing materials encourage multiple issues of policies, for example, use of existing policyholder/certificateholder list for additional sales of similar products to those held, birth date solicitations, scare tactics, etc.

Determine if negative enrollment practices are permitted and used.

Determine if the entity has a system to discourage “over-insurance,” as defined in the entity’s underwriting requirements, of policyholders/certificateholders.

Determine whether individuals in the state have been eligible for guaranteed issue (was previously hyphenated, changed to guaranteed issue without a hyphen) because of terminations of Medicare business by managed care organizations, and review entity practices with respect to eligible individuals.

Review entity communications to company personnel, producers and applicants about open enrollment and guaranteed-issue rights.

Determine that the regulated entity, upon replacement, does not impose any waiting periods, elimination periods or probationary periods in their replacement policies unless the replaced individual had not satisfied their six-month (six month was previously unhyphenated), preexisting condition period under their prior coverage.
STANDARDS
MARKETING AND SALES

Standard 3
The entity obtains receipts from applicants verifying that the outline of coverage has been received and that it is the outline of the policy for which the applicant has applied.

Apply to: All Medicare supplement carriers

Priority: Essential

Documents to be Reviewed

_____ Application files

_____ Outlines of Coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 17

Review Procedures and Criteria

Verify through signed receipts that outlines of coverage have been provided to applicants prior to the sale of a policy or certificate.

Verify that the outline of coverage provided reflects the benefits of the policy for which the applicant applied, and, if not, that the applicant has been provided with a copy of the correct outline of coverage and the required disclosure concerning the substitution.
STANDARDS
MARKETING AND SALES

Standard 4
The Guide to Health Insurance for People with Medicare is provided to the applicant within the time frame required by law and is in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

____ Application files

____ Underwriting files

____ Guide to Health Insurance for People with Medicare

____ Applicable statutes, rules and regulations

Others Reviewed

____ ________________________________

____ ________________________________

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 17

Review Procedures and Criteria

Verify that the Guide to Health Insurance for People with Medicare was received by the applicant, by ensuring that the receipt for the guide contains the signature of the applicant.

Ensure that the applicant was provided with a copy of the guide prior to policy issuance or at the time of issuance, as required by state law.

Ensure that the guide was provided to the applicant within the time frame specified by state law.

Ensure that the guide is provided in the required format.
STANDARDS
MARKETING AND SALES

Standard 5
The entity maintains a system of control over the content, form and method of dissemination of all of its Medicare supplement advertisements.

Apply to: All Medicare supplement products
Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials
_____ Producers’ advertising and sales materials
_____ Guide to Health Insurance for People with Medicare
_____ Outlines of coverage
_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________
_____ _________________________________________

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660)

Review Procedures and Criteria

Ensure that the entity retains responsibility for all advertisements (as the term “advertisement” is defined by state law) regardless of by whom documented, created, designed, (comma inserted after designed,) or presented.
STANDARDS
MARKETING AND SALES

Standard 8
Advertisements truthfully represent the Medicare supplement coverage being marketed.

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers’ advertising and sales materials

_____ Guide to Health Insurance for People with Medicare

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Sections 6 and 7
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not contain words or phrases such as “all,” “full,” “complete,” “comprehensive,” “unlimited,” “up to,” “as high as,” “this policy pays all that Medicare doesn’t” or similar words or phrases in a manner that exaggerates any benefit beyond the terms of the policy.

Advertisements that are invitations to contract should:

• Disclose exceptions, reductions and limitations affecting the basic provisions of the policy;
• If a preexisting conditions limitation applies, ask a question immediately above the signature line concerning the applicant’s understanding of the limitation; and
• Disclose renewability, modification, cancellability, termination, losses covered and premium changes due to age or other reasons in a manner that does not minimize or obscure the qualifying conditions.

Ensure that if the policy is not guaranteed issue (was previously hyphenated, changed to guaranteed issue without a hyphen) or if a preexisting conditions limitation applies, the advertisement does not state or imply that health history will not affect the issuance of the policy or payment of a claim under the policy.
Ensure that provisions that are negative in nature, such as a preexisting conditions limitation, are presented in a negative light and that if the advertisement is an invitation to contract, the term “preexisting conditions limitation,” if used, is defined.

Ensure that advertisements do not state or imply that claim settlements are “liberal” or “generous,” or words of similar import, and do not mislead by quoting unusual claims that may have been paid.
## Standards for Marketing and Sales

### Standard 9

**Testimonials comply with applicable statutes, rules and regulations.**

| Apply to: | All Medicare supplement products |
| Priority: | Essential |

### Documents to be Reviewed

- All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials
- Producers’ advertising and sales materials
- Applicable statutes, rules and regulations

### Others Reviewed

- __________
- __________

### NAIC Model References

- *NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines*, Section 8 (#660)
- *Unfair Trade Practices Act* (#880)

### Review Procedures and Criteria

Ensure that testimonials used in advertising are genuine, represent the current opinion of the author, are applicable to the policy advertised, are accurately reproduced, *(comma inserted after reproduced,)* and otherwise comply with all provisions of state law concerning the use of testimonials.

Ensure that the use of a spokesperson complies with all provisions of state law concerning disclosure of the interests of the spokesperson.
STANDARDS  
MARKETING AND SALES

| Standard 12 | Advertisements do not imply licensing of the entity beyond the jurisdiction in which the entity is licensed or imply a status with any governmental entity. |

Apply to: All Medicare supplement products

Priority: Essential

Documents to be Reviewed

_____ All entity advertising and sales materials, including radio and audiovisual items, such as TV commercials, Internet sites, telemarketing scripts and pictorial materials

_____ Producers’ advertising and sales materials

_____ Guide to Health Insurance for People with Medicare

_____ Outlines of coverage

_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

NAIC Model Rules Governing Advertisements of Medicare Supplement Insurance with Interpretive Guidelines (#660), Section 11
Unfair Trade Practices Act (#880)

Review Procedures and Criteria

Ensure that advertisements do not imply that the entity is licensed in jurisdictions other than that in which it is licensed.

Ensure that advertisements do not imply that the entity’s products are approved, endorsed, (comma inserted after endorsed,) or accredited, or connected with any governmental entity.
D. Producer Licensing

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

E. Policyholder Service

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

F. Underwriting and Rating

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

G. Claims

Use the standards for this business area that are listed in Chapter 20—General Examination Standards.

H. Grievance Procedures

1. Purpose

The grievance procedures portion of the examination is designed to evaluate how well the Medicare Select carrier handles grievances.

A “grievance” means dissatisfaction in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network provider.

Note that these definitions may not include all documented communications that the company tracks as “complaints” under the definition of complaint.

The examiner should review the company procedures for processing grievances. Specific problem areas may necessitate an overall review of a particular segment of the company’s operation.

2. Techniques

A review of grievance procedures should incorporate consumer and provider appeals, consumer direct grievances to the company and those grievances filed with the insurance department. The company should reconcile the company grievance register with a list of grievances from the insurance department. A random sample of grievances and appeals should be selected for review from the company’s grievance register.

The company’s documented grievance procedures should be reviewed. Determine how those procedures are communicated to plan members within membership materials and upon receipt of appeals and grievances.

The examiner should review the frequency of similar grievances and be aware of any pattern of specific types of grievance. Should the type of grievance noted be cause for unusual concern, specific measures should be instituted to investigate other areas of a company’s operation. This may include modifying the scope of examination to examine specific company behavior.
STANDARDS
GRIEVANCE PROCEDURES

<table>
<thead>
<tr>
<th>Standard 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>The entity defines as a grievance any dissatisfaction expressed in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network.</td>
</tr>
</tbody>
</table>

**Apply to:** All Medicare Select carriers

**Priority:** Essential

**Documents to be Reviewed**

- [ ] Sample documents and files, including electronic correspondence
- [ ] Outlines of coverage
- [ ] Policies and/or certificates of coverage
- [ ] Contracts
- [ ] Grievance procedures
- [ ] Applicable statutes, rules and regulations

**Others Reviewed**

- [ ]
- [ ]

**NAIC Model References**

*Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10*

**Review Procedures and Criteria**

Review the contracts, outlines of coverage, grievance procedures, sample grievance files and disclosures to determine if the company is correctly defining “grievance.”
STANDARDS
GRIEVANCE PROCEDURES

<table>
<thead>
<tr>
<th>Standard 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The entity develops documented grievance procedures that comply with applicable statutes, rules and regulations, and provides enrollees with a copy of its grievance procedures.</td>
</tr>
</tbody>
</table>

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

— Procedures manuals
— Policies and/or certificates of coverage
— Outlines of coverage
— All forms used to process a grievance
— Applicable statutes, rules and regulations

Others Reviewed

— _________________________________________
— _________________________________________

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Determine if the entity provides grievance registration information to the policyholder at the time of the issuance of a policy or certificate.

Determine if the entity has procedures to ensure that a copy of its grievance procedures is provided to any enrollee or prospective enrollee upon request.

Determine if the entity includes a copy of its grievance procedures in its policies, certificates (if applicable) and outlines of coverage.

Review the disclosure form(s) to determine if a description of the entity’s grievances procedures is included.

Review the entity’s grievance procedures to ensure that the procedures are aimed at mutual agreement for settlement and that, if applicable, any arbitration procedures are disclosed.
STANDARDS
GRIEVANCE PROCEDURES

Standard 3
The entity documents, resolves and records grievances in compliance with applicable statutes, rules and regulations, and their contract language.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

- Entity’s grievance handling policies and procedures
- Sample of grievance files
- Outlines of coverage
- Policies and/or certificates of coverage
- Applicable statutes, rules and regulations

Others Reviewed

- _________________________________________
- _________________________________________

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

The entity maintains a grievance register that documents all grievances received during the calendar year.

The entity reports all grievances to the insurance commissioner annually, with the information and in the format required by law.

The entity complies with its documented procedures when receiving and resolving grievances.

The entity considers grievances in a timely manner and transmits grievances to appropriate decision-makers.

The entity takes corrective action promptly on valid grievances.

The entity promptly notifies concerned parties of the results of a grievance review.
STANDARDS
GRIEVANCE PROCEDURES

Standard 4
The company provides to any enrollee, who has filed a grievance, detailed information concerning its grievance and appeal procedures, how to use them and how to notify the insurance department, if applicable.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Procedures for processing grievances
_____ Grievance forms and other information provided to an enrollee at the time the enrollee files a grievance
_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________
_____ _________________________________________

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Review the entity’s procedures for processing a grievance to determine if the required disclosures are provided.

Review the entity’s procedures to determine if, when required by state law, the enrollee is advised of the right to contact the insurance department.

Review the grievance procedures to ensure that a provision is made for grievance registration information to be provided at the time of issue and upon request.

As grievances are detected throughout the entire examination, ensure that they have been handled and recorded properly.
STANDARDS
GRIEVANCE PROCEDURES

<table>
<thead>
<tr>
<th>Standard 5</th>
<th>The company reports its grievance procedures to the insurance commissioner on an annual basis.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Apply to:</strong></td>
<td>All Medicare Select carriers</td>
</tr>
<tr>
<td><strong>Priority:</strong></td>
<td>Essential</td>
</tr>
</tbody>
</table>

Documents to be Reviewed

- _____ Procedures for processing grievances
- _____ Procedures for annually reporting grievances to the insurance commissioner
- _____ Applicable statutes, rules and regulations

Others Reviewed

- _____ ___________________________________________________________________________
- _____ ___________________________________________________________________________

NAIC Model References

*Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10*

Review Procedures and Criteria

The examiner should determine whether the entity has procedures in place for recording and reporting grievances to the insurance commissioner.

The examiner should ensure that the entity has reported on an annual basis and in the format prescribed by the insurance commissioner, the number of grievances filed in the previous year and a summary of the subject, nature and resolution of such grievances.
I. Network Adequacy

1. Purpose

The network adequacy portion of the examination is designed to ensure that companies offering Medicare Select plans maintain service networks that are sufficient to ensure that all services are accessible without unreasonable delay. The standards require companies to ensure the adequacy, accessibility and quality of health care services offered through their service networks.

The areas to be considered in this kind of review include the company’s plan of operation and measures used by the company to analyze network sufficiency, contracts with participating providers and intermediaries, and ongoing oversight and assessment of access issues.

2. Techniques

To evaluate network adequacy standards, it is necessary for examiners to request from the company a statement or map that reasonably describes the service area. Additional items for review include a list and description by specialty of network providers and facilities. The examiner should determine whether the company has conducted studies to measure waiting times for appointments and other studies that measure the sufficiency and adequacy of the network. The examiner should also determine how the company arranges for covered services that cannot be provided within the network. Examiners should request the carrier’s documented selection standards for providers and review the plan of operation. Using the list of providers and facilities, examiners should request a sample of specific provider contracts. The review of provider contracts should include an evaluation of compliance with filing requirements and adherence to patient-protection requirements. In addition to direct contracts with providers and facilities, examiners should review the documented guidelines and contractual requirements established for intermediary contracts. Availability of emergency care facilities and procedures should be evaluated. Examiners should obtain verification that accurate provider directories are provided upon enrollment, are updated and dispersed periodically, and that the company has filed its updated list of network providers with the insurance commissioner on a quarterly basis. Another area for review includes grievances related to provider access issues.

3. Tests and Standards

The network adequacy review includes, but is not limited to, the following standards related to the adequacy of the health carrier’s provider network. The sequence of the standards listed here does not indicate priority of the standard.
Standard I
The company demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to ensure that all services to enrollees will be accessible without unreasonable delay.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Selection criteria
_____ Documents related to physician recruitment
_____ Provider directory
_____ List of providers by specialty
_____ Reports of out-of-network service denials
_____ Company policy for in-network/out-of-network coverage levels
_____ Provider/enrollee location reports by geographic location
_____ Any policies or incentives that restrict access to subsets of network specialists
_____ Computer tools used to assess the network’s adequacy
_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________
_____ _________________________________________

NAIC Model References

*Health Benefit Plan Network Access and Adequacy Model Act (#74), Section 5*
*Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10*

Review Procedures and Criteria

Reasonable criteria include, but are not limited to:
- Ratios of providers (primary care providers and specialty providers) to enrollees;
- Geographic accessibility, as measured by the reasonable proximity of participating providers to the business or personal residence of enrollees;
- Waiting times for appointments;
- Hours of operation; and
• Volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

The company develops and complies with documented policies and procedures specifying when the company will pay for out-of-area and out-of-network services that are covered by the policy, or as are required by state law. In any case where the company is required to cover services and it has an insufficient number or type of participating providers to provide a covered benefit, the company shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit were obtained from participating providers or (comma removed after providers) shall make other arrangements acceptable to the insurance commissioner.

The company establishes and maintains adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residences of enrollees. In determining whether a company has complied with this provision, the insurance commissioner shall give due consideration to the relative availability of health care providers in the enrollees’ service area.

The company demonstrates that it monitors, on an ongoing basis, its providers, provider groups and intermediaries with which it contracts to ensure the ability, clinical capacity, financial capability and legal authority, including applicable licensure requirements, to furnish all contracted benefits to enrollees. There are standards pertinent to provider licensing in Section J. Provider Credentialing of this chapter.

The company complies with all applicable provisions of state law not expressly covered by any other of these standards.
STANDARDS
NETWORK ADEQUACY

<table>
<thead>
<tr>
<th>Standard 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The company has a plan of operation for each plan offered in the state, and files updates whenever it makes a material change to an existing plan.</td>
</tr>
</tbody>
</table>

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

- Plan of operation
- Applicable statutes, rules and regulations

Others Reviewed

NAIC Model References

*Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10*

Review Procedures and Criteria

The plan of operation contains evidence of at least the following:

- Covered services are available and accessible though network providers;
- Either the number of network providers in the service area is sufficient to deliver adequately all services, or that the company makes appropriate referrals for provision of such services outside its network;
- There are documented agreements with network providers describing specific responsibilities;
- Emergency care is available 24 hours per day, 7 days per week;
- The provider agreements prohibit the provider from billing or otherwise seeking reimbursement from enrollees, other than for coinsurance, copayments or supplemental charges;
- A description or map of the service area;
- A description of the company’s grievance procedures;
- A description of the quality assurance program, including the formal organizational structure, the criteria for selection, retention and removal of network providers and the procedures for evaluating quality of care and taking corrective action when warranted;
- A list and description of network providers, by specialty; and
- Any other information requested by the insurance commissioner.
STANDARDS
NETWORK ADEQUACY

<table>
<thead>
<tr>
<th>Standard 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>The company ensures that enrollees have access to emergency services 24 hours per day, 7 days per week within its network and provides coverage for urgently needed services and emergency services outside of the service area.</td>
</tr>
</tbody>
</table>

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

- Provider manuals and contracts
- Policy forms
- Plan of operation
- Applicable statutes, rules and regulations

Others Reviewed

- _________________________________________
- _________________________________________

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Within the network, the company operates or contracts with facilities to provide enrollees with access to emergency and urgently needed services on a 24 hours per day, 7 day per week basis.

The company covers in full, emergency services or services that are immediately required for an unforeseen illness, injury or condition, when it is not reasonable to obtain services through network providers.
STANDARDS
NETWORK ADEQUACY

<table>
<thead>
<tr>
<th>Standard 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>The company files with the insurance commissioner all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries.</td>
</tr>
</tbody>
</table>

**Apply to:** Medicare Select carriers

**Priority:** Essential

**Documents to be Reviewed**

- Provider manuals
- Sample of provider contracts
- Credentialing file
- Directory of providers
- Applicable statutes, rules and regulations

**Others Reviewed**

- _________________________________________
- _________________________________________

**NAIC Model References**

*Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10.*

**Review Procedures and Criteria**

Determine if the provider contracts and endorsements have been filed (if required by state law).

Review provider contracts to determine if the provider is listed in the directory and to determine if credentialing is up to date *(hyphens removed from up to date).*
STANDARDS
NETWORK ADEQUACY

<table>
<thead>
<tr>
<th>Standard 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>The company executes with each participating provider documented agreements that are in compliance with applicable statutes, rules and regulations.</td>
</tr>
</tbody>
</table>

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

- Provider manuals, contracts and intermediary subcontracts
- Applicable statutes, rules and regulations

Others Reviewed

- _________________________________________
- _________________________________________

NAIC Model References

*Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10.*

Review Procedures and Criteria

Every contract between a Medicare Select carrier and a participating provider or provider group contains a “hold harmless” provision specifying protection for enrollees from being billed by providers for other than coinsurance, copayments or supplemental charges.

The contract provides an extension of benefits beyond the period during which the policy was in force if *(comma removed after in-force)* the enrollee suffers continuous total disability after contract termination.
STANDARDS
NETWORK ADEQUACY

Standard 7
The company provides at enrollment a directory of providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory and files the directory with the insurance commissioner.

Apply to: Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Provider directory and updates
_____ Provider contracts
_____ Credentialing and re-credentialing documentation
_____ Internet directory
_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________

_____ _________________________________________

NAIC Model References

Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), Section 10

Review Procedures and Criteria

Request information regarding the carrier’s frequency of updates to the provider directory.

Verify that the company is providing directory updates to enrollees and to the insurance commissioner at the frequency required by state law.

Review how provider data is maintained. If the provider directory is not produced from the same system(s) that handles the administration functions, determine if the data is maintained consistently between systems.

If the provider directory is made available on the carriers’ website, verify that a paper version can be requested, as an option, by the enrollee.
J. Provider Credentialing

1. Purpose

The provider credentialing portion of the examination is designed to ensure that companies offering Medicare Select plans have verification programs to ensure that participating health care professionals meet minimum specific standards of professional qualification.

The areas to be considered in this kind of review include the company’s documented credentialing and re-credentialing policies and procedures, the scope and timeliness of verifications, the role of health professionals in ensuring accuracy and the oversight of any delegated verification functions.

2. Techniques

Prior to reviewing records for specific providers, examiners should request all documented credentialing procedures from the company. Examiners should determine the composition of the carrier’s credentialing committee. Examiners should use the company’s provider directory to select a sample of specific provider credential files, drawing from a variety of provider types and facilities. For each provider selected, the examiner should request:

   a. The provider application;
   b. Credentialing verification materials, including materials obtained through primary and secondary sources;
   c. Updates to credentialing information; and
   d. Copies of correspondence to providers that relates to the credentialing process.

Examiners should determine how the credentialing committee permits providers to correct information and provide additional information for reconsideration. In the event the credentialing process is subcontracted, examiners should determine whether the contracting entity is following applicable standards.

3. Tests and Standards

The provider credentialing review includes, but is not limited to, the following standards related to the adequacy of the health carrier’s provider credentialing and contracting processes. The sequence of the standards listed here does not indicate priority of the standard.
STANDARDS
PROVIDER CREDENTIALING

Standard 1
The company establishes and maintains a program for credentialing and re-credentialing of providers in compliance with applicable statutes, rules and regulations.

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

_____ Credentialing plan
_____ Credentialing policies and procedures
_____ Minutes of the credentialing committee
_____ Credentialing plan evaluation reports (if any)
_____ Applicable statutes, rules and regulations

Others Reviewed

_____ _________________________________________
_____ _________________________________________

NAIC Model References

Health Care Professional Credentialing Verification Model Act (#70), Section 5

Review Procedures and Criteria

The company establishes documented policies and procedures for credentialing and re-credentialing of all health care professionals with whom the company contracts and applies those standards consistently.

The company ensures that the carrier’s medical director or other designated health care professional has the responsibility for, and participates in, the health care professional credentialing verification process.

The company establishes a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documents in order to make decisions regarding credentialing verification.

The company makes all application and credentialing verification policies and procedures available for review by the applying health care professional upon written request.

The company keeps confidential all information obtained in the credentialing verification process, except as otherwise provided by state law.

The company retains all records and documents relating to a health care professional’s credentialing verification process for at least the number of years required by state law.
The company’s policies and procedures for credentialing and re-credentialing of providers are in compliance with state law.
K. Quality Assessment and Improvement

1. Purpose

The quality assessment portion of the examination is designed to ensure that companies offering Medicare Select plans have quality assessment programs in place that enable the company to evaluate, maintain and, when required by state law, improve the quality of health care services provided to enrollees. For Medicare Select plans that limit access to health care services to a closed network, the standards also require a quality improvement program with specific goals and strategies for measuring progress toward those goals.

The areas to be considered in this kind of review include the company’s documented quality assessment and improvement policies and procedures, annual certifications, reporting of disciplined providers, communications with members about the program and oversight of delegated quality-related functions.

2. Techniques

In some jurisdictions, the quality assessment and improvement function may be monitored jointly by the Department of Insurance and Department of Health (or similar agency). To evaluate quality assessment and improvement activities, examiners should request information relative to the composition of the quality assessment and improvement committee. Examiners should also determine frequency of quality assessment and improvement meetings. To obtain an accurate assessment of a company’s quality assessment and improvement program, it is advisable to review quality assessment and improvement committee meeting minutes for all meetings conducted during the examination period. Ascertain whether the quality assessment program reasonably encompasses all aspects of the covered health care services. Determine whether the carrier has obtained certification from a nationally recognized accreditation entity. Determine which standards will be met by virtue of the certification process. Examiners should evaluate the process by which quality assessment and improvement information and directives are communicated to network providers. Review procedures such as peer review, for including network providers in the quality assessment and improvement process. Ascertain whether outcome-based goals and objectives are being monitored and met.

3. Tests and Standards

The quality assessment and improvement review includes, but is not limited to, the following standards related to the assessment and improvement activities conducted by the health carrier. The sequence of the standards listed here does not indicate priority of the standard.
STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

<table>
<thead>
<tr>
<th>Standard 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>The company develops and maintains a quality assessment program that is in compliance with state law to evaluate, maintain and improve the quality of health services provided to enrollees.</td>
</tr>
</tbody>
</table>

**Apply to:** All Medicare Select carriers

**Priority:** Essential

**Documents to be Reviewed**

- Quality assessment policies and procedures
- Quality assessment plan (if any)
- Minutes of the quality assessment committee
- Minutes of the board of directors
- Evaluations of the quality assessment program
- Job descriptions of the chief medical officer or clinical director
- Applicable statutes, rules and regulations

**Others Reviewed**

- ________________
- ________________

**NAIC Model References**

*Quality Assessment and Improvement Model Act (#71)*

**Review Procedures and Criteria**

The company develops a quality assessment program and procedures to ensure effective corporate oversight of the program.

The company develops and maintains the infrastructure and disclosure systems necessary to measure the quality of health care services provided to enrollees on a regular basis and appropriate to the types of plans offered by the company.

The company establishes a system designed to assess the quality of health care provided to enrollees. The system includes systematic collection, analysis and reporting of relevant data in accordance with statutory and regulatory requirements.

The company communicates findings in a timely manner to applicable regulatory agencies, providers and consumers as provided for by state law.
The company appoints a chief medical officer or clinical director to have primary responsibility for the quality assessment activities carried out by, or on behalf of, the company (Quality Assessment and Improvement Model Act (#71), Section 7).

The chief medical officer or clinical director approves the documented quality assessment program, periodically reviews and revises the program documents and acts to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director reviews reports of quality assessment activities (Quality Assessment and Improvement Model Act (#71), Section 7).

The company has an appropriate documented policy to ensure the confidentiality of an enrollee’s health information used in the company’s quality assessment programs (Quality Assessment and Improvement Model Act (#71), Section 9).

The company complies with all applicable provisions of state law not expressly covered by any other of these standards.
STANDARDS
QUALITY ASSESSMENT AND IMPROVEMENT

<table>
<thead>
<tr>
<th>Standard 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The company develops and maintains a quality improvement program that is in compliance with applicable statutes, rules and regulations to evaluate, maintain and improve the quality of health services provided to enrollees.</td>
</tr>
</tbody>
</table>

Apply to: All Medicare Select carriers

Priority: Essential

Documents to be Reviewed

- Quality improvement policies and procedures
- Quality improvement plan
- Minutes of the quality improvement committee
- Minutes of the board of directors
- Evaluations of the quality improvement program
- Job descriptions of the chief medical officer or clinical director
- Applicable statutes, rules and regulations

Others Reviewed

- 
- 

NAIC Model References

*Quality Assessment and Improvement Model Act (#71)*

Review Procedures and Criteria

The company develops a quality improvement program and procedures to ensure effective corporate oversight of the program (*Quality Assessment and Improvement Model Act (#71), Section 7*).

The company develops and maintains the infrastructure and disclosure systems necessary to measure, on a regular basis, the quality of health care services provided to covered persons and appropriate to the types of plans offered by the company.

The company establishes a system designed to improve the quality and outcomes of health care provided to enrollees. The system includes systematic collection, analysis and reporting of relevant data in accordance with statutory and regulatory requirements (*Quality Assessment and Improvement Model Act (#71), Section 6C*).
The company has a documented quality improvement plan that includes:

- A statement of the objectives, lines of authority and accountability, evaluation tools, data collection responsibilities, performance improvement activities and annual effectiveness review of the program;
- Intent to analyze processes and outcomes of care to discern the causes of variation;
- Identification of the targeted diagnoses and treatments to be reviewed each year;
- Methods to analyze quality, including collection and analysis of information on:
  - Over- or under-utilization of services;
  - Evaluation of courses of treatment and outcome of care; and
  - Collection and analysis of information specific to an enrollee or provider gathered from multiple sources and documentation of both the satisfaction and grievances of the enrollee(s);
- A method to compare program findings with past performance and internal goals and external standards;
- Methods for:
  - Measuring the performance of participating providers;
  - Conducting peer review activities to identify practices that do not meet the company’s standards;
  - Taking action to correct deficiencies;
  - Monitoring participating providers to determine whether they have implemented corrective action; and
  - Taking appropriate action when they have not;
- A plan to utilize treatment protocols and practice parameters developed with clinical input and using evaluations described above or acquired treatment protocols and providing participating providers with sufficient information about the protocols to meet the standards; and
- Evaluating access to care for covered persons according to the state’s standards, and a strategy for integrating public health goals with services offered under the plan, including a description of good faith efforts to communicate with public health agencies.

The company establishes an internal system to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns and foster an environment of continuous quality improvement (Quality Assessment and Improvement Model Act (#71), Section 6A).

The company ensures that participating providers have the opportunity to participate in developing, implementing and evaluating the quality improvement system (Quality Assessment and Improvement Model Act (#71), Section 6D).

The company provides enrollees with the opportunity to comment on the quality improvement process (Quality Assessment and Improvement Model Act (#71), Section 6E).

The company uses the findings generated by the system to work on a continuing basis with participating providers and other staff to improve the health care delivered to enrollees (Quality Assessment and Improvement Model Act (#71), Section 6B).

The company appoints a chief medical officer or clinical director to have primary responsibility for the quality improvement activities carried out by, or on behalf of, the health carrier (Quality Assessment and Improvement Model Act (#71), Section 7).

The chief medical officer or clinical director approves the documented quality improvement program, periodically reviews and revises the program document and acts to ensure ongoing appropriateness. Not less than semi-annually, the chief medical officer or clinical director reviews reports of quality assessment activities (Quality Assessment and Improvement Model Act (#71), Section 7).

The company has an appropriate documented policy to ensure the confidentiality of an enrollee’s health information used in the company’s quality improvement programs (Quality Assessment and Improvement Model Act (#71), Section 9).
The company complies with all applicable provisions of state law not expressly covered by any other of these standards.
### STANDARDS
#### QUALITY ASSESSMENT AND IMPROVEMENT

<table>
<thead>
<tr>
<th>Standard 3</th>
<th>The company files with the insurance commissioner a documented description, in the prescribed format, of the quality assessment program, which includes a signed certification by a corporate officer of the company that the filing meets the requirements of applicable statutes, rules and regulations.</th>
</tr>
</thead>
</table>

| Apply to: | All Medicare Select carriers |
| Priority: | Essential |

#### Documents to be Reviewed

- [ ] Documented description of the quality assessment program
- [ ] Signed certification by a corporate officer
- [ ] Applicable statutes, rules and regulations

#### Others Reviewed

- [ ] ________________________________
- [ ] ________________________________

#### NAIC Model References

*Quality Assessment and Improvement Model Act (#71), Section 5D*

#### Review Procedures and Criteria

Determine if the forms have been filed.
CMA: combined suggested changes from Consumer Reps, ACLI and Trades/Joint Group

Privacy Protections (D) Working Group Report on Consumer Data Privacy Protections

Exposure Draft
December 7, 2021
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Appendix A: Report on Consumer Data Privacy Protections Page 13
I. Introduction

The Privacy Protections (D) Working Group was appointed in 2019 to review state insurance privacy protections regarding the collection, use, and disclosure of information gathered in connection with insurance transactions and make recommended changes, as needed, to NAIC models addressing privacy protection. This work included the review of an insurer’s use of data collected from a consumer and data supplied to an insurer by a third-party vendor. Rather than focusing on revisions to NAIC models, the main deliverables for 2021 were to set forth a Report on the minimum consumer privacy protections that are appropriate for the business of insurance, after taking into consideration the consumer privacy protections that already exist under applicable state and federal laws.

The Working Group discussed how best to balance the need for information by those conducting the business of insurance and the consumer’s need for fairness in insurance information practices, rights of insurers to use data for legitimate business purposes with consumers’ rights to control what data is used and how it is used. The following privacy protections for consumers were discussed: (1) the right to opt out of data sharing, (2) the right to limit data sharing unless the consumer opts in, (3) the right to correct information, (4) the right to delete information, (5) the right of data portability, (6) the right to restrict the use of data, (7) the right of data ownership, (8) the right of notice, and (9) the right of nondiscrimination and/or non-retaliation.

As a reminder, opting in is not a way the consumer can protect their privacy – it is a way a consumer can waive a privacy protection. The Working Group intended to consolidate (1) and (2) above as a single “right to restrict data sharing, on either an opt-out or an opt-in basis,” however, since these issues were discussed extensively as separate “rights” that for purposes of this Report the issues are being listed separately.

The Working Group received comments from the ACLI, AHIP, APCIA, BCBSA, the Coalition of Health Insurers, NAMIC, MLA, and NAIC consumer representatives Birny Birnbaum, Brenda Cude, Karrol Kitt, and Harry Ting.

II. Overview of Issue

Consumer awareness and regulatory concerns about the use of consumer data by a variety of commercial, financial, and technology companies are increasing. This has led to the adoption of the General Data Protection Regulation (GDPR) in the E.U. and the California Consumer Privacy Act (CCPA) and other state data privacy protection laws in the U.S. Though data privacy concerns extend beyond the insurance sector, the increasing use of data and the passage of these new laws is causing the insurance industry and consumer groups alike to compel Congress to enact federal privacy legislation.

While federal legislative efforts are currently stalled due to other legislative priorities and differing perspectives from consumers and industry on the best path forward, it is likely that Congress will begin focusing on the issue again soon. The current pause provides state insurance regulators an
opportunity to update state privacy protections consistent with the current insurance business environment and potentially forestall or mitigate the impacts of any preemptive federal legislation. State policymakers have also responded to the privacy debate with varying legislative proposals to provide consumers with greater transparency and control over the use of personal information, with California, Virginia, and Colorado being the most recent examples. These comprehensive state data privacy laws each have either entity-level or data-level exemptions for entities subject to or information collected pursuant to the federal Gramm-Leach-Bliley Act (GLBA) and/or the privacy regulations adopted under the Health Insurance Portability and Accountability Act (HIPAA).

III. Summary of Consumer Privacy Protections Provided by NAIC Model Laws

The NAIC has three model laws governing data privacy: Health Information Privacy Model Act (Model #55); NAIC Insurance Information and Privacy Protection Model Act (#670) and Privacy of Consumer Financial and Health Information Regulation (#672), each of which is based upon or influenced by federal privacy laws. The NAIC’s Model #670 contains many of the consumer rights found in these comprehensive state laws, which can be traced back to the Fair Credit Reporting Act (FCRA), and Model #672 is based, in large part, on GLBA and the HIPAA regulations. Generally, insurers and other entities licensed by state departments of insurance have certain exemptions from are carved out of more comprehensive state laws of general applicability. Because of thee exemptions, insurance regulators must be aware when new protections are added to laws applicable to other businesses, especially when these laws address new technologies and ways consumer information is collected and shared, so that comparable protection can be added, as necessary, to the laws governing the insurance industry. Of note, GLBA and HIPAA each set a federal floor for the entities within their scope, upon which states can build. This is what the NAIC did in drafting the Health Information Privacy Model Act (Model #55) and the Privacy of Consumer Financial and Health Information Regulation (Model #672). GLBA applies to the entire insurance industry while HIPAA applies to the health insurance sector and those that collect or use Protected Health Information (PHI).

A. NAIC Insurance Information and Privacy Protection Model Act (Model #670)

The NAIC adopted the NAIC Insurance Information and Privacy Protection Model Act (#670) in 1980 following federal enactment of the Fair Credit Reporting Act in 1970 and the Federal Privacy Act in 1974. This model act establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions by insurance companies, insurance producers and insurance support organizations.

A key aspect of this model is that it establishes a regulatory framework for consumers to: (1) ascertain what information is being or has been collected about them in connection with insurance transactions; (2) obtain access to such information for the purpose of verifying or disputing its
accuracy; (3) limit the disclosure of information collected in connection with insurance transactions; and (4) obtain the reasons for any adverse underwriting decision.

This regulatory framework is facilitated through a requirement that insurers or agents provide a written notice to all applicants and policyholders regarding the insurer’s information practices. The notice must address the following: (1) whether personal information may be collected from persons other than the individual or individuals seeking insurance coverage; (2) the types of personal information that may be collected, the types of sources and investigative techniques that may be used to collect such information; (3) the types of disclosures allowed under the law; (4) a description of the rights established under the law; and (5) notice that information obtained from a report prepared by an insurance support organization may be retained by the insurance support organization and disclosed to other persons.

Of note, the model prohibits disclosure of any personal information about an individual collected or received in connection with an insurance transaction without the individual’s written authorization, subject to limited exceptions. However, some categories of information may be disclosed for marketing purposes if the consumer “has been given an opportunity to indicate that he or she does not want personal information disclosed for marketing purposes and has given no indication that he or she does not want the information disclosed.” Model #670 also provides consumers with the right to request that an insurer provide access to recorded personal information, disclose the identity of the third parties to whom the insurance company disclosed information (if recorded); disclose the source of collected information (if available); and provide procedures by which the consumer may request correction, amendment, or deletion of recorded personal information.

Seventeen (17) states have adopted Model #670: AZ, CA, CT, GA, HI, IL, KS, MA, ME, MN, MT, NV, NJ, NC, OH, OR, and VA.

B. NAIC Health Information Privacy Model Act (Model #55)

The NAIC adopted the Health Information Privacy Model Act (Model #55) following federal adoption of the privacy regulations authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This model sets standards to protect health information from unauthorized collection, use and disclosure by requiring insurance companies to establish procedures for the treatment of all health information by all insurance carriers. The drafters of Model #55 believed it was important that the same rules apply to all lines of insurance, since health insurance carriers are not the only ones that use health information to transact business. For example, health information is necessary for life insurance underwriting, and often essential to property and casualty insurers in settling workers’ compensation claims and personal injury liability claims. Reinsurers also use protected health information write reinsurance.

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The model requires carriers to develop and implement written policies, standards, and procedures for the management of health information, including to guard against the unauthorized collection, use or disclosure of protected health information. It provides consumers with the right to access their protected health information and amend any inaccuracies. The model also requires insurers to obtain written authorization (“opt-in”) before collecting, using, or disclosing protected health information, except when performing limited activities.

Many of the provisions found in Model #55 were later incorporated into the Privacy of Consumer Financial and Health Information Regulation (Model #672).

The following 11 jurisdictions have adopted legislation related to Model #55: CA, CO, DE, KY, LA, ME, MO, ND, RI, SD, TX.

C. NAIC Privacy of Consumer Financial and Health Information Regulation (Model #672)

The NAIC adopted the Privacy of Consumer Financial and Health Information Model Regulation (Model #672) in 2000. The model regulation was drafted to implement the requirements set forth in Title V of GLBA. GLBA imposed privacy and security standards on financial institutions, defined to include insurers and other insurance licensees, and directed state insurance commissioners to adopt certain data privacy and data security regulations. The provisions governing protection of financial information are based on privacy regulations promulgated by federal banking agencies. This model also contains provisions governing protection of health information that were taken directly from Model #55 and from the HIPAA Privacy Rule promulgated by the U.S. Department of Health and Human Services (HHS).

The model regulation provides protection for non-public financial and personal health information about consumers held by insurance companies, agents, and other entities engaged in insurance activities. In general, the model regulation requires insurers to: (1) notify consumers about their privacy policies; (2) give consumers the opportunity to opt-out of prohibit the sharing of their protected non-public financial information with non-affiliated third parties; and (3) obtain affirmative consent from consumers before sharing protected non-public personal health information with any other parties, affiliates, and non-affiliates.

The key difference between the treatment of financial information and health information is that insurers must give consumers the right to “opt out” of the disclosure or sharing of their financial information but insurers must obtain explicit authorization from the consumer (“opt-in”) before sharing health information. Every jurisdiction has a version of this model regulation, although nineteen (19) jurisdictions have only adopted the provisions regarding financial information and not the provisions regarding health information for purposes not within an exemption. Some jurisdictions that have adopted Model #670 have adopted additional provisions from Model #672 by bulletin rather than regulation.
IV. Summary of Health Insurance Portability and Accountability Act (HIPAA)

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which, among other things, authorized the U.S. HHS Department of Health and Human Services to promulgate regulations governing consumer privacy protections. The HIPAA Privacy Rule was finalized in 2000. The rule applies to health plans and health care providers, restricting the permitted uses and disclosure of protected health information. HIPAA preempts state law only to the extent that a covered entity or business associate would find it impossible to comply with both the state and federal requirements.

HIPAA provides individuals the right to (1) access and amend their protected health information, (2) the right to request the restriction of uses and disclosures of protected health information, and (3) the right to receive an accounting of disclosures made to other entities.

A covered entity must obtain the individual’s written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations or otherwise permitted or required by the law. A covered entity is also required to provide notice of its privacy practices.

V. Summary of General Data Protection Regulation (GDPR)

The GDPR became effective in May 2018 and applies to U.S. companies based on whether or not they process data from citizens of the E.U. or are processing data within the E.U. and provided that they have a sufficient nexus with the E.U. over the internet. This law requires companies (referred to as data “controllers”) to obtain explicit consent from consumers to collect their data (“opt in”) along with an explanation of how the data will be used. It also contains standards for safeguarding the data collected. Under the GDPR, a consumer has the following rights: (1) to receive information about the processing of personal data; (2) to obtain access to that personal data; (3) to request that incorrect, inaccurate or incomplete personal data be corrected; (4) to request that personal data be erased when it is no longer needed or if processing it is unlawful; (5) to object to the processing of personal data for marketing purposes or on grounds relating to a consumer’s particular situation; (6) to request the restriction of the processing of personal data in specific cases; (7) to receive personal data in a machine-readable format and the ability to transmit it to another controller, if technically feasible (“data portability”); and (8) to request that decisions based solely on automated processing concerning the consumer or significantly affecting the consumer and based on a consumer’s personal data, are made by human beings or to challenge a decision.

For further clarification - the GDPR does not, necessarily, apply to a company simply because it collects data from citizens of the EU over the internet. Specifically, the company must actively market its products and services to those in the EU. It is a factual determination. For example, routinely shipping goods to the EU, utilizing the French language on the website (in addition to
English) and setting a website up to accept euros would likely result in the GDPR applying to a given company.

VI. Summary of Recently Adopted Consumer Privacy Protection Laws

A. California Consumer Privacy Act (CCPA) and California Privacy Rights Act (CPRA)

In 2018, California became the first U.S. state to adopt a comprehensive privacy law, applicable beyond the insurance industry, imposing broad obligations on businesses to provide consumers with transparency and control of their personal data. The California Consumer Privacy Act (CCPA) became effective in 2020. Since it was adopted, it was amended by the California Privacy Rights Act (CPRA), which becomes effective January 1, 2023. Additionally, the California Attorney General promulgated implementing regulations in 2020.

Scope

The CCPA, as amended by the CPRA (California law) applies to companies doing business in California that collect or process consumers’ personal information and meet one of the following thresholds: (1) has annual gross revenue in excess of $25,000,000 in the preceding calendar year; (2) annually buys, sells, or shares the personal information of 100,000 or more consumers or households; or (3) derives 50% or more of its annual revenue from selling or sharing consumers’ personal information.

Exemptions

The law does not apply to personal information collected, processed, sold, or disclosed pursuant to the federal Gramm-Leach-Bliley Act (GLBA), and its implementing regulations. It also does not apply to protected health information that is governed by the privacy, security, and breach notification rules issued by the U.S. Department of Health and Human Services (HHS). Furthermore, this law contains an entity-level exemption for HIPAA-covered entities or business associates governed by the privacy, security, and breach notification rules issued by HHS.

Consumer Rights

California law provides consumers with the following rights subject to certain limitations: (1) to request deletion of any personal information;\(^1\) (2) to correct inaccurate personal information, taking into account the nature of the personal information and the purposes of the processing of the information; (3) to know about and access the personal information being collected by requesting that the business disclose: the categories and specific pieces of personal information collected, the categories of sources the information was collected from, the business purpose for collecting the information, the categories of third parties with whom the information is shared, and

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\(^1\) And even when information is “deleted,” the CCPA right to deletion allows the business to “maintain a confidential record of deletion requests solely for the purpose of preventing the personal information of a consumer who has submitted a deletion request from being sold, for compliance with laws or for other purposes.”
the specific pieces of personal information that was shared; (4) to request the personal information provided by the consumer in a format that is easily understandable, and to the extent technically feasible, in a structured, commonly used, machine-readable format that may also be transmitted to another entity at the consumer’s request without hindrance; (5) to know what personal information is sold or shared and to whom; (6) to opt out of the sale or sharing of personal information; (7) to limit the use and disclosure of sensitive personal information aside from permissible enumerated purposes; and (7) to not be retaliated against for requesting to opt out or exercise other rights under the law.

Business Obligations

The law imposes the following obligations on all covered businesses: (1) prohibits retaining a consumer’s personal information for longer than reasonably necessary for the disclosed purpose; (2) requires implementing reasonable security procedures and practices; (3) requires notice of the following: collection of personal information, including sensitive personal information, retention of information, right to opt out of sale and sharing, and financial incentives; (4) prohibits using sensitive personal information outside of enumerated purposes when a consumer has requested not to use or disclose such data.

Enforcement

The CPRA amends the CCPA by placing administrative enforcement authority with the California Privacy Protection Agency, a new state agency created by the CPRA. Under the CPRA, the California Attorney General retains authority for seeking injunctions and civil penalties. Additionally, if personal information is breached, the consumer can pursue a private civil action against the company.

B. Colorado Privacy Act (CPA)

Scope

The Colorado Privacy Act (CPA) takes effect on July 1, 2023. Subject to certain limitations this law applies to entities that conduct business in Colorado or produce or deliver commercial products or services intentionally targeted to residents of Colorado and satisfy one of the following thresholds: (1) controls or processes the personal data of 100,000 or more consumers in a year; or (2) derives revenue or receives a discount on the price of goods or services from the sale of personal data and processes or controls the personal data of 25,000 or more consumers. The law defines “controllers” as those that “determine the purposes for and means of processing personal data” and defines “processors” as those that “process data on behalf of a controller.”
Exemptions

The law contains data-based exemptions (rather than entity-level exemptions) for protected health information collected, processed, or stored by HIPAA-covered entities and their business associates, and information and documents created by a HIPAA-covered entity for purposes of complying with HIPAA and its implementing regulations. Additionally, the law contains an exemption for any personal data collected, processed, sold, or disclosed pursuant to the Gramm-Leach-Bliley Act (GLBA), and implementing regulations, if such collection, processing, sale, or disclosure is in compliance with that law.

Consumer Rights

The CPA provides consumers with the following rights: (1) to opt out of targeted advertising, sale of personal data, and profiling; (2) to confirm whether a controller is processing the consumer’s personal data and the right to access such data; (3) to correct inaccuracies in personal data; (4) to delete personal data; and (5) to obtain the personal data in a portable and readily usable format that allows the consumer to transmit the data to another entity.

Business Obligations

The CPA imposes affirmative obligations on controllers, including the following: (1) provide consumers with an accessible, clear, and meaningful privacy notice; (2) specify the express purposes for which personal data are collected and processed; (3) collection of personal data must be adequate, relevant and limited to what is reasonably necessary in relation to the specified purposes; (4) not process personal data for purposes that are not reasonably necessary to or compatible with the specified purposes, without obtaining consent from the consumer; (5) take reasonable measures to secure personal data; (6) not process personal data in violation of any law that prohibits unlawful discrimination; and (7) not process a consumer’s sensitive data without first obtaining the consumer’s consent. Additionally, controllers are required to enter into contracts with data processors, referencing the responsibilities under the CPA and controllers must conduct a data protection assessment prior to any processing activities that have a heightened risk of harm to consumers.

Enforcement

The CPA does not contain a private right of action but does provide the state attorney general and district attorneys authority to take action against entities for violations.

C. Virginia Consumer Data Protection Act (CDPA)

Scope

The Virginia Consumer Data Protection Act (CDPA) becomes effective January 1, 2023. Subject to certain limitations, this law applies to entities that conduct business in Virginia or produce products or services targeted to Virginia residents when they control or process personal data of at least 100,000 consumers or control or process personal data of at least 25,000 consumers and also derive over 50% of gross revenue from the sale of personal data.
Exemptions

The law contains entity-level exemptions for those subject to GLBA and HIPAA. It specifically exempts financial institutions and data subject to GLBA, and covered entities or business associates governed by the privacy, security, and breach notification rules issued by the U.S. HHS Department of Health and Human Services. It also exempts protected health information under HIPAA.

Consumer Rights

The CDPA provides consumers with the following rights: (1) to confirm whether or not a controller is processing the consumer’s personal data and if so, to provide the right to access such personal data; (2) to correct inaccuracies in the consumer’s personal data, taking into account the nature of the personal data and the purposes of processing of the consumer’s personal data; (3) to delete personal data provided by or obtained about the consumer; (4) to obtain a copy of the consumer’s personal data in a portable and readily usable format that allows the consumer to transmit the data to another controller; and (5) to opt out of the processing of the personal data for purposes of targeted advertising, sale of personal data, and profiling.

Business Obligations

Under the law, controllers have the responsibility to do the following: (1) limit the collection of personal data to what is adequate, relevant, and reasonably necessary in relation to the purposes for which such data is processed; (2) not process personal data without consumer consent for purposes that are neither reasonably necessary to nor compatible with the disclosed purposes for which such personal data is processed; (3) establish, implement, and maintain reasonable data security practices to protect personal data; (4) not process personal data in violation of any laws that prohibit unlawful discrimination against consumers and not discriminate against consumers exercising their rights under this law; and (5) not process sensitive data concerning a consumer without obtaining the consumer’s consent. In addition, controllers must provide consumers with a reasonably accessible, clear, and meaningful privacy notice. Processing activities undertaken by a processor on behalf of a controller must be governed by a data processing agreement. Controllers also must conduct data protection assessments that evaluate the risks associated with processing activities.

Enforcement

Similar to the Colorado law, the Virginia law does not contain a private right of action but does provide the state attorney general authority to pursue action against entities for violations.

VII. Summary of Working Group Discussions of Selected Key Points

The Working Group began discussions December 8, 2019, during the Fall National Meeting with the following minimum consumer privacy protections being considered as appropriate for the
business of insurance. These rights were based on the Working Group’s proposed 2020 charges and are included in the Working Group's initial 2019 Work Plan:

1. the right to receive notice of an insurer’s privacy policies and practices;
2. the right to limit an insurer’s disclosure of personal data;
3. the right to have access to personal data used by an insurer;
4. the right to request the correction or amendment of personal data used by an insurer;
5. the right of data ownership; and
6. the right of data portability.

An example of the other types of issues the Working Group will need to discuss includes clarifying the specific circumstances for when a “right” does exist. Is it really a “right to request” as contained in the California law? Or is it merely a right to delete inaccurate information like FCRA? Or is it a right to request deletion of inaccurate information as described in Model #670?

Eventually the Working Group decided on nine (9) categories to study. In addition to the six above, the Working Group added (7) the right of data ownership, (8) the right of notice, and (9) the right of nondiscrimination and/or non-retaliation.

The Work Plan also stated that the Working Group discussions would focus on data privacy (and not data security) and identify areas within existing NAIC models and state requirements where consumer data privacy protections might need to be enhanced due to changes in technology. In her December 8 presentation, Jennifer McAdam (NAIC) outlined existing privacy provisions in NAIC models and state insurance laws. She said the difference between data privacy and data security is that data privacy is about how data is being collected and used by businesses; while data security is about how data that a business has already collected, has in its possession, and is stored and protected from unauthorized access. She said the two are often conflated and there are some laws that address both – for example, the GDPR.

Furthermore, as many comments have noted, the two issues overlap because a breach of security often results in a loss of privacy. Ms. McAdam said the CCPA is an example of a data privacy law that governs how businesses collect and use consumer data; the rights consumers have to know how that data is being used; the rights consumers have to challenge the accuracy of the data; and how it is being used. Data privacy laws are focused on legal protections for data and consumer rights: In comparison, data security laws, such as the NAIC’s Insurance Data Security Model Act (#668), require operational and technological protections sufficient to ensure that the legal protections are meaningful. Ms. McAdam explained that Model #668 governs how businesses protect the data once it has been collected as well as what businesses need to do if those protections fail as the result of a data breach or other cybersecurity event.

The Working Group operated under these distinctions.

State insurance regulators were concerned about the consumer data that insurers were already presenting in rate filings that had ballooned up to thousands of pages of different data points being
gathered by insurers on consumers. Regulators have also seen an increased reliance on third-party risk scores that aggregate consumer information in order to make determinations and conclusions about consumer information. Regulators noted that insurers have a responsibility to ensure that the third parties used are following state laws and complying with the state’s standards for accuracy and fairness. In addition to providing disclosure of the third parties used by insurers when consumers request it, insurers are required to report how the information was gathered; where it was drawn from (e.g., web traffic, geolocation data, social media, etc.); and why the company thinks it needs to use those particular data points.

Industry asked the Working Group to consider: 1) workability by allowing for various exemptions for operational and other reasons that acknowledge vital business purposes for insurers to collect, use, and disclose information. For example, Article IV of the NAIC Model #672 was developed to implement the GLBA, and the exceptions embedded into Section 13 of Model #672 are instructive as to the types of operational functions that need to be preserved and facilitated; 2) exclusivity by avoiding dual regulation, so insurers are not simultaneously subject to potentially inconsistent or conflicting interpretations by more than one regulator; 3) clarity by asking that care be taken to consider how best to dovetail new requirements with existing models/laws/regulations; consulting other resources and educating legislators on how privacy bill language impacts the insurance industry, including the legal requirements to retain and use certain data, as well as data mandates; 4) an effective date that allows advance time (like the two to five years that was afforded under the GDPR) for insurers to be ready for implementation, to avoid having piecemeal revisions like the CCPA and the GDPR, as well as a roll-out period with different dates for different provisions within that time frame as a more measured approach to undertake such a significant endeavor.

Consumer Representatives asked the Working Group to consider that: 1) data vendors are scraping personal consumer information from public sources to produce consumer profiles, scores, and other tools for insurers. The data vendor products, while assembled from public information, raise concerns over consumers’ digital rights and privacy; 2) many data vendors and many types of personal consumer information are not subject to FCRA consumer protections. In turn, many of the types of data and algorithms used by insurers are not subject to either FCRA consumer protections (even though they are the functional equivalent of a consumer report) or the NAIC model law/regulation protections; 3) it is unclear whether the NAIC models cover the new types of data being generated by consumers as part of, or related to, insurance transactions. For example, consumers are producing large volumes of data through telematics programs from devices collecting personal consumer data in the vehicle or home or through wearable devices; 4) there are several organizations working on consumer digital rights (such as the Center for Digital Democracy, the Electronic Privacy Information Center, the Electronic Frontier Foundation, the Public Knowledge-Privacy Rights Clearinghouse, the Public Citizen, the U.S. Public Interest Research Group, and the World Privacy Forum) from whom input and presentations at Working Group meetings could be solicited; and 5) if consumer disclosures are to be used, that disclosure
should be a compliance or enforcement tool that would be created using consumer focus testing and established best practices for the creation of such consumer disclosures.

The COVID-19 pandemic slowed the Working Group’s discussions in 2020, however, discussions continued through seven virtual meetings and two regulator-only meetings of subject matter experts as areas of concentration were being narrowed leading to the Working Group receiving additional guidance from its parent committee.

In April 2021, the Working Group’s discussions were redirected to six consumer data privacy rights or types of consumer data privacy protections based on the specific examples identified in item 1.c. of the NAIC Member Adopted Strategy for Consumer Data Privacy Protections received through its parent Committee, the Market Regulation and Consumer Affairs (D) Committee. The Working Group’s task was to comment on the following consumer privacy rights concerning consumers’ personal information as a basis for a privacy protection framework for the insurance industry (not just health insurance):

1. Right to opt out of data sharing;
2. Right to limit data sharing unless the consumer opts in;
3. Right to correct information;
4. Right to delete information;
5. Right to data portability;
6. Right to restrict the use of data.

Consequently, the Working Group was also tasked with analyzing or determining how insurers were protecting these rights – either to comply with state or federal statutory or regulatory requirements, on their own initiative or through the adoption of voluntary standards. In 2021, the Working Group met ten times and the regulator only subject matter experts met nine times.

Prior to the 2021 Summer National Meeting, the Working Group focused on discussion of, and input on, the following key points from regulators, industry, and consumers for each of the six consumer privacy data rights noted above: definitions; examples; consumer risk/impact; current state and federal laws/rules; insurer/licensee impact; actions necessary/insurer obligations to minimize consumer harm; and recommendations. Suggestions that separate privacy requirements be established for each line of business were discussed, but there was consensus that this did not seem to be feasible, as different consumer data privacy requirements across lines of business would limit both consumer protections and understanding.

It was noted during Working Group discussions that insurers are increasingly utilizing third party vendors as sources of data collection and that such vendors may not be subject to regulation by state insurance departments. Regulators stated that the insurers they regulate bear the responsibility for compliance with state insurance privacy requirements. Insurers felt they could not be held responsible because they did not know how such vendors collected or used consumer data and had no way to control the vendors’ business activities. Regulators and consumer representatives...
expressed different opinions indicating that insurers’ contracts with such vendors could and should be written to require vendors and insurers maintain compliance with insurance regulations regarding consumer data privacy.

During the 2021 Summer National Meeting, NAIC members further recommended that the Working Group's discussion be expanded to include the issue of consumer data ownership.

Working Group discussions revealed that state insurance regulators and consumer representatives believe consumers own the data that is collected and used by the insurance industry to market, sell, and issue insurance policies. It was felt that the type of data collected (name, age, date of birth, height, weight, income, physical condition, personal habits, etc.) describes who a person is and distinguishes one person from another by its very nature. When a consumer shares their data with an insurance company, it is with the understanding that the consumer is letting the company borrow it for a time to determine what insurance rates and insurance coverage the consumer needs. The consumer is not giving up their data to an insurer so it can be sold or given to other organizations from whom the consumer is not seeking insurance coverage, or any other product. Consumer representatives indicated that this practice had happened when they did an online search for insurance rates on health plans. As a result, the consumer representative received hundreds of cold calls from companies selling products other than insurance. When the consumer representative asked with whom the insurance company shared his data, the company sent him a list of 1,700 companies – none of which sold insurance. [Trades ask to delete this portion or to make clear that it is opinion and being reported by consumer group but not verified. I do not agree with deleting.]

The Report in Appendix A is designed to be the foundation for the minimum consumer data privacy protections that are appropriate for the business of insurance to be applied to the NAIC models as revisions. It is intended to kick start the next step in creating revisions by defining the parameters of the existing consumer data privacy rights; by suggesting definitions and by showing examples of consumer risks impact. Further discussion is necessary, however, to clarify consumer data privacy rights that may not be fully protected in federal laws or fully covered under NAIC Model laws, and to decide how to provide appropriate protections.

VIII. Conclusion and Recommendations

Months of detailed discussions with regulator, industry, and consumer stakeholders, and the comments they have submitted, have led the Working Group to determine that the NAIC Insurance Information and Privacy Protection Model Act (Model #670) and the Privacy of Consumer Financial and Health Information Regulation (Model #672) have in the past provided an effective regulatory framework for consumer privacy protections to oversee and enforce consumer data privacy as required by state and federal statutes and regulation. However, these models were adopted by the NAIC 20 and 40 years ago, respectively; with only 17 jurisdictions adopting Model #670.
However, in consideration of the many business developments and technological improvements that have occurred in recent years, as well as the rate of increase in the use of new technologies (AI, machine learning, accelerated underwriting, rating algorithms, etc.), and big data by insurers, the Working Group recommends additional considerations of the ways that Models #55, #670 and #672 could be amended to ensure that regulators and legislators can continue to have a robust menu of options to provide consumer data privacy protections essential to meet the consumer data privacy challenges presented by the public use of technology and data by insurers in today’s business environment.

As a reminder, the standards established in these models, while not only being between 20 and 40 years old, are considered to be a ‘floor,’ they are basic requirements, and these requirements are not to be considered a ‘ceiling’ that limits future NAIC initiatives. As business practices and technological developments have progressed so too must the consumer, the industry and the regulator.

It is clear that with the proliferation of data and the use of such data by licensed entities, that insurance regulation needs to modernize to protect the consumer of unintended consequences of the use ownership and security of such data. It is the intention of this Working Group to recommend that either the NAIC models be reopened and revised, or a new Model Law be created concerning the 9 categories listed in this Report, including a focus on data ownership, data rights and data protections. The work product going forward can use the GDPR as a possible template, along with other recently enacted state laws, while keeping in mind federal laws that already protect consumers’ data. Emphasis will be given to data transparency, customer control, customer access, data accuracy, and data ownership and portability as explained in Appendix A.

Subsequent to systemic and transparent decisions relating to Appendix A discussions and adoption of any model law changes, the Working Group also recommends the NAIC’s *Market Regulation Handbook* and the NAIC’s *IT Examiners’ Handbook* be updated, as necessary, to provide guidance to state insurance regulators so they can verify insurers’ compliance with the state’s regulatory framework for consumer privacy protections.
Appendix A

National Association of Insurance Commissioners
Report on Consumer Data Privacy Protections

By adhering to the same/similar intent behind the drafting of the NAIC’s Principles on Artificial Intelligence, this Report also requests that all “… insurance companies and all persons or entities facilitating the business of insurance that play an active role” in the protection of and usage of consumer data … promote, consider, monitor and uphold the principles as described in this Report.

This Report is intended to be a high-level report of the discussions and research conducted by the Privacy Protections (D) Working Group. The focus of our work was determining the minimum consumer data protections that are appropriate for the business of insurance. Once determinations were made, the Working Group discussed whether or not the current model laws are sufficient in order to continue protecting consumers and providing regulatory oversight, are revisions needed or does the Working Group need to draft a new model. This Report can be viewed as being similar to the Ai Principles in that it provides insight to regulatory expectations and serves as an outline for actions to be discussed taken going forward.

This Report only provides research information guidance to the Regulator and does not carry the weight of law or impose any legal liability. This guidance only can serve serves to inform state insurance departments and insurance companies of intended recommendations designed to address improvements needed for data privacy protections and to highlight issues needing further discussion.

Appendix B contains a list of resources relied upon during the pendency of this Working Group.

Because the business operations of insurance companies are dependent upon the collection and use of personal information and data, state insurance regulators have long understood the need to balance an insurance company’s need to collect consumer information and data with the consumer’s right to understand limit the collection and use of this data.

The NAIC adopted the Insurance Information and Privacy Protection Model Act (Model #670) in 1980 to establish standards for the collection, use and disclosure of information gathered in connection with insurance transactions. A key aspect of this model is that it establishes a regulatory framework for consumers to (1) ascertain what information is being or has been collected about them in connection with insurance transactions; (2) obtain access to such information for the purpose of verifying or disputing its accuracy; (3) limit the disclosure of information collected in connection with insurance transactions; and (4) obtain the reasons for any adverse underwriting decision. This regulatory framework is facilitated through a requirement that insurers or agents provide a written notice to all applicants and policyholders regarding the insurer’s information practices.
The NAIC adopted the *Privacy of Consumer Financial and Health Information Model Regulation* (Model #672) in 2000. The model regulation was drafted to implement the requirements set forth in Title V of the federal *Gramm-Leach-Bliley Act* (P.L. 106-102) of 1999 (GLBA). GLBA imposed privacy and security standards on financial institutions and directed state insurance commissioners to adopt certain data privacy and data security regulations. The model also contains provisions governing protection of health information that were taken directly from the *Health Insurance Portability and Accountability Act* (HIPAA) Privacy Rule promulgated by HHS. The NAIC model regulation requires insurers to: (1) notify consumers about their privacy policies; (2) give consumers the opportunity to prohibit opt-out of the sharing of their protected non-public financial information with non-affiliated third parties; and (3) obtain affirmative consent from consumers before sharing protected non-public personal health information with any other parties, affiliates, and non-affiliates. The key difference between the treatment of financial information and health information is that insurers must give consumers the right (with limited exceptions) to “opt out” of the disclosure or sharing of their non-public financial information to third-parties for the third party’s own business use, but insurers must get explicit authorization (“opt in”) before sharing health information absent an applicable exception.

This *Report* addresses consumer data privacy protections of (1) transparency; (2) consumer control; (3) consumer access; (4) data accuracy; and (5) data ownership and portability. The *Report* intentionally excludes standards for data security and standards for the investigation and notification to an insurance commissioner of a licensed insurance entity’s cybersecurity event, which since these issues are the subject of separate model laws and interpretive guidance.

The following definitions are used for the purposes of this policy statement.

A. “Adverse Decision” means declination of insurance coverage, termination of insurance coverage, charging a higher rate for insurance coverage, or denying a claim.

B. “Consumer” means an individual who is seeking to obtain, obtaining, or have obtained a product or service from an insurer. For example, an individual who has submitted an application for insurance is a consumer of the company to which he or she has applied, as is an individual whose policy with the company has expired.

C. “Customer” means a consumer with whom an insurer has an on-going relationship.

For purposes of this Report, customers are a subset of consumers, so there is no reason to reference “customer or consumer.”

D. “Licensee” means any insurer, producer, or other person licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to a state insurance law.

For purposes of this Report, what is defined above in (D) is a “regulated entity,” however, the models have been using the term “licensee” so this Report will continue to use the more familiar terminology.

E. “Personal Information” means any individually identifiable information or data gathered in
connection with an insurance transaction from which judgments can be made about an 
individual’s character, habits, avocations, finances, occupation, general reputation, credit, 
health, or any other personal characteristics. Personal information includes:

1. “Non-Public Personal Information,” which means information that a consumer provides to 
a licensee to obtain an insurance product or service (like income, credit history, name and address); information about a consumer a licensee has as a result of a transaction involving 
an insurance product or service (like premium payment history, how much a life insurance policy is worth, and the value of personal property insured); and all other information about 
a consumer that a licensee uses in connection with providing a product or service to a consumer.

2. “Non-public personal health information,” which means any information that identifies a 
consumer in some way, and includes information about a consumer’s health, including past 
and present physical and mental health, details about health care, and payment for health care.

I. Transparency [Trades have a lot of comments; see ACLI pt 19]

It is recommended that a licensee should provide a clear and conspicuous notice to consumers 
that accurately reflects its privacy policies and practices when it first requests personal 
information about the consumer from the consumer or a third party.

It is recommended that a licensee should also provide a periodic notice of its privacy policies 
and practices to customers when substantive changes have occurred not less than annually during 
the continuation of the customer relationship.

If a licensee makes an adverse decision based on information/data that was not supplied by the 
consumer, it is recommended that the licensee should provide the consumer with the specific 
reasons for the adverse decision. [Note: this standard is already a requirement – for 
declinations/nonrenewals the consumer is to be given the reason in such detail as to not require 
the need for further inquiry. Use Cons Rep example?]

**Going forward the WG types of issues to understand - would ensure all definitions, such as 
“on-going relationship,” consumer and customer are [copasetic]; company business operations 
are considered, record retention practices are understood, what happens to personal data/info 
when a person applies for but decides to not purchase a policy; when they cancel the policy; 
ensure the findings from the gap analysis have been addressed.

II. Consumer Control [Trades – change to Consumer Preference Default Mechanism]

It is recommended that licensees should, at a minimum, provide consumers the opportunity to
prohibit limit the sharing of their non-public personal information with third parties, except for specific purposes required or specifically permitted by law. (Opt-Out)

It is recommended that A licensees should obtain affirmative consent from consumers before sharing non-public personal health information with any other entity, including its affiliates and non-affiliates. (Opt-In)

III. Consumer Access

It is recommended that Any consumer should have the right ability to submit a request to a licensee to obtain access to his/her personal information used by the licensee in its operations. Upon request, within a specified period of time, the licensee should within 30 business days provides a copy of the consumer’s personal information, an explanation on how the personal information was used (i.e., rating, underwriting, claims), and provides the source of the personal information. If personal information is in coded form, the licensee should would be expected to provide an accurate translation in plain language.

IV. Data Accuracy

It is recommended that Within a specified period of time, 30 business days after receiving a written request from a consumer to correct, amend, or delete personal information used by the licensee in its operations, within its possession the licensee should will either make the requested correction, amendment, or deletion or notify the consumer of its refusal to do so, the reasons for the refusal, and the consumer’s right to file a statement of dispute setting forth what the consumer thinks is the correct information and the reasons for disagreeing with the licensee.

If the licensee corrects, amends, or deletes personal information, the licensee should notify any person or entity that has received the prior personal information within a specified period of time the last 7 years. If the licensee does not correct, amend, or delete the disputed personal information, the licensee should notify any person or entity that has received the prior personal information within a specified period of time the last 7 years of the consumer’s statement of dispute.

V. Data Ownership and Portability

A consumer customer should have the right to request a copy of his/her personal information that he/she has provided to the licensee for use in the licensee’s operations. A licensee should provide a consumer customer a copy of his/her personal information within a specified period of time.
business days of the request. Examples of this type of personal information include telematics data and “Internet of Things” (“IoT”) data.

[Pull information from minutes pertaining to category of data ownership, post Summer Nat’l Mtg]

**Office of Research Integrity {ORI} within the DHHS - Data Ownership.** Data ownership refers to both the possession of and responsibility for information. The control of information includes not just the ability to access, create, modify, package, derive benefit from, sell or remove data, but also the right to assign these access privileges to others.

Scofield (1998) suggest replacing the term ‘ownership’ with ‘stewardship’, “because it implies a broader responsibility where the user must consider the consequences of making changes over ‘his’ data.”

**National Institute of Standards and Technology (NIST) – Information owner** – An official with statutory or operational authority for specified information and responsibility for establishing the controls for its generation, collection, processing, dissemination, and disposal.

Data ownership formalizes the role of data owners and establishes accountability, assigning responsibility for managing data from creation to consumption. It puts rules and processes in place to ensure that the right people define usage directives, set quality standards, and consistently resolve data issues.

- Are there other points in the CO, VA, or Calif. laws that we want to include here?
Appendix B – Version 3

National Association of Insurance Commissioners

Resources on Consumer Data Privacy Protections

Reviewed by the Privacy Protections (D) Working Group

1. California Consumer Privacy Act (CCPA)
2. California Privacy Rights Act (CPRA)
3. Colorado Privacy Act (CPA)
4. General Data Protection Regulation (GDPR)
5. Health Insurance Portability and Accountability Act (HIPAA)
6. Gramm-Leach-Bliley Act (GLBA)
7. Federal Credit Reporting Act (FCRA)
8. NAIC Health Information Privacy Model Act #55
9. NAIC Insurance Data Security Model Act #668
10. NAIC Information and Privacy Protection Model Act #670
11. NAIC Privacy of Consumer Financial and Health Information Regulation #672
12. Virginia Consumer Data Protection Act (CDPA)
13. Troutman Analysis of Virginia Consumer Data Protection Act
14. Presentation by Dr. Karrol Kitt (The University of Texas at Austin) and Dr. Brenda J. Cude (University of Georgia) on the Additional Insurer Responsibility to Protect Consumer Data due to Consumers’ Lack of Knowledge and Understanding of Privacy Risks
15. Presentation by Dr. Harold M. Ting (Consumer Healthcare Advocate) Exploring Results of His Secret Shopper Research and the Effects on the Privacy of Consumer Data
16. Nine Privacy Principles developed by Dr. Harold M. Ting (Consumer Healthcare Advocate)
17. Presentation by Clay McClure (Blue Cross Blue Shield Association) on the Need for Privacy Gap Analysis
18. Presentation by Damon Diedrich (CA) on California’s Privacy Legislation (CCPA and CPRA)
19. Presentation by Katie Johnson (VA) on Virginia’s Privacy Legislation
20. Abbreviated Data Privacy Legislation Chart 10.8.21 prepared by Jennifer McAdam (NAIC Legal)

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In 2021, this working group had ten open calls between Mar. 29 and Nov. 22, 2021.

The Regulator-Only Subject Matter Experts had eight calls.

The Working Group heard eight presentations as well as Federal and State Legislative Updates at seven meetings in 2021:

1. Karrol Kitt (NAIC Consumer Representative)
2. Brenda Cude (NAIC Consumer Representative)
3. Harry Ting (NAIC Consumer Representative)
4. Clay McClure, BCBSA
5. Damon Diederich (CA)
6. Katie Johnson (VA)
7. Model #670 / CCPA Privacy Comparison by Jennifer McAdam (NAIC)
8. GLBA / HIPAA Privacy Comparison by Jennifer McAdam (NAIC)
9. Federal Legislative Updates at most open meetings by Brooke Stringer (NAIC)
10. State Legislative Updates at most open meetings by Jennifer McAdam (NAIC)
    a. Abbreviated Data Privacy Legislation Chart
    b. State Privacy Law Comparison Chart

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Four NAIC Models were reviewed:
1. NAIC Health Information Privacy Model Act #55
2. NAIC Insurance Data Security Model Act #668
3. NAIC Insurance Information and Privacy Protection Model Act #670
4. NAIC Privacy of Consumer Financial and Health Information Regulation #672

State Laws reviewed:
1. California Consumer Privacy Act (CCPA)
2. California Privacy Rights Act (CPRA)
3. Colorado Privacy Act (CPA)
4. Virginia Consumer Data Protection Act (CDPA)

Federal Laws reviewed:
1. Health Insurance Portability and Accountability Act (HIPAA)
2. Gramm-Leach-Bliley Act (GLBA)
3. Federal Credit Reporting Act (FCRA)

Reviewed the European Union’s General Data Protection Regulation (GDPR)

Drafts (All with Privacy Policy Statement in their titles) were exposed and posted for comment on:
1. April 28, 2021
2. July 1, 2021
3. August 26, 2021

The Final Exposure Draft Report (which included the Privacy Policy Statement as Appendix A) was exposed and posted for comment on November 18, 2021.

Rpt Privacy Protections Received D Cmte
The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 4, 2021. The following Working Group members participated: Damion Hughes, Chair, and Eleanor Coe and Dennis Newman (CO); Erica Weyhenmeyer, Vice Chair (IL); Chris Erwin, Teri Ann Mecca, and Crystal Phelps (AR); Sarah Borunda and Catherine O’Neil (AZ); Steve DeAngelis (CT); Patrice Garnette (DC); Susan Jennette and Frank Pyle (DE); Elizabeth Nunes (GA); Daniel Mathis (IA); Lori Cunningham and Ron Kreiter (KY); Jill Huisken and Isaac Kane (MI); Paul Hanson (MN); Cynthia Amann, Jo LeDuc, and Win Nickens (MO); Tracy Biehn (NC); Edwin Pugsley (NH); Ralph Boeckman (NJ); Joel Bengo (NM); Hermoliva Abejar (NV); Sylvia Lawson and Sharon Ma (NY); Rodney Beetch (OH); Landon Hubbard (OK); Sandra Emanuel and Ana K. Pace (OR); Gary Jones and Crystal Welsh (PA); Brett Bache, Jack Broccoli, Segun Daramola, and Brian Werbeloff (RI); Matthew Tarpley (TX); Andrea Baytop, Julie Fairbanks, and Bryan Wachter (VA); Mary Block and Karla Nuissl (VT); Jeanette Plitt (WA); and Barbara Belling, Diane Dambach, Mary Kay Rodriguez, and Jody Ullman (WI).

1. **Heard Opening Remarks**

Mr. Hughes welcomed Pennsylvania to the Working Group, represented by Gary Jones and Crystal Welsh.

2. **Adopted its Oct. 7 Minutes**

The Working Group met Oct. 7 and took the following action: 1) adopted its Sept. 2 minutes; 2) discussed a revised draft Chapter 25—Conducting the Medicare Supplement Examination for inclusion in the *Market Regulation Handbook* (Handbook); 3) discussed a revised draft Chapter 24—Conducting the Health Examination for inclusion in the Handbook; and 3) received and discussed verbal updates from state insurance regulator volunteers who reviewed models with the potential to affect the examination standards of the Handbook. The models discussed included the *Real Property Lender-Placed Insurance Model Act* (#631), the *Insurance Holding Company System Regulatory Act* (#440), the *Corporate Governance Annual Disclosure Model Act* (#305), the *Corporate Governance Annual Disclosure Model Regulation* (#306), and the *Suitability in Annuity Transactions Model Regulation* (#275).

Mr. Pyle made a motion, seconded by Mr. Boeckman, to adopt the Working Group’s Oct. 7 minutes (Attachment Six-A). The motion passed unanimously.

3. **Adopted a Revised Draft Chapter 25 for Inclusion in the Handbook**

Mr. Hughes said the draft chapter, which had been circulated on Sept. 27, had been initially discussed during the Working Group’s Oct. 7 meeting, and no comments had been received on the draft chapter. Ms. Rodriguez said she had reviewed the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651), and she provided suggested revisions in track changes for the Working Group’s review. She recommended changing all occurrences of the word “written” to “documented,” as “documented” would appear to be more relevant based upon the current business environment in 2021. She added references to Model #651 where appropriate in the exam standards of Chapter 25, and she suggested other revisions, including, but not limited to, network adequacy exam standards 1 and 7, as well as the marketing and sales section of the chapter. Ms. Rodriguez asked that a change be made to the “Documents to be Reviewed” section in Standard 1 of the “Network Adequacy” section of the chapter; she recommended changing “Provider/enrollee location by ZIP code” to “Provider/enrollee location reports by geographic location.”

Ms. Plitt made a motion, seconded by Ms. Weyhenmeyer, to adopt the draft Chapter 25 (see *NAIC Proceedings – Fall 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment Four*), with the inclusion of the revision recommended by Ms. Rodriguez to Network Adequacy Standard 1. The motion passed unanimously.
4. **Adopted a Revised Draft Chapter 20—Conducting the Health Examination for Inclusion in the Handbook**

Mr. Hughes said the draft chapter, which had been circulated on Sept. 30, had been initially discussed during the Working Group’s Oct. 7 meeting, and no comments had been received on the draft chapter. Mr. Hughes said that Darcy Paskey (WI) had submitted the draft for the Working Group’s consideration. As Ms. Paskey was not able to be at the meeting, Ms. Damback spoke on her behalf. Ms. Damback said that Ms. Paskey had reviewed the *Health Maintenance Organization Model Act (#430)* and recommended one revision: adding “Quality of care complaints” to the Documents to be Reviewed in Quality Assessment and Improvement Standard 4.

Ms. Damback said that Ms. Paskey had also proposed that since the *Health Carrier Grievance Procedure Model Act (#72)* includes experimental and investigational treatment in the definition of “adverse determination,” the definitions section of both Model #430 and the *Health Carrier External Review Model Act (#75)* should be revised, for the sake of consistency, to include experimental and investigational treatment in the definition of adverse determination. Mr. Hughes said revisions to NAIC models would be beyond the scope of the Working Group. However, he said this issue could be brought to the attention of the appropriate working group(s) for future consideration. Ms. Damback said that upon further review of the chapter, Ms. Paskey determined there was no need at this time to create a new marketing and sales examination standard regarding contract requirements.

Ms. Weyhenmeyer made a motion, seconded by Ms. Phelps, to adopt the revision Ms. Paskey suggested to draft Chapter 24 (see *NAIC Proceedings – Fall 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment Three*). The motion passed unanimously.

5. **Discussed Draft Revisions to Chapter 21—Conducting the Property and Casualty Examination, Oct. 27 Draft**

Mr. Hughes said the draft chapter, which was circulated on Oct. 27, had been provided by Sharon Shipp (DC) for the Working Group’s consideration. Mr. Hughes said that Ms. Shipp had reviewed the recently adopted Model #631 and had recommended revisions to various areas of the chapter. As Ms. Shipp was not able to be at the meeting, Ms. Garnette provided an overview of the revisions:

- Adding “certificate of insurance” to the “Documents to be Reviewed” section of Marketing and Sales Standard 1 and a reference to Model #631 in the NAIC Model References of that examination standard.
- Adding “Documentation showing regulated entity’s separate rates for mortgage servicer obtained lender-placed insurance versus voluntary insurance on real estate owned property” to the “Documents to be Reviewed” section of Underwriting and Rating Standard 4 and a reference to Model #631 in the NAIC Model References of that examination standard.
- Adding “Applicable reports filed with the commissioner (e.g., required reporting for insurers with at least $100,000 in direct written premium for lender-placed insurance, required rate filing for insurers with an annual loss ratio of less than 35% in any lender-placed program for two consecutive years)” to Underwriting and Rating Standard 6 and a reference to Model #631 in the NAIC Model References of that examination standard, as well as revising the first paragraph of the Review Procedures and Criteria to read: “Losses under each policy should be clearly and accurately maintained at the regulated entity, so that paid amounts, reserves, deductibles, and any excess amounts paid to the mortgagor can be easily reviewed. The sample data should be compared to the unit statistical reports to verify accuracy of reporting of the following items: ...”
- Revising Underwriting and Rating Standard 8 to read: “Underwriting, rating, and classification are based on adequate information developed at or near inception of the coverage rather than before the effective date of the insurance, near the expiration of a claim, or following a claim”; adding a reference to Model #631 in the NAIC Model References of that examination standard; and revising the first paragraph of the Review Procedures and Criteria to read: “Decisions should be based on information that reasonably should have been developed at the inception of the policy or during initial underwriting and not, through audit or other means, before the policy went into effect or after the policy has expired.”
- Adding “Books and records containing compensation, contingent commissions, profit sharing, and other payments dependent on profitability or loss ratios” and “Third-party agreements for outsourced services” to the “Documents to be Reviewed” section of Underwriting and Rating Standard 13 and a reference to Model #631 in the NAIC Model References of that examination standard.
Lisa Brown (American Property Casualty Insurance Association—APCIA) said that in Underwriting and Rating Standard 6 of the draft chapter, the applicability of the examination standard should be revised in scope to not be limited only to workers’ compensation examinations. She also suggested that language be added to Ms. Shipp’s proposed new language to mirror the provisions of Section 9G Filing, Approval and Withdrawal of Forms and Rates of Model #631, for the purpose of carving out lender-placed flood insurance. Mr. Hughes requested that comments on the draft be provided to Ms. Wallace by the comments due date of Nov. 27. Ms. Brown said that she will submit her comments to the Working Group by that time.

6. Discussed Draft Revisions to Chapter 20, Oct. 27 Draft

Mr. Hughes said the draft chapter, which was also circulated on Oct. 27, had been provided by Ron Kreiter (KY) for the Working Group’s consideration. Mr. Hughes said that Mr. Kreiter had reviewed Model #440 and had recommended revisions to various areas of the chapter.

Mr. Kreiter recommended adding a reference to Model #440 to Operations/Management Standard 1 and new review procedures/criteria: 1) determine if the NAIC Liquidity Stress Test (LST) Framework needs to be used for a specified data year; 2) determine if there is a holding company system in place and if so, whether there should be a group capital calculation request from the U.S. Federal Reserve or whether a lead state commissioner should require a group capital calculation for U.S. operations of any non-U.S.-based insurance holding company system; and 3) determine if the confidentiality of any group capital contribution or group capital ratio is maintained and if the confidentiality of the LST results and supporting disclosure are maintained, which includes any Federal Reserve Board filings and information.

Mr. Kreiter also recommended adding a reference to Model #440 in Marketing and Sales Standard 1, and new review procedures/criteria. For the review of group capital calculation, resulting group capital ratio and liquidity stress test:

- Review the making, publishing, disseminating, circulating, or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station or any electronic means of communication available to the public, or in any other way as an advertisement, announcement, or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, the liquidity stress test results, or supporting disclosures for the liquidity stress test of any insurer or any insurer group, or of any component derived in the calculation by any insurer, broker, or other person engaged in any manner in the insurance business because it would be misleading and is therefore prohibited; and
- Review if any materially false statement with respect to the group capital calculation, resulting group capital ratio, an inappropriate comparison of any amount to an insurer’s or insurance group’s group capital calculation or resulting group capital ratio, liquidity stress test result, supporting disclosures for the liquidity stress test, or an inappropriate comparison of any amount to an insurer’s or insurance group’s liquidity stress test result or supporting disclosures is published in any written publication and if the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement or the inappropriateness, as the case may be, then the insurer may publish announcements in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

Mr. Hughes requested that comments on the draft be provided to Ms. Wallace by the comments due date of Nov. 27.

7. Received Updates from State Insurance Regulator Volunteers Reviewing Models Potentially Affecting the Handbook

Mr. Hughes said various state insurance regulator volunteers have been reviewing adopted models that have the potential to affect the examination standards of the Handbook. The purpose of each state insurance regulator’s review was to see whether any revisions need to be made to the Handbook regarding the specific model they volunteered to review.

Mr. Hughes said Mr. Werbeloff volunteered to review an initial draft of revisions to Chapter 23—Conducting the Life and Annuity Examination of the Handbook; the draft incorporated changes relating to the revisions adopted in February 2020 to Model #275. Mr. Hughes said the draft has not yet been circulated, as he wished to have state insurance regulator volunteers review the draft to see whether it was acceptable for presentation to the Working Group “as is” or if further revisions are needed prior to exposure.
Mr. Werbeloff said that he had received feedback from Mr. Pyle regarding some minor changes to the draft. Mr. Werbeloff said he will be emailing all of the insurance regulator volunteers who have reviewed the draft to see if the draft can be considered final and ready for exposure at the Working Group or if more revisions need to be made. Mr. Werbeloff said that he will provide a few paragraphs that will accompany the draft when it is eventually presented to the Working Group.

Mr. Hughes said that Ms. Amann is continuing to review Model #305 and Model #306. Ms. Amann said the models set forth expectations for a company board of directors and management and expectations regarding what a company entity is supposed to be doing regarding its enterprise risk management.

Ms. Amann said rather than inserting corporate governance methodology into numerous exam standards in the Handbook, alternatively, a new subsection could be added to Chapter 20 regarding what financial analysts are looking for when they perform a corporate governance review, and such a section could also provide guidance to a market conduct examiner or a market analyst on what information they can review that was obtained by financial analysts. Ms. Amann said that such information can be used in conducting a market conduct exam, in market exam planning, or when performing a Level 2 analysis.

Ms. Amann said that during the course of a market conduct exam, if a problematic issue is identified, it can theoretically be backtracked to where weak oversight or lack of internal controls were found in a corporate governance review. Ms. Amann said that information can be combined with found errors and that a more comprehensive correction action plan can be developed for the company that is the subject of an exam.

Ms. Abejar said it would be helpful to create guidance in the Handbook for market conduct examiners on how to use information that financial analysts obtain in a company’s Own Risk and Solvency Assessment (ORSA) and information that financial examiners obtain in a company’s Exhibit M. Ms. Abejar said that market conduct examiners can obtain a lot of information about the direction of a company and its strategy by reviewing information obtained by financial analysts and financial examiners. Ms. Plitt said that in Washington, financial examiners and financial analysts perform corporate governance reviews; these reviews are not typically performed by market conduct examiners. However, that notwithstanding, she said it would be beneficial to market conduct examiners to include guidance in the Handbook addressing where market conduct examiners can look for and how to interpret the findings of corporate governance reviews performed by state insurance department financial examiners and financial analysts. Ms. Plitt said it is beneficial for market conduct examiners to know how to read financial examination reports.

Ms. Nunes said in the Financial Condition Examiners Handbook, part of the Exam Planning Memo guidance includes paragraphs such as “Did the analyst do preliminary analytics….” If a market conduct examiner can obtain such analytics from a financial analyst, then a market conduct examiner would not have to duplicate the task of performing such analytics. Ms. Nunes, therefore, suggested that it may be enough to insert a short guidance in the Handbook, directing the market conduct examiner to the individual financial regulators performing corporate governance reviews.

Mr. Hughes reminded Ms. Amann and the Working Group that the Working Group’s charge is to discuss the role of market conduct examiners in reviewing insurers’ corporate governance as outlined in the corporate governance-related models (Model #305 and Model #306) and not to develop examination standards/examiner guidance at this point in time. Mr. Hughes asked Ms. Amann to provide him with a summary of how Exhibit M compares to market conduct examination standards, and he said that any drafts that might arise out of this charge would go before the entire Working Group, not a subset of regulators. Mr. Hughes said another issue for the Working Group to consider is whether corporate governance methodology would be better served or have a more logical place in exam planning or market analysis (e.g., Level 2 analysis) rather than in market conduct.

8. Received an Update on the Working Group’s Group Supervision Charge

Tim Mullen (NAIC) provided background regarding the Working Group’s charge to: “Discuss the effectiveness of a group’s supervision of market conduct risks, and develop examination procedural guidance, as necessary.” Mr. Mullen said former Nebraska Director of Insurance Bruce Ramge, who was the long-term chair of the Working Group at the time the charge was added to the Working Group’s 2021 charges, was also involved in the NAIC financial regulatory sector. Mr. Mullen said the purpose of adding the charge in 2021 was to start a conversation/discussion at the Working Group to see if there are any concepts in financial regulation that might be applicable to market conduct regulation. Mr. Mullen said there is no intent in the charge for market conduct regulators to duplicate financial efforts; the purpose of the charge is to promote discussion regarding the issue at the Working Group to see if any of the activities that are performed in group supervision by financial regulators can be leveraged by market conduct regulators.
Mr. Mullen said that while the “windows and walls” approach where financial regulators have the ability or “windows” to scrutinize group activity across a group holding company and “walls” to protect the capital of the insurer may not exactly translate to market conduct, issues for the Working Group to consider with regard to this charge are: 1) whether market conduct regulators benefit from looking at the Group Profile Summary (GPS) that is completed on the financial side, as well as the structure of the business operations of a holding company (e.g., the organizational structure of business segments, the insurance entities within the group holding company, the jurisdictions in which each is licensed, etc.); 2) whether market regulators would consider reviewing all entities within a group holding company, especially as it pertains to the use of data and technology platforms, since if a problematic issue is found by market regulators in one particular entity in a holding group, is there a need to take a look at all entities within that holding group (provided they are using the same technologies and platforms) to see if the problematic issue exists in other entities within the holding company and, therefore, needs to be addressed in a market conduct examination; and 3) whether there is a need, based upon the Working Group’s discussion of these two issues, to develop specific market conduct procedures regarding an assessment of the activities of a group holding company.

9. Discussed Other Matters

Mr. Hughes said one of the Working Group’s charges is to develop uniform market conduct procedural guidance (e.g., a library or depository of electronic documents such as exam call letters, exam templates, etc.). To address this charge, he said he had asked during its Oct. 7 meeting that Working Group members and interested state insurance regulators provide additional ideas for uniform guidance that could be included in an electronic library of resources for state insurance regulators. Ms. Amann said that at the time of the 2004 Market Conduct Examiners Handbook, she thought there was a collection of templates (exam planning materials, interrogatories, exam announcements) that were collected from the then members of the Market Regulation and Consumer Affairs (D) Committee. Mr. Hughes asked that state insurance regulators email him additional feedback regarding this charge by Nov. 27.

Mr. Hughes said due to the timing of the holidays and the 2021 Fall National Meeting, the next Working Group meeting will occur in early 2022, and a notice of the meeting will be distributed by NAIC staff. Mr. Hughes thanked the members of the Working Group for their contributions in 2021, specifically the regulator subject matter experts (SMEs) who volunteered to review models and provide exposure drafts in 2021 for the Working Group’s review.

Having no further business, the Market Conduct Examination Guidelines (D) Working Group adjourned.

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The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Oct. 7, 2021. The following Working Group members participated: Damion Hughes, Chair, and Eleanor Coe (CO); Erica Weyhenmeyer, Vice Chair (IL); Teri Ann Mecca and Crystal Phelps (AR); Sarah Borunda (AZ); Kurt Swan (CT); Patrice Garnette and Sharon Shipp (DC); Susan Jenette and Frank Pyle (DE); Elizabeth Nunes (GA); Lori Cunningham and Ron Kreiter (KY); Mary Lou Moran (MA); Jill Huisken and Isaac Kane (MI); Cynthia Amann, Stewart Freilich, Jo LeDuc, and Win Nickens (MO); Tracy Biehn and Teresa Knowles (NC); Maureen Belanger (NH); Mary Lou Moran (MA); Jill Huisken and Isaac Kane (MI); Cynthia Amann, Stewart Freilich, Jo LeDuc, and Win Nickens (MO); Tracy Biehn and Teresa Knowles (NC); Maureen Belanger (NH); Erin Porter (NJ); Joel Bengo and Leatrice Geckler (NM); Hermoliva Abejar (NV); Sylvia Lawson and Sharon Ma (NY); Rodney Beech (OH); Landon Hubhart and Shelly Scott (OK); Sandra Emanuel, Brian Fordham, Colette Hittner, and Ana K. Pace (OR); Katie Dzurec (PA); Brett Bache, Jack Broccoli, Matt Gendron, Segun Daramola, and Brian Werbeloff (RI); Matthew Tarpley (TX); Julie Fairbanks and Bryan Wachter (VA); Mary Block and Christina Rouleau (VT); Jeanette Plitt (WA); Diane Dambach, Darcy Paskey, and Mary Kay Rodriguez (WI).

1. Heard Opening Remarks

Mr. Hughes welcomed Georgia to the Working Group, represented by Ms. Nunes and Scott Sanders.

2. Adopted its Sept. 2 Minutes

The Working Group met Sept. 2 and took the following action: 1) adopted a Title in-force standardized data request (SDR) and a Title claims SDR for inclusion in the reference documents of the Market Regulation Handbook (Handbook); and 2) received and discussed verbal updates from state insurance regulator volunteers who reviewed models with the potential to affect the examination standards of the Handbook. The models discussed included the Unfair Trade Practices Act (#880), the Insurance Holding Company System Regulatory Act (#440), the Corporate Governance Annual Disclosure Model Act (#305), the Corporate Governance Annual Disclosure Model Regulation (#306), the Suitability in Annuity Transactions Model Act (#275), the Health Maintenance Organization Model Act (#430), and the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651).

Ms. Weyhenmeyer made a motion, seconded by Mr. Pyle, to adopt the Working Group’s Sept. 2 minutes (Attachment Six-A1). The motion passed unanimously.

3. Discussed a New Draft Chapter 25—Conducting the Medicare Supplement Examination for Inclusion in the Handbook

Mr. Hughes said the draft chapter, which was circulated on Sept. 27, was provided by Ms. Rodriguez for the Working Group’s consideration. Ms. Rodriguez said she reviewed Model #651, and she provided suggested revisions in track changes for the Working Group’s review. She recommended changing all occurrences of the word “written” to “documented,” as “documented” would appear to be more relevant based upon the current business environment in 2021. She mentioned that the terms “policyholder,” “enrollee,” etc. are used interchangeably throughout Chapter 25, and she recommended that a decision be made on which term should be used within the chapter, and perhaps the entire Handbook. She added references to Model #651 where appropriate, in the exam standards of Chapter 25, and she suggested other revisions, including, but not limited to, network adequacy exam standards 1 and 7, as well as the marketing and sales section of the chapter. Mr. Hughes said no comments had yet been received on the draft chapter, and he asked that comments on the draft be submitted by Oct. 28.

4. Discussed a New Draft Chapter 20—Conducting the Health Examination for Inclusion in the Handbook

Mr. Hughes said the draft chapter, which was circulated on Sept. 30, was provided by Ms. Paskey for the Working Group’s consideration. Ms. Paskey said she reviewed Model #430, and she provided a suggested revision to the quality assessment and improvement examination standard 4, adding a new category of documents—quality of care complaints—to the documents to be reviewed section of the exam standard. She recommended the creation of an additional marketing and sales examination standard to address contract requirements, which are referenced in Section 8 of Model #430. She said she reviewed the grievances and external review examination standards in the chapter, and she noted that the definition of adverse determination...
in Model #430 and the Uniform Health Carrier External Review Model Act (#75) does not include experimental and investigational treatment, whereas the Health Carrier Grievance Procedure Model Act (#72) includes experimental and investigational treatment in the definition of adverse determination. She proposed that the definitions section of Model #430 and Model #75 be revised, for the sake of consistency, to include experimental and investigational treatment in the definition of adverse determination. Mr. Hughes said revisions to NAIC models would be beyond the scope of the Working Group; however, this issue could be brought to the attention of the appropriate working group for future consideration. He asked Ms. Paskey to provide suggested language for a new marketing and sales standard regarding contract requirements. Ms. Paskey said she would be able to draft this language for the Working Group’s review. Mr. Hughes said no comments had yet been received on the draft chapter, and he asked that comments on the draft be submitted by Oct. 30.

5. Received Updates from State Insurance Regulator Volunteers Reviewing Models Potentially Affecting the Handbook

Mr. Hughes said various state insurance regulator volunteers have been reviewing adopted models that have the potential to affect the examination standards of the Handbook. The purpose of each state insurance regulator’s review was to see whether any revisions need to be made to the Handbook regarding the specific model they volunteered to review.

Ms. Shipp, who reviewed the Real Property Lender-Placed Insurance Model Act (#631), recommended that updates be made to Chapter 21—Conducting the Property and Casualty Examination of the Handbook regarding the model. She said Section 4—Term of Insurance Policy; Section 5—Calculation of Coverage and Payment of Premiums; Section 6—Prohibited Practices; Section 8—Evidence of Coverage; and Section 9—Filing, Approval and Withdrawal of Forms and Rates all contained provisions that should be incorporated into various sections of Chapter 21. Mr. Hughes asked Ms. Shipp to provide her suggested revisions to the chapter. Ms. Shipp said she would be submitting these for the Working Group’s consideration on an upcoming call.

Mr. Kreiter reviewed Model #440, which was amended in 2020. He said he drafted and provided Mr. Hughes and Ms. Weyhenmeyer with revisions incorporating provisions from Model #440 into Operations and Management Standard 1 and Marketing and Sales Standard 1 of Chapter 20—General Examination Standards of the Handbook. Mr. Hughes said this would be exposed for Working Group consideration and discussed on an upcoming call.

Mr. Hughes said Mr. Werbeloff volunteered to review an initial draft of revisions to Chapter 23—Conducting the Life and Annuity Examination of the Handbook; the draft incorporated changes relating to the revisions adopted in February 2020 to Model #275. The draft Mr. Werbeloff reviewed was created by the former Nebraska Department of Insurance (DOI) Director, Bruce R. Ramge, in 2020 as a “first draft,” and the draft had not yet been circulated, as Mr. Hughes wished to have state insurance regulator volunteers review the draft to see whether it was acceptable for presentation to the Working Group as is or if further revisions would be needed prior to exposure.

Mr. Werbeloff said the revisions proposed by Director Ramge would have removed some of the relevant content of the chapter. Mr. Werbeloff said he created a redline to: 1) incorporate the former director’s suggested revisions; and 2) reincorporate the content in the chapter that should be retained. He indicated that Mr. Gendron, Steve DeAngelis (CT), and Mr. Swan were all part of the review of the redlined draft, and he asked Mr. Hughes to solicit one or more additional volunteers to review the draft before forwarding it to the Working Group for its review and consideration. Mr. Pyle volunteered to review the draft.

Ms. Amann said she is continuing to review Model #305 and Model #306. She indicated that there are six categories of review in Exhibit M, each of which have multi-part questions, and these categories appear to overlap somewhat with Market Analysis Level 1 and Level 2 review questions. She said she is continuing to review the models, specifically Exhibit M regarding potential application to market conduct examinations review criteria and how corporate governance review could be included in the procedural guidance in the Handbook. Ms. Abejar added that if market regulators are examining a foreign company, they should be able to talk to the domestic financial analyst of the state of domicile. Mr. Hughes said the Working Group will continue to discuss this issue on future open Working Group calls.

6. Discussed Other Matters

Mr. Hughes said the Market Analysis Procedures (D) Working Group adopted revisions in early 2021 to chapters of the Handbook related to market analysis—Chapters 6, 7, 8 and 9—and the chapters went before the Market Regulation and Consumer Affairs (D) Committee for consideration of adoption at the Spring National Meeting. Mr. Hughes said Petra Wallace (NAIC) is reviewing the language of the Spring National Meeting minutes to see if the chapters can be directly placed in the
2022 Handbook or if, when they were adopted by the Market Regulation and Consumer Affairs (D) Committee, the Committee indicates that the Working Group needs to vet the chapters again before being incorporated into the 2022 Handbook.

Mr. Hughes said one of the Working Group’s charges is to develop uniform market conduct procedural guidance (e.g., a library or depository of electronic documents such as exam call letters, exam templates, etc.) and he asked that Working Group members and interested state insurance regulators provide additional ideas for uniform guidance that could be included in an electronic library of resources for state insurance regulators for this charge. Ms. Abejar suggested that for new examiners, there should be a repository of market risks and how to identify them. Mr. Hughes asked that state insurance regulators email him additional feedback regarding this charge so that this can be discussed during the next Working Group meeting.

Mr. Hughes said the Working Group’s charge relating to group supervision of market conduct risk is being reviewed by NAIC Market Regulation staff and Financial Regulatory Services staff. After that review concludes, it will be discussed during a future Working Group meeting.

Mr. Hughes added that while examination guidelines and/or standards in the Handbook are only based upon adopted NAIC models, the Working Group monitors other working groups and NAIC initiatives relating to ongoing work on models that have the potential to affect the examination guidelines in the Handbook, and there may be updates on these at future Working Group calls (e.g., updates on the work of the Big Data and Artificial Intelligence (EX) Working Group, the Long-Term Care Insurance Model Update (B) Subgroup, and the Accelerated Underwriting (A) Working Group) as they become available.

Mr. Hughes said the next Working Group call is scheduled to occur Nov. 4, and a notice of the call will be distributed by NAIC staff.

Having no further business, the Market Conduct Examination Guidelines (D) Working Group adjourned.

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The Market Conduct Examination Guidelines (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Sept. 2, 2021. The following Working Group members participated: Damion Hughes, Chair, Eleanor Coe, Neil A. Derr, and Dennis Newman (CO); Erica Weyhenmeyer, Vice Chair (IL); Mel Heaps and Gwen McClendon (AR); Sarah Borunda (AZ); Euclid Ritchens and Kurt Swan (CT); Patrice Garnette (DC); Frank Pyle (DE); Daniel Mathis (IA); Ron Kreiter and Sandra Stumbo (KY); Mary Lou Moran (MA); Jill Huiskens and Isaac Kane (MI); Paul Hanson (MN); Cynthia Amann, Jo LeDuc, and Win Nickens (MO); Tracy Biehn and Teresa Knowles (NC); Maureen Belanger and Edwin Pugsley (NH); Ralph Boeckman (NJ); Joel Bengo and Myra L. Morris (NM); Hermoliva Abejar and Barbara D. Richardson (NV); Sylvia Lawson and Sharon Ma (NY); Rodney Beetch and Jana Jarrett (OH); Landon Hubbard and Shelly Scott (OK); Brian Fordham (OR); Gary Jones and Crystal Welsh (PA); Brett Bache, Segun Daramola, and Brian Werbeloff (RI); Matthew Tarpley (TX); Andrea Baytop, Julie Fairbanks, and Bryan Wachtler (VA); Mary Block and Christina Rouleau (VT); John Haworth and Jeanette Plitt (WA); Barbara Belling, Diane Dambach, Darcy Paskey, Mark Prodoehl, Rebecca Rebholz, and Mary Kay Rodriguez (WI); and Desiree Mauller (WV). Also participating was: Reva Vandevoorde (NE).

1. **Heard Opening Remarks**

Mr. Hughes welcomed Rhode Island to the Working Group, represented by Mr. Gendron and Mr. Bache.

2. **Adopted New Draft Title SDRs for Inclusion in the Reference Documents of the Market Regulation Handbook**

Mr. Hughes said the Title In Force and Title Claims Standardized Data Requests (SDRs) were first circulated on March 23, and comments were received in April 2021 on the SDRs from Colorado, Nebraska, Rhode Island, the American Land Title Association (ALTA), and the Center for Economic Justice (CEJ). He said the comments were discussed on the June 10 call. At that call, the Title Insurance SDR regulator-only subject matter experts (SMEs) were asked to reconvene to review the comments received, make revisions where needed to the SDRs, and submit the SDRs to the Working Group as revised exposure drafts for discussion at the next scheduled Working Group call. Mr. Hughes said no additional comments were received on the drafts.

Mr. Hughes said revised SDRs were circulated on Aug. 26; they both contain redline revisions to various fields and field descriptions, and several fields were rearranged, predominantly in the Title Claims SDR, to improve the flow of the fields within the SDR. Mr. Newman, who is a member of the SMEs who made the revisions, said the SMEs took all comments received into consideration, and the SDRs were fleshed out to capture additional information needed when conducting a title examination. The SDRs were also made more user friendly to more logically align with the title examination process.

Ron Blitenthal (Old Republic National Title Insurance Company) asked that language be added to both SDRs to indicate that not all fields are required data elements that may be requested by a state insurance examiner and fields may be changed, or removed by examiners, as deemed applicable. Mr. Hanson said SDRs are designed to be a template that examiners use as a starting point for fields to consider when conducting a title examination, and not every field may be requested by an examiner.

Mr. Hughes verified with Petra Wallace (NAIC) that information addressing how state insurance regulators use SDRs in the market conduct examination process is incorporated into Chapter 15—Standardized Data Requests of the Market Regulation Handbook, and no changes were made to the SDRs regarding Mr. Blitenthal’s comment.

Biny Birnbaum (CEJ) asked that a reference to “direct issue” be added to the Title In Force SDR to address direct issue, where a title policy is issued directly by a title insurer and there is no title agent involved. The Working Group did not make this change, and Mr. Birnbaum withdrew his suggestion. He said all data elements requested in both SDRs are necessary for a market conduct examiner to perform an effective review of title transactions, and examiners using the SDRs should have a reasonable expectation that a regulated entity receiving the SDRs can provide the data elements requested in the SDR.

Mr. Blitenthal asked that the Claim Status field in the Title Claims SDR be revised to include additional language so that it also captures claims in instances where a title insurance company has fixed a title defect—i.e., where the title issue was resolved by the title insurer—and the title insurer was able to clear the title without payment. Mr. Newman suggested that a new code “T”
with the description “title cleared” be added to the Claim Status field description in the Title Claims SDR to address Mr. Blitenthal’s comment.

Ms. Plitt made a motion, seconded by Ms. Weyhenmeyer, to adopt the Title In Force SDR (see NAIC Proceedings – Fall 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment One) and the Title Claims SDR (see NAIC Proceedings – Fall 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment Two) with that change. The motion passed unanimously.

3. Received Updates from State Insurance Regulator Volunteers Reviewing Models Potentially Affecting the Market Regulation Handbook

Mr. Hughes said various state insurance regulator volunteers reviewed models amended in 2020 and other recent model activity identified in Working Group calls earlier this year. The purpose of each state insurance regulator’s review was to see whether any revisions need to be made to the Market Regulation Handbook (Handbook) regarding the specific model they were asked to review. Ms. Weyhenmeyer reviewed the recently amended Unfair Trade Practices Act (#880). She indicated that the updates to the model adopted in early 2021 expanded on the definition of anti-rebating, and after a review of Chapter 20—General Examination Standards of the Handbook, she felt that changes to the Handbook would not be necessary. Mr. Birnbaum said in the revised model, there is language added indicating that if certain value-added services are provided, then certain criteria would need to be met. He recommended that revisions to the Handbook would need to occur. Ms. Weyhenmeyer asked Mr. Birnbaum to submit suggested revisions, and the Working Group can discuss how to proceed regarding Model #880 during a future meeting.

Mr. Kreiter reviewed the Insurance Holding Company System Regulatory Act (#440), which was amended in 2020. He said he reviewed the background regarding the adoption of the 2020 amendments, and he found that there are still open-ended questions among the states regarding the model. He said there is language in the model that could be placed within Standard 1 of Chapter 20 of the Handbook, and he is still reviewing the model for additional applicable updates to the Handbook.

Ms. Amann reviewed the Corporate Governance Annual Disclosure Model Act (#305) and the Corporate Governance Annual Disclosure Model Regulation (#306) and provided her perspective of how the concepts within the models may affect market regulation oversight of regulated entities and her recommended next steps. She said the models were adopted in November 2014, and while neither model prescribes governance standards, they do require the reporting of what an insurer is currently doing in certain critical risk areas. Ms. Amann said, like Mr. Kreiter’s review and comment, there are several NAIC financial-related working groups that are still sorting out procedures regarding corporate governance.

Ms. Amann said the areas in corporate governance that would likely pertain to market conduct examiners include compliance functions, internal auditing, and the market conduct decision process. She said she is working on cross referencing the examination standards/review criteria in the Handbook against Exhibit M review criteria. She said while new examination standards may not arise out of her review, there are new review criteria that could be developed. Mr. Hughes said the Working Group will continue to discuss this issue on future open Working Group calls.

Mr. Hughes said Mr. Werbeloff volunteered to review an initial draft of revisions to Chapter 23—Conducting the Life and Annuity Examination of the Handbook; the draft incorporated changes relating to the revisions adopted in February 2020 to the Suitability in Annuity Transactions Model Regulation (#275). The draft that Mr. Werbeloff reviewed was created by the former Nebraska Department of Insurance (DOI) Director, Bruce R. Ramge, in 2020 as a “first draft,” and the draft had not yet been circulated, as Mr. Hughes wished to have state insurance regulator volunteers review the draft to see whether it was acceptable for presentation to the Working Group as is or if further revisions would be needed prior to exposure. Mr. Werbeloff said the draft Director Ramge created was a good initial draft. Mr. Werbeloff said he was not sure that the examination standards that Director Ramge drafted would replace existing examination standards in the chapter or if they would be incorporated as additional examination standards. Mr. Werbeloff indicated that a further review would be necessary to ascertain what language should be kept; if additional review criteria should be developed; and if duplicative review criteria exists, in which case, that language should be removed from the draft. He indicated that he would continue to review the draft regarding these three areas, and Mr. Swan volunteered to assist Mr. Werbeloff with this project.

Ms. Paskey reviewed the Health Maintenance Organization Model Act (#430), which was amended in 2020. She indicated that minor revisions to Chapter 24—Conducting the Health Examination of the Handbook should be made by adding review criteria regarding contract requirements, adding content regarding quality-of-care complaints, and making updates to the grievance and
external review sections regarding adverse determinations and experimental and investigational treatment determinations. She also indicated that references to Model #430 should be added throughout the chapter, where applicable. Mr. Hughes asked Ms. Paskey to create a redlined version of Chapter 24 for the Working Group to review at its next scheduled call.

Ms. Rodriguez reviewed the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651), which was amended in 2020. She recommended multiple grammatical changes to Chapter 25—Conducting the Medicare Supplement Examination of the Handbook, such as changing “written” to “documented,” as the term “documented” appears to be more relevant in 2021. She noted that the terms in Chapter 25 such as “company,” “carrier,” “entity,” etc., are used interchangeably throughout the chapter, and she recommended that a decision be made on which term is appropriate to use in the chapter and perhaps throughout the entire Handbook. She noted that the terms “policyholder,” “enrollee,” etc., are also used interchangeably in the chapter, and a decision should also be made regarding that usage in the chapter, as well as in the entire Handbook. She recommended that changes be made to Section C—Marketing and Sales and Examination Standards 1 and 17 in the Network Adequacy section of the chapter. She also indicated that references to Model #651 should be added throughout the chapter, where applicable. Mr. Hughes asked Ms. Rodriguez to create a redlined version for the Working Group to review at its next call.

4. **Discussed Other Matters**

Mr. Hughes said the next Working Group meeting is scheduled to occur Oct. 7, and a notice of the meeting will be distributed by NAIC staff.

Having no further business, the Market Conduct Examination Guidelines (D) Working Group adjourned.
The Market Analysis Procedures (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 18, 2021. The following Working Group members participated: John Haworth, Chair (WA); Rebecca Rebholz, Vice Chair (WI); Crystal Phelps (AR); Sarah Borunda (AZ); Don McKinley (CA); Damion Hughes (CO); Steve DeAngelis (CT); Susan Jennette (DE); Scott Woods (FL); Erica Weyhenmeyer (IL); Tate Flott (KS); Sandra Stumbo (KY); Mary Lou Moran (MA); Dawna Kokosinski (MD); Connie Mayette (ME); Jill Huisken (MI); Cynthia Amann, Teresa Kroll, and Jo LeDuc (MO); Paul Hanson (MN); David Dachs (MT); Reva Vandevoorde (NE); Maureen Belanger (NH); Erin Porter (NJ); Joel Bengo (NM); Hermoliva Abejar (NV); Guy Self (OH); Landon Hubbart (OK); Jeffrey Arnold (PA); Matt Gendron (RI); Shelley Wiseman (UT); Will Felvey (VA); Isabelle Turpin Keiser (VT); and Theresa Miller (WV). Also participating were: October Nickel (ID); Shane Quinlan (NC); Tony Dorschner (SD); and Stacie Parker (TX).

1. **Adopted its Summer National Meeting Minutes**

Mr. Flott made a motion, seconded by Ms. Rebholz, to adopt the Working Group’s July 1 minutes (see NAIC Proceedings – Summer 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment Four). The motion passed unanimously.

2. **Discussed Market Analysis Training**

Mr. Haworth said comments and suggestions have been sent in by interested state insurance regulators and compiled. He said the suggestions can be divided into three types: 1) training methods; 2) training topics; and 3) discussion.

Mr. Haworth said the training method suggestions for how training can be delivered include: 1) more virtual sessions; 2) recorded sessions that are available on demand; 3) tutorials; 4) the use of outside vendors; and 5) leveraging and adapting what is already available through the NAIC. He noted that these suggestions are not mutually exclusive. For example, any training that is provided can be presented both virtually and in person and also be recorded at the same time.

Mr. Haworth said training topic suggestions include: 1) Market Analysis Review System (MARS), Level 1, and Level 2 training; 2) MCAS ratios and the identification of outliers; 3) the use of Tableau and other visualization tools; and 4) general training for new analysts and smaller departments.

Mr. Haworth said the ideas labeled as discussion do not fit neatly into the other two categories. He said they include: 1) the creation of monthly market analyst groups to discuss analysis techniques; and 2) a suggestion to reorganize i-Site+ to put all market conduct tools on one page.

Mr. Haworth said he and Ms. Rebholz will review these ideas with NAIC staff support to come up with some ideas for implementing the suggestions and begin moving forward with enhanced training for market analysts. He said he will report back to the Working Group.

Mr. Hughes said a training course could start with an overview of the tools in i-Site+ and then drill down into the individual tools. Mr. Dorschner noted that the NAIC’s Market Analysis Techniques – Online course provides a lot of insight.

3. **Discussed Standard MCAS Ratios for Travel Insurance MCAS and STLD Insurance MCAS**

Mr. Haworth said the Market Conduct Annual Statement Blanks (D) Working Group adopted the travel and short-term, limited-duration (STLD) MCAS blanks earlier in 2021. He noted that after a new MCAS blank is adopted, it is the responsibility of the Market Analysis Procedures (D) Working Group to develop and adopt scorecard ratios for the new blanks. He said the scorecard ratios are the ratios that are publicly made available on the MCAS web page, usually on a state-wide basis, so no individual company ratios are identifiable. He said that typically there are less than 10 ratios that are identified for publication on the MCAS scorecard page for a line of business, but the Working Group can adopt more ratios if it makes sense to do so.

Mr. Haworth said that to begin the discussion of which ratios to adopt for the travel and STLD blanks, NAIC staff support drafted a list of possible ratios for both lines of business. He said the draft ratios are only suggestions. The Working Group can
adopt all of them or just some of them. He said the Working Group could also come up with different ratios or different ways of calculating the ratios. He said the draft’s main purpose is just to begin the discussion.

Mr. Haworth said there are six proposed ratios for the travel line of business. He said the ratios closely follow the ratios already used on the homeowners and auto MCAS lines of business. These ratios are for the entire blank and are not broken down by coverage type. He noted that if it makes sense to have any particular ratios broken out by coverage type, that also can be considered.

Mr. Haworth said there are 16 potential ratios proposed for the STLD line of business. He said that is a lot of ratios, but this is merely a list of suggestions, and not all of them need to be adopted. He said the ratios closely track with the health MCAS line of business but focus more on the issues or concerns with STLD, such as the percentage of policies sold through associations not situated in the state.

Ms. LeDuc said the proposed travel ratio 3, “Percentage of Claims Paid Beyond 30 Days,” included the data element for “claims paid under 30 days” in both the numerator and the denominator. Randy Helder (NAIC) said that would be an error and should only be included in the denominator. He said he would edit that.

Ms. LeDuc asked why ratio 4, “Cancellations by Insured to Total Cancellations and Expirations,” used total cancellations in the denominator. She said cancellations are normally compared to policies issued. Mr. Helder said policies issued was not a data element in the travel blank, and policies in-force at the beginning or policies in-force at the end of the reporting period would miss a number of policies since travel policies are usually written for a period less than a year.

Ms. LeDuc asked what the ratio would tell the analyst. Mr. Helder said he thinks that a high percentage on this ratio compared to other companies may indicate a problem with the product or service that is causing the consumer to cancel with more frequency. Birny Birnbaum (Center for Economic Justice—CEJ) said ratio 4 has no purpose since most, if not all, cancellations will be by the consumer. He said the ratio would be near 100% for all companies. Mr. Helder noted that the denominator includes not just cancellations but also all policies that expired, so the ratio would usually be below 100%. He said the expirations were included in the denominator to capture all policies that were in-force at some point in the year.

Mr. Birnbaum said it is important to publish ratio information by coverage part. He also suggested publishing the premium information that will be reported on the travel MCAS blank since there is no other source for travel insurance premium information.

Mr. Hughes said that for the STLD MCAS ratio, it would be helpful to have a ratio comparing the number of claim denials for preexisting conditions to the total number denials for any reason. He said this ratio may indicate the consumer did not understand that coverage was not compliant with the federal Affordable Care Act (ACA) and was only STLD.

Ms. Rebholz suggested forming two subject matter expert (SME) groups to hone the ratios and bring them back to the Working Group. Mr. Haworth agreed that was a good idea. Ms. LeDuc and Ms. Weyhenmeyer volunteered to be on the SME groups. Mr. Haworth asked anyone who is interested in being on one or both groups to let Mr. Helder know. He said that comments can also be sent to Mr. Helder.

4. Discussed Market Analysis Tools

Mr. Haworth said the current i-Site+ market analysis tools and data elements will be affected by the creation of improved tools and dashboards. He said one of the projects in the NAIC’s State Ahead strategic plan is to create Tableau dashboards to replace current i-Site market regulation tools and applications. He said NAIC staff prepared a list of market information system tools that are in line for elimination because they will become obsolete once the new dashboards are completed. He said it would be inefficient to dedicate resources to maintaining two tools that do essentially the same job. Mr. Haworth said that during the creation of the Tableau dashboards, it became clear that some of the current tools in i-Site+ are not being used very often and two of the reports—the MCAS Line Report and the Market Analysis Profile (MAP) Demographics—are included on the list.

Mr. Haworth said the Working Group is not making the decision on the elimination of these tools. He said that will be the task of the Market Information Systems Research and Development (D) Working Group, which will be reviewing the same list. He said that since the Market Analysis Procedures (D) Working Group is responsible for the market analysis that relies heavily on these tools, he thinks it is important that the Working Group have an opportunity to review and make any suggestions or recommendations about the list.
Ms. LeDuc said she is supportive of using visualization in market analysis, but she cautioned against just importing the current data and replicating the tools in Tableau. She said the current reports have data elements that have not been found to be useful and some data elements that should be added. She said it would be useful to take the opportunity to improve the data being presented.

Mr. Quinlan asked if the underlying data that support the new tools would be available for download to the market analyst. He said that there are instances where multiple Tableau dashboards need to be opened to obtain the same data available in one i-Site+ tool. Teresa Cooper (NAIC) said the Market Analysis Prioritization Tools (MAPT) is not going away at this time. She said the data will be available for download, and the Enterprise Data Platform teams are working on improving the way ad hoc querying is done. She also encouraged the state insurance regulators to provide advice and feedback on the tools being developed.

Mr. Quinlan noted that some of the Tableau reports can be difficult to work with, such as the plots of all the data of companies for one data element. All the representative points of data are congested. Kyle Lichtenberger (NAIC) said he is working on making the dashboards intuitive and noted that choosing a company on the report will highlight the dots representing the company for each year. He said he is happy to work with the state insurance regulators to explain and improve the dashboards.

Ms. Nickel said she appreciates Ms. LeDuc’s advocacy for visualization, but she would still like to have the data presented as it is presented in the MAPT and not always in a visualization. Ms. Nickel said downloadable options for the data need to be made available also. Ms. LeDuc said that in Missouri, they will download the data and merge it with internal data, so they still need access to the data.

Mr. Haworth asked that comments on the market analysis tools be sent to Mr. Helder by Dec. 10.

5. Discussed Other Matters

Ms. Parker asked the Working Group for clarification on the MCAS reporting of multiyear guaranteed annuities (MYGA) that have a term of three or five years. She said that at the end of the term, the owner of the MYGA has the option to purchase a new contract using the cash value from the previous contract. She said Texas thinks this should be reported as an internal replacement and a surrender of the old contract. She said she sent this question to the Market Analysis Bulletin Board, and a few states responded in agreement with Texas that the transaction is a surrender of the original contract. She wanted to know if anyone else on the Working Group had thoughts about this. She also asked if there should be some clarifications of the data call and definitions.

Ms. Nickel said she responded to the bulletin board question and agrees that there needs to be a clarification in the definitions of “replacement” and “surrender.” Ms. Parker says that the writers of MYGAs may get identified as outliers because they write the short-term products and would report more replacements and surrenders, even if there are no surrender fees. Ms. Nickel suggested new data elements may be necessary for this product. She said she has reached out to companies that seem to be outliers and determined everything is alright, but it takes time to do that. Mr. Flott and Mr. Gendron agreed that new data elements may be appropriate. Mr. Gendron said this also happens with safe harbor sales, and he said he encourages companies to put explanations in the interrogatories if they think their numbers inaccurately identify them as an outlier.

Ms. Nickel said that on the property/casualty (P/C) side, there are also carriers that continually misreport their claims data. She asked if that should continue to be allowed or if the carriers should have their feet held to the fire on this issue.

Mr. Haworth asked for comments to be sent to Mr. Helder by Dec. 10.

Having no further business, the Market Analysis Procedures (D) Working Group adjourned.

MAPWG 2021 Fall National Meeting Minutes
The Market Conduct Annual Statement Blanks (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 22, 2021. The following Working Group members participated: Rebecca Rebholz, Chair (WI); Tate Flott, Vice Chair (KS); Sarah Borunda (AZ); Janice Davis (FL); Erica Weyhenmeyer (IL); Lori Cunningham (KY); Mary Lou Moran (MA); Salama Karim-Camara (MD); Jill Huiskens (MI); Jo LeDuc (MO); Reva Vandevoorde (NE); Leatrice Geckler (NM); Glynda Daniels (SC); Maggie Dell (SD); Shelli Isiminger (TN); Shelley Wiseman (UT); and John Haworth (WA).

1. **Adopted its July 28 Minutes**

The Working Group met July 28 and took the following action: 1) adopted its June 30 minutes; 2) received an update on the life Market Conduct Annual Statement (MCAS) draft edits for accelerated underwriting (AU); 3) received an update on the Other Health Drafting Group; 4) discussed the lawsuit definitions and placement of the lawsuit data elements for the homeowners and private passenger auto (PPA) MCAS; and 5) requested submission of suggested edits to existing MCAS blanks and data call and definitions.

Mr. Haworth made a motion, seconded by Mr. Flott, to adopt the Working Group’s July 28 minutes (see NAIC Proceedings – Summer 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment Five). The motion passed unanimously.

2. **Received an Update on the Life MCAS Draft Edits for AU**

Ms. Rebholz stated that earlier this year, the Accelerated Underwriting (A) Working Group worked to add AU data elements to the life MCAS reporting, but the Working Group decided it would be best to wait for the Accelerated Underwriting (A) Working Group to adopt a definition of AU for the sake of consistency between the two working groups. She stated that the Accelerated Underwriting (A) Working Group has exposed a draft document for a public comment period ending Dec. 3, which will be discussed during the Working Group’s Dec. 6 meeting. Ms. Rebholz stated that once the Accelerated Underwriting (A) Working Group adopts its definition of AU, then the Market Conduct Annual Statement Blanks (D) Working Group can continue its work to add AU data elements and definitions to the life MCAS.

Rikki Pelta (American Council of Life Insurers—ACLI) asked if the list of subject matter expert (SME) group volunteers that participated previously would be contacted for additional information. Teresa Cooper (NAIC) stated they would be contacted and that anyone else who would like to join the SME group should let her know so they can be added.

3. **Received an Update on the Other Health Drafting Group**

Randy Helder (NAIC) stated the Other Health Drafting Group has not met recently. Mr. Helder stated the new chair of this Drafting Group is Mary Kay Rodriguez (WI), and the people that previously participated in the blank discussions for the short-term, limited-duration insurance (STLDI) would be contacted about meeting soon. He stated that anyone else who would like to join the Drafting Group should contact him.

4. **Received a Proposal from the SME Group on Lawsuit Definitions and Placement of the Lawsuit Data Elements for the Homeowners and PPA MCAS**

Ms. Rebholz stated that this proposal is part of the meeting materials and that a comment period is open, so no decisions need to be made today as the proposal will be considered at a later meeting. She stated Ms. Weyhenmeyer led the SME group discussions.

Ms. Weyhenmeyer stated the SME group worked to provide a proposal that simplifies the lawsuit reporting and its definition as much as possible. She stated the SME group proposes the following for the homeowners and PPA MCAS lawsuit reporting: 1) removing the lawsuit data elements from the claims reporting section; 2) creating a new reporting section for the lawsuit data elements; 3) reporting the lawsuit data elements by claims coverage type as has been done in the past; 4) adding reporting for “non-claim-related lawsuits”; and 5) updates to the definition of “lawsuits” to accommodate the new
reporting structure. Ms. Weyhenmeyer stated the proposed definition is similar to the definition used for other MCAS lines of business, which was done for consistency. She stated a few of the simplifications to the definition could be made to the definition in other lines of business if the Working Group finds that it would be useful. She stated that additionally noted while preparing items for this meeting is the need to add an interrogatory to capture comments for the newly added lawsuit section, which is not an item showing in the meeting materials. She stated this would need to be added because the definition of “class-action lawsuits” requires an explanatory note.

Ms. Nichols asked that everyone review the draft proposal and provide any comments to Ms. Cooper by Dec. 17.

5. Received a Proposal from the SME Group on Reporting of the Digital Claims Interrogatory Question

Ms. Rebholz stated that this proposal is included in the meeting materials and that there is a comment period open for the digital claims interrogatory question proposal, so a decision does not need to be made today as it will be considered in a later meeting.

Ms. Weyhenmeyer stated that during the Working Group’s June 30 meeting, it was voted to include an interrogatory to capture third-party vendors providing third-party data and algorithms used in the digital claims process. She stated the wording approved during that meeting included “and for each vendor, identify the vendor’s specific role in the digital claims process” to address concern of whether a third-party vendor is being used appropriately. The SME group was tasked to revisit this interrogatory and make a recommendation of how third-party vendor data would be reported. She stated that in this proposal, the requirement to identify vendor roles is removed, allowing for the single element capture of names of third-party vendors, similar to the capture of names of managing general agents (MGAs) and third-party administrators (TPAs).

Ms. Rebholz asked that any comments on the digital claims interrogatory question proposal be provided to Ms. Cooper by Dec. 17.

6. Discussed Other Matters

Ms. Rebholz stated she and Mr. Flott would not be the chair and vice chair of this Working Group in 2022.

Having no further business, the Market Conduct Annual Statement Blanks (D) Working Group adjourned.
The Privacy Protections (D) Working Group met in San Diego, CA, Dec. 11, 2021. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (KY); Damon Diederich (CA); Erica Weyhenmeyer (IL); LeAnn Crow (KS); T.J. Patton (MN); Molly Plummer (MT); Jon Godfread, Chris Aufenthie, and Johnny Palsgraaf (ND); Martin Swanson (NE); Teresa Green (OK); Raven Collins (OR); Gary Jones (PA); and Don Beatty (VA). Also participating were Lori K. Wing-Heier (AK); Doug Ommen (IA); Robert Wake (ME); Chlora Lindley-Myers (MO); and Barbara D. Richardson (NV).

1. Adopted its Nov. 22, Oct. 25, and Oct. 11 Minutes

Ms. Amann said the Working Group met Nov. 22, Oct. 25, and Oct. 11.

During its Nov. 22 meeting, the Working Group took the following action: 1) heard an update on state privacy legislation; 2) received comments on the right to data portability and the right to restrict the use of data in the privacy policy statement exposure draft; 3) walked through the final exposure draft of the privacy report to the Market Regulation and Consumer Affairs (D) Committee on the privacy policy statement and the right to consumer ownership of data; and 4) discussed comments on the right to restrict the use of data; the right of portability; and the right of consumer data ownership from the Coalition of Health Insurers, America’s Health Insurance Plans (AHIP), the Blue Cross Blue Shield Association (BCBSA), the Independent Insurance Agents & Brokers Association (IIABA), the National Association of Mutual Insurance Companies (NAMIC), the American Council of Life Insurers (ACL), and NAIC consumer representatives: Birny Birnbaum (Center for Economic Justice—CEJ), Harry Ting (Healthcare Consumer Advocate), Karrol Kitt (University of Texas at Austin), Bonnie Burns (California Health Advocates), and Erica Eversman (Automotive Education & Policy Institute—AEPI).

During its Oct. 25 meeting, the Working Group took the following action: 1) reviewed an update to the Abbreviated Data Privacy Legislation Chart and the State Privacy Law Comparison Chart; and 2) received comments on the right to delete information from the ACLI, Ms. Kitt, and the Coalition of Health Insurers.

The Working Group also met Oct. 11 and took the following action: 1) adopted its Aug. 30, Sept. 13, and Sept. 25 minutes; 2) heard an update on State Privacy Legislation; and 3) received comments on the right to correct information from the ACLI, Dr. Ting, and the Coalition of Health Insurers.

Mr. Kreiter made a motion, seconded by Mr. Diederich, to adopt the Working Group’s Nov. 22 (Attachment Nine-A), Oct. 25 (Attachment Nine-B), and Oct. 11 (Attachment Nine-C) minutes. The motion passed unanimously.

2. Received Comments on the Final Exposure Draft of its Report on Consumer Data Privacy Protections

Ms. Amann said the Working Group received written comments and suggested edits from the ACLI; AHIP; the American Property Casualty Insurance Association (APCIA); the BCBSA; the IIABA; the Medical Professional Liability Association (MPLA); NAMIC; the Non-Health (Life and Property/Casualty [P/C]) Joint Trades; the Coalition of Health Insurers; and NAIC consumer representatives: Brenda J. Cude (University of Georgia), Ms. Kitt, and Dr. Ting. Ms. Amann said each organization will have two minutes to summarize their additional comments, as these issues have already been discussed during one of the 10 Working Group meetings this year. However, to clear up any continued confusion about the duties and activities of this Working Group, she said she and the vice chair would like to take a few minutes to give their comments and submit Appendix B as a new attachment first. She said the Working Group’s 2021 adopted charges are to:

Review state insurance privacy protections regarding the collection, use, and disclosure of information gathered in connection with insurance transactions, and make recommended changes, as needed, to certain NAIC models, such as the NAIC Insurance Information and Privacy Protection Model Act (#670) and the Privacy of Consumer Financial and Health Information Regulation (#672).
Ms. Amann said the Working Group was given the following clarification by the Market Regulation and Consumer Affairs (D) Committee on behalf of NAIC members (which was discussed by the Working Group at that time and many times in subsequent meetings and has been posted to the Working Group’s webpage since March 29).

**NAIC Member-Adopted Strategy for Consumer Data Privacy Protections:**

1. Charge the Market Regulation and Consumer Affairs (D) Committee with:
   a. Summarizing consumer data privacy protections found in existing NAIC models: *Health Information Privacy Model Act* (#55), *NAIC Insurance Information and Privacy Protection Model Act* (#670), *Privacy of Consumer Financial and Health Information Regulation* (#672).
   b. Identifying notice requirements of states, the European Union’s (EU’s) General Data Protection Regulation (GDPR), and the California Consumer Privacy Act (CCPA) and how insurers may be subject to these requirements.
   c. Identifying corresponding consumer rights that attach to notice requirements, such as:
      - The right to opt-out of data sharing.
      - The right to correct or delete information.
      - The right of data portability.
      - The right to restrict the use of data.
      - How insurers may be subject to these requirements.
   d. Setting forth a policy statement on the minimum consumer data privacy protections that are appropriate for the business of insurance.
   e. Delivering a report on items a. – d. above by the 2021 NAIC Fall National Meeting.

2. In 2022, engage with State Attorneys General (AGs), the U.S. (Congress), and federal regulatory agencies on state and federal data privacy laws to minimize preemption provisions and maximize state insurance regulatory authority.

3. Reappoint the Privacy Protections (D) Working Group to revise NAIC models, as necessary, to incorporate minimum consumer data privacy protections that are appropriate for the business of insurance. Complete by the NAIC 2022 Fall National Meeting.

Ms. Amann said the Working Group has been transparent about its actions, discussing any issues brought before it, indicating that regulator-only subject matter experts (SMEs) were meeting periodically (eight times) to determine format and processing issues, as necessary, while the Working Group was holding its discussions during a series of 10 open meetings in 2021. She said there has been a lot of discussion about whether the word “right” should be used when discussing consumer privacy issues; however, that is the term used by NAIC membership to the Market Regulation and Consumer Affairs (D) Committee in its privacy strategy to the Working Group. She said the Working Group clarified that it would not be interpreted to be an absolute right, but it should be a functional right that would serve to help protect consumers’ privacy and the protection of consumer data as it is used within insurance markets. She said companies have expressed concerns that the term “privacy policy statement” appeared suddenly, and they had no opportunity to review or comment on it or on the report to the Market Regulation and Consumer Affairs (D) Committee; however, the term “privacy policy statement” has been used since the Working Group’s first meeting this year in March. She said exposure documents using the name “privacy policy statement” have been posted to the Working Group’s web page multiple times and remain there to this day. She said each of the exposure documents had been discussed in detail, as evidenced in the minutes of these meetings. She said the format may have changed, but the content has not, other than to be tweaked as further discussions are warranted. She said the latest version of the privacy policy statement is included in the Working Group’s report to its parent committee.

Ms. Amann said the draft of the privacy report to the Market Regulation and Consumer Affairs (D) Committee was exposed Nov. 18 for a two-week public comment period that ended Dec. 2. She said an extended exposure period was not necessary because the Working Group had already discussed these issues previously. She said the exposure draft report does not recommend copying the GDPR, nor any existing state law; however, it does include the federal, state, and international legislative issues discussed and key discussion points that were selected to give those reading it from a much higher viewpoint an idea of the breadth of the discussions because to include all of them would have made the report unmanageable at over 100 pages. She asked those present to note that the report also includes the right to consumer data ownership added by NAIC members at the NAIC Summer National Meeting in Columbus, OH; Appendix A – the privacy policy statement with “NAIC” removed from the title and the title changed to Working Group Report; and Appendix B – a list of meetings and resources reviewed by the Working Group this year. She said the Working Group would like to leave those present with the fact that the exposure draft before them is simply a report of a working group to its parent committee of its activities and work on its charges.
throughout the year. She said the report is not a model act or law, a white paper, or a bulletin or legal recommendation of any sort; but it is a recommendation by a Working Group that revisions are needed to Model #670 and Model #672, as they are outdated and need to be revised to accommodate the existing technology used in insurance solicitation and implementation today. She said the Working Group would not know its fate for 2022, as charges have not yet been adopted by the two possible committees that might do privacy protections. Mr. Kreiter said he agrees with everything the chair said, and he wanted to emphasize that the Working Group is transparent about its meetings, including those of regulator-only SMEs who discussed format, procedures, and processes to move the Working Group forward. He said neither the Working Group nor the SMEs had any secret meetings.

Chris Petersen (Arbor Strategies LLC), speaking on behalf of the Coalition of Health Insurers, said some suggested guidelines for future changes to NAIC privacy models would be to focus on revising Model #672 because most states have adopted it, whereas most states have not adopted Model #670 and the wording in it is outdated. He recommended continued use of opt-in for health with no caveat to prevent sharing “under law” (e.g., in fraud detection, prevention, and enforcement situations) because market conduct examinations would require authorization. He said this language already exists in Model #672 due to the opt-out requirements of the Gramm-Leach-Bliley Act (GLBA), so that would be a good place to start.

Ms. Kitt said industry has lots of new products and it is past time to modernize NAIC privacy models. She said consumer representatives support opt-in for all lines of insurance rather than opt-out, as the responsibility for ensuring the privacy of consumer data should be on the companies rather than the consumer, who has little to no understanding of insurance products, let alone the collection and use of their data during the marketing, sales, underwriting, and claims process. She said the amount of data and personal information collected by insurers and their third-party affiliates has expanded greatly, so it is now a monumental task to reign its use and the degree of sharing that occurs without the consumer’s knowledge, consent, or approval. She said insurers must be held accountable for the data received from third-party affiliates and how it is to be used. She said she is disappointed that the Working Group is using the report and NAIC models as a basement statement. She said there needs to be a balance of the insurer’s use with the consumer’s need, and the consumer needs to be given a greater amount of leverage. She said the last paragraph of the report discusses the ongoing relationship of insurer and consumer to mean that such a relationship exists for as long as the consumer has a policy. She wondered if that would still be true if the consumer does not take a policy or cancels that policy after a time. She said specific reasons should be given to consumers for adverse selection; rather than an insurer saying the consumer’s credit score is too low, the insurer should say the consumer’s score of 585 does not meet the acceptable score of 650 set by the insurer. She said new products in the market today warrant new privacy rules. Mr. Birnbaum said the term “rights” needs to be replaced with the phrase “need for fairness” throughout the report, as it would be a more accurate description of the intent of revisions to consumer privacy notice and disclosure requirements.

Bob Ridgeway (AHIP) said the NAIC will move forward with revisions to Model #672 as recommended by the Working Group, and AHIP members support this approach. He agreed that the nine categories rather than rights need to be part of the discussion as the models are revised in the future. Wesley Bissett (IIABA) said the NAIC was ahead of the curve in privacy in the past because it used principle-based requirements that were not technology specific. He said revisions should be considered only where there are gaps or potential for consumer harm using a cost/benefit analysis, and everyone should understand that this report is a high-level overview or the big picture, if you will, of the consumer data privacy discussion. Kristin Abbott (ACLI) and Shelby Schoonesee (ACLI) said they agree with their colleagues representing the other industry trades; however, they reiterated that the current models had sufficient consumer privacy requirements already, given that no consumer complaints have been received about data privacy.

Ms. Amann said Dr. Ting was unable to present to the Working Group due to a conflict with another meeting, but said she wants to invite those assembled to see and hear his presentation on consumer privacy during the NAIC/Consumer Liaison Committee meeting on Dec. 13.

3. **Adopted the Final Exposure Draft of its Report on Consumer Data Privacy Protections**

Ms. Amann said the Working Group would ensure that protection standards articulated in the NAIC *Market Regulation Examination Standard Handbook* would be addressed by the Working Group in its discussions going forward should the Working Group be reestablished by the Innovation, Cybersecurity, and Technology (H) Committee or the Market Regulation and Consumer Affairs (D) Committee in 2022. Mr. Diederich said he supports the Working Group report, especially in the current environment where pocket computers are tracking consumer data digitally and the pandemic has changed how we live such that nothing is surprising nor earth shattering any more. Mr. Wake said Model #672 is the vehicle that should be used,
and it is outdated, including the opt-in for health insurance with its exceptions to broad principles. Ms. Amann said the Working Group would keep and use the comments received when reviewing models in the future, as well as 2021 business practices.

Mr. Diederich made a motion, seconded by Mr. Kreiter, to adopt the final exposure draft of the Privacy Protections (D) Working Group Report on Consumer Data Privacy Protections with edits agreed to by Working Group members, interested state insurance regulators, and interested parties (see NAIC Proceedings – Fall 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment Five). The motion passed by a majority with one abstention. The report is adopted and will be presented to the Market Regulation and Consumer Affairs (D) Committee for its acceptance during its Dec. 15 meeting.

Having no further business, the Privacy Protections (D) Working Group adjourned.
Privacy Protections (D) Working Group
Virtual Meeting
November 22, 2021

The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Nov. 22, 2021. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (KY); Damon Diederich and Sam Singh (CA); Erica Weyhenmeyer (IL); LeAnn Crow, Tate Flott, and Shannon Lloyd (KS); T.J. Patton (MN); Molly Plummer (MT); Chris Aufenthie and Janelle Middlestead (ND); Gary Jones (PA); and Katie Johnson and Don Beatty (VA). Also participating were: Kurt Swan (CT); Jan Davis (FL); Robert A. Wake (ME); Marjorie Thompson (MO); and Shelley Wiseman (UT).

1. Received a Legislative Update from NAIC Staff

Brooke Stringer (NAIC) said legislation had been drafted on both sides of the aisle, but there is nothing substantive yet.

Jennifer McAdam (NAIC) said there had been no activity as state legislatures will not meet again until Feb. 2022. However, she said most states will begin preparations in December and January.

2. Received Comments on Segment Five and Segment Six of the Privacy Policy Statement Exposure Draft

Ms. Amann said written comments were received on Segment Five—The Right to Data Portability and Segment Six—The Right to Restrict the Use of Data from the American Council of Life Insurers (ACLI) and on Segment Five from the Coalition of Health Carriers. She said comments received by the deadline are posted to the Working Group’s web page. Ms. Amann said comments received after the deadline would be posted soon. She said all comments received would be considered by the Working Group for incorporation into the exposure draft as it goes through the segments to complete its charges. She said the discussion at this meeting would be on comments received on Segment Five and Segment Six.

Kristin Abbott (ACLI) said her comments are on behalf of Shelby Schoensee (ACLI) as well. Ms. Abbott said ACLI members support a consumer’s right to request a copy of certain personal identifiable information (PII) and to provide that requested information in a usable format requested by the consumer, if technically feasible. She said given the lack of demand or any direct practical benefit to consumers, ACLI members were concerned with the cost and significant security risks in trying to accommodate such requests. Ms. Abbott asked that the Working Group consider the unintended and disruptive consequences of offering consumers an indefinite, absolute right to restrict all uses of their personal information or only to certain uses specified by the consumer. She said ACLI members appreciate the work the Working Group is doing and look forward to continuing this conversation in relation to the latest exposure draft. Ms. Amann said she appreciates the comments made and that she is picking up some of the more consistent thoughts from various interested parties, so she asked interested parties not to think that their comments have been ignored. She said everyone’s comments will be in the draft eventually. However, some may not show up until version two or seven or 12. Karrol Kitt (The University of Texas at Austin) asked Ms. Abbott if she was referring to the fact that there is little demand for the portability of consumer data or if there is little benefit. She asked if the ACLI could substantiate how consumer demand is related to consumer knowledge. Ms. Kitt said since there is no historical data collection, there needs to be a new understanding and new disclosures to build consumer knowledge as it relates to such consumer data privacy issues due to the new technical insurance environment.

Ms. Amann said the existing models did not contemplate the current environment, so the models need to be revised, but to what extent and whether revised disclosures are the answer has yet to be determined. She said historically consumers have not been aware or knowledgeable about such issues. However, she said this will be a major focus for the Working Group in 2022. Birny Birnbaum (Center for Economic Justice—CEJ) said consumers are seen as commodities by industry; those insurers can get to purchase or use their products by limiting consumers’ choices via algorithms. However, he said to consumer advocates, consumers are persons who need to know what choices are available to them. Mr. Birnbaum said consumers should have access to their own health information like they have access to their financial information so they can share either with those the consumer chooses.

Chris Petersen (Arbor Strategies LLC), speaking on behalf of the Coalition of Health Carriers, asked how federal Health Insurance Portability Accessibility Act (HIPAA) requirements would allow insurers to share a consumer’s data as it is specifically prohibited. He said the individual consumers would have to request their own data and then share it with other...
entities themselves. He said financial institutions could share consumers’ information with their consent. Mr. Petersen said there are different sets of rules for financial and health concerns. He said the Working Group takes a term and treats it differently from the way it is generally known (e.g., within the General Data Protection Regulation [GDPR]). Mr. Petersen said the Working Group should not use the term “portability” as it is defined in the GDPR, but rather the Working Group needs to define “portability” differently or use the term “access.” He said the Working Group should also look at the NAIC Insurance Information and Privacy Protection Model Act (#670) and HIPAA. Mr. Birnbaum said that would be inappropriate because the GDPR allows entities to destroy data. Mr. Wake said HIPAA mandated a data standardization regime. Mr. Diederich said insurers need to disclose this information via authorizations. Mr. Petersen said the term “portability” is not used in the insurance industry. Ms. Schoensee said that this is a complicated issue but that all participants have the same goal, which is to find a balance between insurers and consumers. She said there needs to be additional, meaningful, and thoughtful consideration before the Working Group can move on to an exposure draft. Ms. Amann said there will be more robust discussions and definitions to come and while the Working Group is revising the NAIC models in 2022. She said the Working Group welcomes everyone’s input as it develops a succinct draft of revisions needed. Wes Bissett (Independent Insurance Agents & Brokers of America—IIABA) asked when data ownership and potential public policies were added to the rights discussed by the Working Group. Ms. Amann said the Working Group has noted during almost every meeting that right is being used with a lowercase “r” to reflect that it is not an absolute right, but more like a category for discussion. She said the right of consumer data ownership was informally added to the Working Group’s discussions during the Innovation and Technology (EX) Task Force at the Summer National Meeting.

Mr. Bissett said he appreciates the review of privacy laws, but he is concerned with the policy statement in Appendix A. He said the privacy policy statement in Appendix A was not discussed previously within the Working Group meetings. Mr. Bissett said he is concerned that in the paper, it refers to a right of data ownership as though it is some sort of already existing inalienable right. He said there are references to it sort of being a minimum consumer privacy protection that should apply in the business of insurance. So, Mr. Bissett said asked, “Has the Working Group already made the decision, so we are now at the point where there ought to be a requirement related to data portability? What is going to happen next? Is it that the existing models will be revised so that they reflect the existence of this?” Ms. Amann said that is not the case. She said the right of data ownership was not included when the Working Group started down the road on their charges. However, at the Summer National Meeting, the Working Group was given the authority to add data ownership as one of the rights being reviewed. Ms. Amann said the Working Group is talking about rights with a lowercase “r” and not as in an inalienable right as Mr. Bissett mentioned. She said data ownership is an issue that will be fought over going forward. She said the Working Group has not made a definitive statement on it but rather put it in as a placeholder to be discussed more in the future. Mr. Bissett said maybe the paper needs to make clearer that these are potential public policy outcomes that are being discussed, that they are all on the table, and that no decisions have been made yet. He said the suggestion or implication appeared to be in the paper right now and that the Working Group appeared to have concluded that if there is not a right to something like data portability, then there ought to be such a right, and that the models were going to be revised to provide those rights.

Ms. Amann said if that is what people are seeing, the Working Group need to correct it because that is not the intention. She said the Working Group has identified certain rights, but the Working Group has not made any decisions about all consumers needing to have these 10 topics or rights. Ms. Amann said these rights are areas of concern that state insurance regulators and consumer representatives have pertaining to the privacy of consumer data, so the Working Group does not want to get hung up on the word “right” at this time. She said it is a way to say that these are top eight or 10 topics pertaining to privacy and privacy protections that the Working Group wanted to address. Lois E. Alexander (NAIC) reminded everyone that the Working Group received the strategic initiative from NAIC members in April regarding privacy wherein the members identified these issues as “rights,” so the Working Group has used that term because it is the term used by NAIC members in their directive passed on through the parent committee. Mr. Bissett said the term is still a source of ongoing confusion. He said even if one looks at these as potential requirements that would apply to industry, some industry folks at least wonder where these came from. Mr. Bissett said in the paper, there is a reference that insurance licensees should provide a periodic notice of its privacy policies and practices not less than annually. He said he does not remember the meeting where that was discussed, or if there was a vote taken on that, which flies in the face of what state and federal regulators have done in recent years on that.

Ms. Amann said going forward, these are the types of issues that may warrant regulatory requirement, regulatory input, or some sort of oversight because of the impact upon the consumer. So, she said while it is not the intent of this report, those types of issues could become the topics for discussion going forward. However, she said the Working Group is not there right now and is not making any kind of regulatory requirements in this policy statement. Ms. Amann said if language comes across that way, the Working Group can make some refinements to it for clarification. She said that she appreciates the comments and said sometimes the only way one can tell if something that was written hit the mark is to say it out loud and to hear others give an
impression of how they are taking it. Ms. Alexander said to clarify, what is in the paper that Mr. Bissett is talking about is just a summary of discussions of selected topic; it is not cast in stone.

Mr. Bissett said his chief concern and that of others in the industry is with Appendix A, which seems to be almost like a mini model law of its own or a series of recommendations. He said that is where he saw the recommendation that there ought to be no less than an annual privacy notice requirement and it talks about a specific timing of 30 days. He said this seems to be a specific public policy requirement or recommendation that has not been talked about. Mr. Bissett said perhaps there should be further conversation about whether there needs to be access to and obligations put on licensees or certain types of licensees. He said it seems like the hand is being put on the scale with specific recommendations that are being made in the appendix and based on this assumption, industry’s recommendation at this point would be to remove Appendix A altogether or at least to continue discussions. Ms. Amann said an undercurrent to the whole issue is that Model #672 long at 77 pages, so it needs a great deal of streamlining to make clear what is expected, what someone can or cannot request, and what someone can or cannot do. She said one of the problems with the whole privacy issue is that there are a lot of requirements already and maybe the requirements are not stated as clearly as possible. Or, she said maybe consumers do not act as they should with how business do. She said one of the problems with the whole privacy issue is that there are a lot of requirements already and maybe the requirements are not stated as clearly as possible. Or, she said maybe consumers do not act as they should with how business has evolved now as compared to when these models were initially drafted. Mr. Bissett said he thinks it would be a helpful tool for industry, regulators, and policymakers if a state is interested in a particular issue, that the provision of a model law where that is addressed would link up issues as to how these issues are addressed in other NAIC models.

Mr. Birnbaum said the charge to the Working Group is to review problems in protections and make recommended changes as needed to certain models. He said what Mr. Bissett is saying is that the Working Group should remove any recommendations. However, if the Working Group did that, it would not be carrying out its charge. He said the Working Group is making recommendations. It is not making law, and that is exactly what the Working Group is charged with doing. Mr. Bissett said those recommendations had not been discussed. Mr. Birnbaum said the recommendations had been discussed in this Working Group. Mr. Wake said one thing Mr. Bissett might be trying to say is that some of the existing provisions should be removed or streamlined because the things Mr. Bissett was concerned about are taken straight out of existing models. Mr. Wake said it might be fair to say that as the Working Group considers how to strengthen the models, it might also look at what the models are currently doing that could be done better in some other form next year.

Mr. Diederich said much of what is in the policy statement can be found in the existing models, such as the 30-day requirement for disclosure. Mr. Birnbaum said the Working Group is following its charges by making draft recommendations. Mr. Wake said the issues Mr. Bissett has concerns with are already in the models.

Mr. Petersen said the insurance trades, property/casualty (P/C), life, and health met prior to this Working Group meeting to discuss the exposure draft, and they have technical concerns about the definition of “portability” in the paper not being that most commonly used; about opt in being described as an authorization when generally it is used in a state as getting permission to use information for marketing purposes; and that discussions seem to have been occurring in private. He said many of his comments, such as a safe harbor for insurers subject to HIPAA, have been presented in several meetings, but they have not been discussed during any of these meetings. However, he felt the report and policy statement included items that had not been discussed in open meetings. Ms. Amann said there is nothing nefarious going on and that a lot of the writing of the paper was simply to move it along to get an issue put on paper so that the Working Group can make it clear to the Executive (EX) Committee, as well as to the Market Regulation and Consumer Affairs (D) Committee that the Working Group believes that these were chosen as they rise to the level of needing to be addressed better than they are currently in Model #670 and the Privacy of Consumer Financial and Health Information Regulation (#672). She said the Working Group believes that these issues merit attention going forward and that at a minimum, Model #670 and Model #672 need to be updated. She said as far as anything being in the appendix that is trying to set requirements, the Working Group will make sure that it does not. Its sole intention is to draw the reader’s attention to areas that the Working Group has concerns with, which is why it is in an appendix, where it reads better when compared to the rest of the paper. She said the technical concerns are a problem because certain terms are used interchangeably, which has also been a problem for other Working Groups working on similar issues. Ms. Amann said they are terms of art, so people who know that read the document a certain way and others who read it interchangeably do not see the distinction, so the Working Group will be mindful of that. She said the Working Group needs to be mindful that it does not use terms incorrectly. Ms. Amann said she does not know if it would increase anyone’s comfort level but asked if the reader who has been involved would agree that the Working Group could do that as a minimum. Ms. Amann said the Working Group talked about the safe harbor issue during one meeting, but the Working Group is not ready to go down that road yet because it is not 100% on changes that it believes are needed. She said the Working Group welcomes comments from everyone on the paper to make sure that it is being read correctly.

Mr. Wake said he is surprised to hear that there was a recommendation on portability in the paper, so he looked at the paper
again and found that portability data is mentioned. He said portability is one of the issues the Working Group recommended be addressed, but in the appendix, the only recommendation regarding portability is the right of access to one’s personal information. Mr. Wake said two-thirds of the states do not have Model #670. He said he imagines that many companies provide the access voluntarily, even in the states that do not mandate it, so that is not really a groundbreaking recommendation in that area. Going beyond that, he said the Working Group needs to think carefully about what the right should be in terms of what opt in means. Mr. Wake said opt in means something affirmative is needed from the consumer before it can be done. In terms of use, it generally does mean disclosure, so he said Mr. Petersen is not wrong, but neither is the paper.

Bob Ridgeway (Blue Cross Blue and Shield Association—BCBSA) asked if the Working Group could move on to the exposure draft. He said Mr. Petersen is correct in that the Working Group had discussed some of the things he wanted to say today and so far, he supports the comments and observations Mr. Petersen made. Mr. Ridgeway said he wants to do some level setting to find out if he is right or not. On Page 13 of the policy statement, there is a paragraph that says, “This policy statement serves the purpose of informing licensed insurance entities, consumers, etc., on what the current models support as the minimum consumer data privacy protections.” Mr. Ridgeway said he believes that the core of that sentence is that this is a level-setting document. He said this is where the Working Group is now and that he is not reading it to say any of the issues there are necessarily for further discussion or comment or objection. Mr. Ridgeway said it looks as if it says this is just what is in the models now, what is supported as far as their models, and that is the status quo. He said he is also hearing that this is not the end of the Working Group’s tasks, but that the Working Group intends to go on from here and begin to do the true gap analysis that it has discussed during open meetings for a long time, identify specific gaps, and figure out how best to address those gaps as a policy matter. Mr. Ridgeway asked if that is roughly where the paper is now and where the Working Group would be going from here.

Ms. Amann said “yes.” She also recognized that there are many nuances to every word used in the paper. Ms. Amann said she is not trying to minimize anyone’s concerns, but the paper is about bringing to light certain issues that consumers are having and that state insurance regulators are having where the Working Group believes improvements are needed. She said all this paper is doing is noting the status quo as of right now. Ms. Amann said the intent is not to have the paper say there is no regulatory requirement, but rather that improvements are needed.

Mr. Ridgeway said that is helpful and that he hopes it is to others participating in the meeting. He also said he agrees with Mr. Birnbaum that the Working Group would probably do better going forward to change the verbiage about this “rights” and instead refer to them as potential issues. Ms. Amann said as Ms. Alexander mentioned, “right” was the term given to the Working Group by NAIC membership through the Market Regulation and Consumer Affairs (D) Committee. She said she appreciates the willingness of the Working Group to have the discussion about whether each issue needs to be a right or if it needs to be called something else. Mr. Wake said the Committee also gave the Working Group the charge to a draft a policy statement, and he said that given the state of the deliberations over the last several months, it does not seem right to make any ringing policy statement that goes beyond here are the policies that have been expressed as recommendations to the states and its existing model laws.

Angela Gleason (American Property Casualty Insurance Association—APCIA) said she thinks everyone’s concern is with Appendix A and where it is going. Ms. Gleason said she understands that some of it is a statement of existing law, but that the existing laws are complex, so to boil that down into a sentence or two causes a lot of concern. She said all these models are complex, and yet California and Virginia have been able to balance consumer rights and businesses’ ability to do business. Ms. Gleason said this issue necessitates some complexity as the concern is that it is hard to boil this down in terms of identifying something as an expectation that there might be a right for the consumer’s protection, but there are other pieces that go around that protection. She said that is where industry is coming from, so they appreciate this conversation and will provide some edits that may be more than technical, though.

Mr. Birnbaum said what he hears industry saying is that they want this Working Group to make a variety of policy decisions on behalf of the consumer and that they want those policy decisions to be essentially what industry believes that the policy should be. He said that what the Working Group’s charge was is to explore the issues, identify the issues, ask what has been done, and ask what still needs to be done. Mr. Birnbaum said when this policy statement and report go to the parent committee, whether that is the new Innovation, Technology, and Cybersecurity (H) Committee or the Market Regulation and Consumer Affairs (D) Committee, that is where a lot of those policy decisions are going to be made and from where the specific guidance to the Working Group is going to come. So, he said the issues that industry is looking at, such as going line by line through these models, will come later, but first some guidance is needed as to what the Working Group is trying to accomplish. Mr. Birnbaum said he thinks industry is putting the cart before the horse by asking the Working Group to do a lot of stuff when it has been asked to come up with some policy issues first for its parent committee to consider. He said the Working Group is
hearing from industry that the Working Group needs to identify problems that industry somehow has not recognized, or is not willing to recognize, and that the Working Group has been looking at that these issues from the beginning. Now industry wants the Working Group to basically throw everything out and start over again. Mr. Birnbaum said what the Working Group is seeing is an industry strategy to basically slow or delay this process of getting a policy paper in front of the policymakers to decide. He said the consumer representatives strongly object to that tactic.

Mr. Ridgeway said he finds Mr. Birnbaum’s comments offensive. Mr. Birnbaum said what he finds offensive is industry’s portrayal that this Working Group has not identified what the problems are or what the concerns are and that it should start from the beginning again.

Ms. Gleason said that she is not saying the Working Group should start from the beginning; she is saying she does not necessarily understand an example of where the problem is because industry is not getting complaints from consumers. She said she understands that this issue been pushed back on industry by saying maybe consumers do not know what to complain about or who to complain to, but she said she had not heard anything other than identifying what the issues are. Ms. Gleason said each side is showing their position, and the Working Group has not had a conversation about it until now. She said she understands that is another step, but she is not in any way telling this Working Group to start over. Ms. Gleason said she is just asking for some understanding because industry does not understand what the issues are.

Ms. Amann said that she can see where this misunderstanding could have happened because the Working Group started down a certain road with the templates for each of the rights under which it was going to try to give a little bit more detail. She said the decision was made to do the policy statement because consumer representatives brought their information and wanted to give the Working Group assistance on this issue. With many other points of view, Ms. Amann said the intent was that the policy statement would be a good road map to follow when the Working Group moved into the modifications of the models. She said the Working Group has concluded that Model #670 and Model #672 need fixing, so that is where the Working Group is going. Ms. Amann said the Working Group will report this recommendation to the Market Regulation and Consumer Affairs (D) Committee at the Fall National Meeting in this format with any necessary corrections addressed. She said if there is something in the report or policy statement that makes it sound like there is a conclusion or that there is a regulatory recommendation, that is not the intent right now. Ms. Amann said the report will not have the 15 examples per right that the Working Group initially started collecting because the report and policy statement are at a much higher level.

Bonnie Burns (California Health Advocates) said this is a new area for her and that she would like to weigh in with total support of Mr. Birnbaum’s position. She said one of the things that she had not heard discussed during this meeting that she is concerned about is what companies do with the data that they have, whether companies tailor information sent to consumers based on the data that they have, or whether companies withhold some of the information. Based on the data that companies have, Ms. Burns said she has concerns about how the data is used beyond what Mr. Birnbaum and the rest of the Working Group and industry have been talking about. Ms. Amann said she knows that is one of the charges for the Innovation, Technology, and Cybersecurity (H) Committee for 2022 is to delve into more of the data collection, data usage, and all that interplay. She said to the extent that consumer data, privacy protection, and that overlap, the Working Group will address that going forward, but for purposes of the paper for this policy statement, the Working Group just has a short little instruction to fulfill. Ms. Burns said she can tell everyone from her own experience that consumers know there is a lot of data held by companies, but they have no idea what that data is or how they can do anything about it. She said knowledge about how what data companies have or how they use it is not available to consumers, so the fact that consumers have not submitted a lot of complaints is not surprising. Mr. Petersen said Ms. Burns is suggesting that other than the notices that companies send out on a regular basis on health insurance, that companies also tell people that they have this information and how they use it. He said this way, the right to access would be that consumers have the right to change it, which is what he has heard consumer representatives say. Mr. Petersen said the context is what more the Working Group can do other than inform people through notices that were prescribed in those notices by law. Ms. Burns said for one thing, those consumer notices had not been tested because consumers do not understand them and do not realize what they are supposed to do with them. Mr. Petersen said the federal government dictates the language companies must use in the required notices. Harry Ting (Health Care Consumer Advocate) asked if the health information collected on consumers is gathered using cookies. If so, he asked if cookies and other data scanning online software is covered by HIPPA because if it is not, then consumers generally do not understand that it is being collected and that it could be harmful. Mr. Ting said it is important that consumers be able to observe what data cookies and online scanning are obtaining if that is being used. Mr. Petersen asked Mr. Ting if this question is about who is collecting that information because some of the examples that have been used during this meeting are not about health insurance carriers collecting the data. Mr. Ting said that is exactly why he asked because such notices are probably not required for health insurance carriers. Mr. Petersen said to the extent that consumers go online and use some sort of research system to try to find health insurance coverage, one could be making their personal data available to outside third parties, which may not even be covered by insurance laws. Mr. Ting said
the insurers should be held responsible if they are working with certain organizations to obtain data. Then insurers should make the consumer data privacy notice a requirement of the organizations that they are getting the data from. He said he understands that enforcement might be difficult, but that could be part of a requirement that would be added to the regulation.

Ms. Amann said those would be the types of issues the Working Group would have to flush out next year when looking at Model #670 and Model #672 because she guarantees that the models did not include the word “cookies” or any of the InsurTech terms or practices. She said to the extent that the Working Group wants to ensure that the models are applicable to InsurTech, the Working Group would have to include any licensed third-party administrator (TPA) or other entity to ensure that those models overtly state who is covered and who is not, which will take a great deal of drafting. Mr. Ridgeway said if the consumer hit the covered entity or health insurer, each has information on a consumer and shares that with some other entity, then they must issue a notice to the consumer. He said they can only do so if that other entity becomes what is known as a business associate, and they sign documents binding themselves to basically the same requirements that HIPPA imposes on the health insurer. Mr. Ridgeway said on the other hand, if this is somebody who reveals information on the Internet or somehow an individual who does that is one of the Working Group’s concerns, that at least has increasingly been when data becomes easily transferable by the consumer from one entity to the other. The consumers probably do not have much recollection or realization that when they are turning their information loose on the Internet, it is gone, there is no telling who is going to get it, and there is no way consumers can pull it back out.

Mr. Ting said he is a volunteer Senior Health Insurance Information Program (SHIIP) counselor, so he counsels people dealing with Medicare. He said he had an individual last month who was covered by a Medicare supplement policy that she had been under for 10 years. He said she was happy with it, but she got a cold call from an agent who wanted to switch her to a different plan. She told the agent that she was not interested. Without her knowledge, she got a letter from the insurance company that she had previously saying that effective next month, she would no longer be on their plan. Mr. Ting said he had to call Medicare to find out what happened. Mr. Ting said he found out that this person had her information and switched the policy by sharing her data without notice or her agreement. So, he said there are situations where people are unethically doing this, but when he talks to individuals and he thinks they are understanding, it is not clear whether they are covered by HIPAA because companies are using this data inappropriately and harming innocent people. Mr. Ting said that is an example of something where he would like to see that there are adequate rules that should help to protect seniors and other vulnerable populations against situations where those kinds of unethical practices occur. Mr. Ridgeway said this type of situation is covered under agent licensing laws. He said if the agent who did that was, in fact, a licensed agent and has not been reported to his or her state insurance regulator, the agent should be. Ms. Amann said this is a good conversation to have going forward so that the Working Group can ensure that if it does need to refer something to another Working Group, it can. She said she welcomes having examples brought up if it helps identify a gap.

Cate Paolino (National Association of Mutual Insurance Companies—NAMIC) said she had a few items, and they probably run more to the procedural for now. She said the email that accompanied the exposure draft had requested feedback to find minor edits. She said so many things come to mind because there is so much to look at that her comments may be more substantial than minor edits. Ms. Amann said to look at the policy statement as a road map with placeholders where areas to be discussed reside, and then provide comments in the form of bullet points (in the interest of time) marking areas of concern or where something may need to be added. She asked that they not be read as written, but more as a thought put out in front of the parent committee to let it know that are many issues that need to be reviewed. Ms. Amann said it is a higher level than a white paper would be because a white paper does eventually come to conclusions, so this is more of a good recommendation or a good area for the Working Group to delve into further. She said she recognizes the Working Group will go through the Model #670 and Model #672 line by line, but she does want the Working Group to have a better idea now of the areas that need consumer protection or regulatory oversight of company practices because to make sure that the models are as succinct as they can be. Ms. Amann said that the Working Group does want to just wordsmith it, but rather wants to change them to reflect actual practices that are occurring. She said the Working Group should think of it as a little bit more than an outline, but a lot less than a white paper.

Ms. Paolino asked whether there might be any flexibility regarding the deadline. Ms. Amann said the Working Group must be able to get comments in, compile them into some sort of format, then work with Ms. Alexander to draft something into the report. Ms. Amann said while she is not opposed to another day or two, the Working Group needs the comments quickly. She said they do not have to be formal—just bullet points or a simple statement. That was one of the initial reasons to back up and start over with a more high-level approach, so the Working Group could give everyone an idea of where it is going and what areas it feels have the most need for consumer protection or the most need for regulatory responsibility.

Erica Eversman (Automotive Association) said consumers do not seem to have any problems entering personal or intimate data
online into Twitter or Facebook. However, as it relates to consumers not knowing or consumers not making comments, complaints, or concerns about data collection or their access to data, she reiterated what Ms. Burns and Mr. Ting were saying in that the consumers she deals with have absolutely no idea how insurance operates. She said they do not know how insurance decisions are determined, how their premiums are determined, or that there are departments of insurance (DOIs) to whom they can reach out for help. Ms. Eversman said consumers do not know how any of this works, so they would never have any idea that they could make a complaint or request information about themselves from their insurer. Ms. Abbott said she would like to echo the concerns raised by industry representatives today and that ACLI members have many similar concerns, especially in relation to the appendix, and that they really appreciate the clarification. Randi Chapman (BCBSA) said she wants to echo the comments that her colleagues across the industry trades have made and to thank all of them for speaking up. She also said she appreciates the additional clarity provided during this meeting. She asked if it is possible to extend the comment deadline to Dec. 6. Ms. Amann said she will discuss this with the Working Group vice chair and NAIC staff and will send an email with a decision about timing for comments.

Mr. Ting suggested an edit on Appendix A. He said right now, it is a policy statement on consumer data privacy protections. If it were changed to a policy statement on consumer data privacy protection issues, that might clarify one thing and then in the paragraph or two where different subject areas were introduced, the Working Group could say that these are areas that have been identified for examination to see if there are any improvements needed. Mr. Birnbaum asked if the principals for artificial intelligence (AI) represent an example of a policy statement by the NAIC. Ms. Amann said “yes.” Mr. Ting said his research on personal information ownership indicates there is a broad consensus across the board that there is no established legal basis for saying that anyone has full ownership of the data that the Working Group is talking about. He said there are certain circumstances where that data can be used, even if the person does not want it to be used, such as where there are legal issues involving fraud or other types of issues if there are national security issues and so forth, so his sense is that basically there is no legal basis to say that anyone has full ownership or full control over the data. He said what that really means is the Working Group needs to look at each of the issues as it is evolving. How is such data being used? What kind of data can people collect? What kind of data can people share? How can they share it? Mr. Ting said that is really the basis on which the Working Group must look at data ownership rather than saying that someone owns it entirely.

Ms. Amann said she will discuss this with Mr. Kreiter and Ms. Alexander. Then she will get an email out with some reminders. She said the intent is to receive comments by Dec. 2 because the Working Group has a national meeting to get ready for. She said another document that was done at a high level was the paper on accelerated underwriting, and it touches on some of these issues—at least tangentially. So, that is another document to read to get thoughts on where state insurance regulators are coming from that the Working Group hopes to get moved up at the Fall National Meeting.

Ms. Amann said at the Fall National Meeting, the Working Group will discuss comments received by Dec. 2 on the final exposure draft of the report to the Market Regulation and Consumer Affairs (D) Committee. She reminded the Working Group members that they need to register for the Fall National Meeting to participate and that those attending the Working Group meeting virtually will be able to participate by audio only. Ms. Amann said there will not be cameras, but the sound is usually good, so they can hear everybody speak.

Having no further business, the Privacy Protections (D) Working Group adjourned.
The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Oct. 25, 2021. The following Working Group members participated: Ron Kreiter, Vice Chair (KY); Sam Singh (CA); Erica Weyhenmeyer (IL); LeAnn Crow (KS); Chris Aufenthie (ND); Teresa Green (OK); Scott D. Martin (OR); and Gary Jones (PA).

1. Received a Legislative Update from NAIC Staff

Brooke Stringer (NAIC) said as mentioned during its Oct. 11 meeting, the Working Group is starting to see an uptick in federal interest on data privacy again. She said the U.S. Senate Committee on Commerce, Science, and Transportation held a series of hearings on protecting consumer privacy. Ms. Stringer said Committee Chair Maria Cantwell supports a comprehensive federal privacy law that provides clear protections for consumers, articulates specific limits and obligations of companies, and grants the Federal Trade Commission (FTC) the resources and explicit authority necessary to enforce the new law; however, specifics about preemption and private right of action are still unresolved. She said since the U.S. Congress has not moved substantially on data privacy, the FTC is considering writing rules to strengthen online privacy protections to circumvent the congressional logjams. Ms. Stringer said the rules under consideration could impose significant new obligations on businesses across the economy related to how they handle consumer data. She said the FTC released a report to Congress in September that highlighted its priorities for future data security and privacy protection efforts and urged Congress to allocate more resources to the agency so it could expand its data security and privacy protections efforts. Ms. Stringer said the link to the FTC report is: [https://www.ftc.gov/system/files/documents/reports/ftc-report-congress-privacy-security/report_to_congress_on_privacy_and_data_security_2021.pdf](https://www.ftc.gov/system/files/documents/reports/ftc-report-congress-privacy-security/report_to_congress_on_privacy_and_data_security_2021.pdf).

Going forward, Ms. Stringer said the FTC intends to focus its data security and privacy protection efforts on four key initiatives:
1) integrating competition concerns;
2) advancing remedies;
3) focusing on digital platforms; and
4) expanding the understanding of algorithms.
Ms. Stringer said the FTC will develop a greater understanding of algorithms, as well as the consumer protection and competitive risks they may pose. She said the FTC will also provide more in-depth guidance for businesses on using algorithms and artificial intelligence (AI) fairly and equitably. In particular, she said the FTC would like to understand the ways that algorithms may create racial bias and work to prevent such uses of algorithms.
Ms. Stringer said the FTC will also act to encourage companies to comply with its previously issued recommendation that companies “test their algorithms, both at the outset and periodically thereafter, to make sure it doesn’t create a disparate impact on a protected class.”

2. Received Comments on Segment Four of the Exposure Draft

Mr. Kreiter said written comments were received on Segment Four from the American Council of Life Insurers (ACLI) and NAIC consumer representative Karrol Kitt (The University of Texas at Austin). He said comments received by the deadline are posted to the Working Group’s web page. Mr. Kreiter said comments received after the deadline would be posted soon. He said all comments received would be considered by the Working Group for incorporation into the exposure draft as it goes through the segments to complete its charges. Mr. Kreiter said the discussion at this meeting would be on comments received on Segment Four—the right to delete data.

Shelby Schoensee (ACLI) said on behalf of herself and Kristin Abbott (ACLI), this week recognizes consumers’ legitimate interest in requesting deletion of personal information. She said the ACLI is committed to maintaining the integrity of the information used to provide products and services to consumers. Ms. Schoensee said the NAIC Insurance Information and Privacy Protection Model Act (#670) currently provides consumers with robust rights to correct, amend, or delete personal information while still recognizing that insurance companies may deny those requests when retention is legally, or practically, required. She said that exceptions to the right to deletion should be clear to consumers so they understand that maintaining data regarding consumers’ contracts may include many decades and that such data may become subject to litigation for years in the future. Ms. Schoensee said the ACLI supports the approach of existing frameworks, which acknowledge those realities and provide appropriate exceptions. She said the need for insurers to retain customer and personal information in order to comply with such rules, administer policies, and pay claims is critical. Ms. Schoensee said the ACLI supports reasonable laws and regulations and giving consumers the ability to request deletion. She said the ACLI also believes that the necessary exceptions
should be clear and consistent for consumers. She said the ACLI recommends that existing models and several already-enacted state privacy laws should be relied upon in developing a comprehensive list of exceptions.

Ms. Kitt said individual consumers need to have access to the information that is being collected on them so they can make any corrections that may be needed if something is misstated. She said she is also a strong supporter of the consumer’s right to be forgotten—that is, to have any data collected on them to not be held indefinitely by companies. Ms. Kitt said once the use for the data has been completed, such as for underwriting new coverage or paying a claim, then the consumer should have the right to request that the data in question be considered forgotten by the company. She said the data should be held in a private section apart from that available for current use. While in this holding area, she said the data should not be sold, reviewed, or accessed for any other purpose. Once the relationship with the insurer ceases to exist due to a policy cancellation or change to another carrier, the data should be deleted completely, unless it needs to be held for legal purposes. In any case, the data should not be actively used by the company for any purpose once the relationship ends.

Chris Petersen (Arbor Strategies LLC), speaking on behalf of the Coalition of Health Carriers, said Ms. Kitt, Bonnie Burns (California Healthcare Advocates), and Birny Birnbaum (Center for Economic Justice—CEJ) have raised some additional consumer rights and issues that have not yet been addressed by this Working Group. He said they are correct in that some of these rights assume a right to access. Mr. Petersen said he was under the impression that the Working Group identified six of the more contentious issues or the six issues that are not uniform. He said the right to receive a privacy notice is a statutory right that it is not in this discussion, but he did not think the Working Group was talking about getting rid of that. He asked if the six rights in this framework paper were supposed to be the only rights given, the most contentious, or something else. Mr. Petersen said Arbor Strategies’ recommendation is for the right to delete to be included with the right to correct as it is included that way in the models and other legislation currently. However, he said that it should not be an absolute right as he had previously stated. Mr. Petersen said no action had been taken by the Working Group on his recommendations or on those of other interested parties. He said that there needs to be clear definitions developed for each of these rights as they are rather vague currently. He also recommended that the Privacy of Consumer Financial and Health Information Regulation (#672) be the focus of this group as it already includes privacy notice and consent disclosure requirements, as well as the federal Health Insurance Portability Accessibility Act (HIPAA).

Ms. Burns said she wanted to reinforce what Ms. Kitt said about some of the contacts that she has with consumers. She said that she does a lot of research online that involves health insurance in one form or another and that she consistently gets advertising for all kinds of health products from agents and agencies selling insurance even though she has blockers on her browser.

Mr. Birnbaum said the requirements for companies maintaining data for purposes unrelated to an ongoing business relationship should be distinguished from companies maintaining data and using it for ongoing business purposes. He said it is fine for a company to maintain a consumer’s data if a company no longer has an active ongoing relationship with the consumer and is maintaining data to comply with either data maintenance requirements or other requirements, but he said it is another thing to use the data that the company is maintaining. Mr. Birnbaum said compliance with the law should not be seen as an open opportunity to continue to use those data for purposes for which the consumer has not agreed. He said the other two points would be the right to delete presumes that a customer has knowledge of the data collected by an insurer and how it is used. However, massive amounts of data are collected by insurers that do not require consent by the consumer, such as research collection, and the uses of most data are obscure to most consumers. Mr. Birnbaum said any consumer right to delete data must require that the consumer has knowledge about the data that is being collected and how it is being used. He said the right to delete also presumes that there is a usable and responsive mechanism that exists for consumers to perform such deletion. Mr. Birnbaum said deletion mechanisms can be completely defeated by overly expansive terms and conditions of online agreements or by overly expansive or obscure privacy policies. So, he said that he mentioned all of this so that the right to delete is not viewed as something that is set off by itself, but that it is tightly integrated with all of the other consumer data requirements and consumer privacy protections.

Following up on a couple of Mr. Petersen’s comments, Mr. Birnbaum said with health insurance being subject to HIPPA, it has more responsibilities than property/casualty (P/C) insurers and even life insurance. He said what may be a required notice for health insurers or requirement for health insurance is not necessarily the same requirement for life insurance, or for P/C insurers. Mr. Birnbaum said the right to a notice and a consent to collect and use tends to be limited by the federal Fair Credit Reporting Act, which does not apply to a lot of the new sorts of data that insurers are now collecting. He said when talking about opt in or opt out, the presumption is that there is an opportunity for consent disclosure and consent that does not necessarily exist. Mr. Birnbaum said it certainly does not exist on the property category side for things like social media or web browsing data that are not subject to the requirements of credit reporting yet. He said the Working Group needs to think about
the current models in light of the new types of data that are available and the limitations of existing frameworks to reach some new types of data.

**Mr. Kreiter** said **Mr. Birnbaum** is correct that some of the items Ms. Stringer presented on the federal level are going to filter down to things that the Working Group will need to consider.

**Cate Paolino (National Association of Mutual Insurance Companies—NAMIC)** said as the Working Group goes through the rights, some of them have begun to blend together. For example, some of the things the Working Group is talking about may ultimately not relate to deletion, such as things that need to be done for maintaining information for regulatory purposes or for compliance purposes. Things that are spelled out in Model #670 and listed in NAMIC’s letter may change when the facts of case litigation occur years later. She said this is less about the deletion of the record and more about something other than that. To reiterate, Ms. Paolino said Model #670 contains many of the provisions and a reasonable way to frame up the right to deletion in terms of how it dovetails with some of the other things.

**Mr. Kreiter** said the Working Group was tasked with analyzing and determining how these six privacy rights are being protected. He said because of the change in certain federal statutes, the Working Group is trying to work on shifting ground. However, he said the Working Group will continue accepting comments and obtaining ideas to determine if the Working Group can develop a report of recommendations to the Market Regulation and Consumer Affairs (D) Committee that the Working Group can agreed upon. When Mr. Petersen asked when the report or determinations would be made, Mr. Kreiter said he did not have an exact date, but said he thinks it would be coming together soon so a final draft of the report could be exposed for a public comment period and edits prior to the Fall National Meeting. He asked Lois E. Alexander (NAIC) if that was her understanding. Ms. Alexander said that the Working Group had been charged with analyzing federal and state legislation, as well as the current NAIC models. She said the six rights that were handed down by the members to the Working Group as a privacy strategy also needed to be reviewed. Ms. Alexander said the Working Group was charged with making recommendations regarding possible revisions to the existing models or the creation of a new model if necessary. She said these recommendations, as Mr. Kreiter noted, will be presented with the Working Group’s report with its privacy policy statement to the Market Regulation and Consumer Affairs (D) Committee at the Fall National Meeting. When Mr. Petersen asked if those recommendations would be considered and voted on in a public meeting, Ms. Alexander said they would. Mr. Petersen said the Working Group had not discussed any of the issues yet. However, Ms. Alexander said the Working Group has been discussing these issues since December 2019, when the initial work plan was introduced. Since that time, the public discussions have been ongoing, with everyone having an opportunity to discuss other pertinent aspects of consumer data privacy rights as they were developed. She said the Working Group has not discussed the last privacy rights yet and that the Working Group will come up with a report.

Mr. Kreiter said during its next meeting on Nov. 8, the Working Group will discuss comments received by Oct. 25 on Segment Five—the right of data portability, as addressed in Pages 39–46.

Having no further business, the Privacy Protections (D) Working Group adjourned.
The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Oct. 11, 2021. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (KY); Damon Diederich (CA); LeAnn Crow (KS); Chris Aufenthie (ND); Teresa Green (OK); and Don Beatty (VA). Also participating were: Giovanni Muzzarelli (CA); Scott Woods (FL); Tate Flott and Brenda Johnson (KS); Robert Wake (ME); Jo LeDuc (MO); Hermoliva Abejar (NV); Mary Block (VT); Barbara Belling, Darcy Paskey, and Mark Prodoehl (WI).

1. Adopted its Sept. 27, Sept. 13, and Aug. 30 Minutes

Ms. Amann said the Working Group met Sept. 27, Sept. 13, and Aug. 30 and took the following action: 1) adopted its July 12 minutes; 2) heard an update from the NAIC Summer National Meeting; 3) heard updates on federal and state legislative activity by NAIC Legal staff; 4) heard an update on California Proposition 24 by Mr. Diederich; 5) exposed the first exposure draft of the Privacy Policy Statement; 6) received additional comments from a consumer perspective by NAIC consumer representative Harry Ting (Health Consumer Advocate); and 7) received comments on Segment One – Right to Opt-Out of Data Privacy and Segment Two – Right to Opt-In to Data Privacy from the American Council of Life Insurers (ACLI), the Coalition of Health Carriers, the American Property Casualty Insurance Association (APCIA), the Medical Professional Liability (MPL) Association, and NAIC consumer representatives Brenda J. Cude (University of Georgia) and Karrol Kitt (University of Texas at Austin).

Mr. Kreiter made a motion, seconded by Mr. Beatty, to adopt the Working Group’s Sept. 27 (Attachment Nine-C1), Sept. 13 (Attachment Nine-C2), and Aug. 30 (Attachment Nine-C3) minutes. The motion passed unanimously.

2. Received a Legislative Update from NAIC Staff

Brooke Stringer (NAIC) said activity in the privacy arena was picking up with the U.S. Senate Committee on Commerce, Science, and Transportation having hearings with a former Federal Trade Commission (FTC) official testifying on behalf of the effort. She said Chairwoman Maria Cantwell (D-WA) was also pushing for the creation and funding of a new privacy and data enforcement agency. She said a recent Wall Street Journal article distributed to Working Group members and interested state insurance regulators indicated that the FTC has been supportive of privacy regulation by states as well. Ms. Stringer said a group of democratic senators had also called upon the FTC to begin rulemaking with ranking member Senator Roger Wicker (R-MS) wanting the U.S. Congress (Congress) to do it instead to avoid business confusion and strengthen online privacy disclosures. Ms. Amann asked if any drafting had begun. Ms. Stringer said there had been some proposals, but no compromise ones yet. She also said the Senate Committee on Commerce, Science, and Transportation wants to find a consensus.

Jennifer McAdam (NAIC) said there had also been some state legislative activity with work on regulations for the California Consumer Privacy Act (CCPA) currently and the California Consumer Rights Act (CCRA) later; passage by Colorado and Virginia as well as the Uniform Laws Commission (ULC); legislation pending in Ohio; and House Bill 2968 proposed in Oklahoma on computer data. She said state legislatures will meet next in February 2022; however, she said most states will begin preparations in December 2021 and January 2022. She said updated state legislative charts would be posted soon.

3. Received Comments on Segment Three of the Exposure Draft

Ms. Amann said written comments were received on Segment Three from the ACLI, the Coalition of Health Carriers, and Dr. Ting. She said comments received by the deadline are posted to the Working Group’s web page. She said comments received after the deadline would be posted soon. She said all comments received would be considered by the Working Group for incorporation into the exposure draft as it goes through the segments to complete its charges. She said the discussion at this meeting would be on comments received on Segment Three – Right to Request Correction of Data, as addressed in pages 32–36.

Kristin Abbott (ACLI) said her comments are on behalf of Shelby Schoensee (ACLI) as well. Ms. Abbott said ACLI members support the reasonable ability for consumers to request that inaccurate personal information be amended or corrected and
challenge such requests based upon the nature, source, or use of the information. She said this important consumer protection principle is one the insurance industry has long supported under existing laws and regulations that remain highly relevant today, such as the **NAIC Insurance Information and Privacy Protection Model Act (#670)**, the Fair Credit Reporting Act (FCRA), and the Health Insurance Portability and Accountability Act of 1996’s (HIPAA’s) Right to Request an Amendment of Protected Health Information. She said these same principles should also apply to newer forms and sources of personal information because insurers understand the critical importance of data integrity and that it be kept accurate and up to date where necessary and as soon as reasonably possible, subject to certain conditions and verification. She said ACLI members share the Working Group’s commitment to consumer protection but request that the Working Group keep in mind the importance of context as recommendations are considered. She said it is one thing for an insurer to agree to update out-of-date contact information such as a mailing address, email address, or telephone number, or a change in name or demographic status. She said it is another thing for an insurance customer or claimant to request an alteration or change in personal information collected and relied upon for risk evaluation and decision-making regarding underwriting, the extent of coverage, or claims. She asked the Working Group to consider the underwriting process and where information is obtained directly from the individual or from third parties. She said in instances where the information is obtained from an individual, it is important to allow for a correction or amendment when information is validated as having been incorrectly transcribed or otherwise inputted into an insurance company’s underwriting process. She said in instances where information is obtained from a third party, such as their attending physician, an insurance company is not the appropriate entity to make a correction to the underlying information. She said those documents are controlled by the physician, and correction and/or amendment requests should be directed to the physician rather than the insurer. She said if the physician does not make such a change, then Model #670 contemplates adding a statement to the policy file indicating this dispute. She also said new technologies, including artificial intelligence (AI) or AI-enabled systems are revolutionizing and benefitting nearly all aspects of society and the economy. She said given the significant ethical and technical challenges and risks that extend far beyond the U.S. insurance industry and continue to challenge many stakeholders, the ACLI hopes that the Working Group will avoid prematurely making overly prescriptive recommendations regarding the Right to Correct Personal Information that deviate from the existing privacy laws and regulations that insurers continue to abide by. Ms. Schoensee asked if consumers are positive as to their rights to information and/or correction.

Chris Petersen (Arbor Strategies LLC), speaking on behalf of the Coalition of Health Carriers, said use of the phrase, “the right to request” is inaccurate because what should be discussed is the process on how to exercise a request and what companies need to do, which is already covered in Model #670 and HIPAA. He said the Coalition of Health Carriers would like more precise definitions to be used, such as those included in its comment letter. He said word processing is needed, not regulation. He said the issue is data security versus data privacy, which is about the uses and disclosure of information. He said good data security means all data is locked up. He said record retention is generally set by state statute. He said consumers should never have an absolute right to correct data. He said much of the data used must be kept for criminal investigations and similar legally required situations, so consumers should be able to request data but not the right to correct it, which is stated in Model #670, HIPAA, and the FCRA. He said consumers should want the source of the inaccurate data to fix whatever is incorrect, not the insurance companies. Angela Gleason (APCIA) said she agrees with the ACLI and the Coalition of Health Carriers because they have the best interests of consumers in mind, but it seems consumers would like sources to correct data for all requesters. Cate Paolino (National Association of Mutual Insurance Companies—NAMIC) said there are two primary themes: 1) the nature of roles and relationships that industry helps consumers navigate as fiduciaries; and 2) the importance of details, which should be meaningful; therefore, she recommends that no significant changes or revisions to the models are needed, nor is any new model.

Ms. Abejar said the right to delete should adhere to statutory retention requirements. Dr. Ting said companies need to minimize the data collected to only what is absolutely necessary to provide the insurance coverage purchased so there would be less data for companies to control. He also said personal data should never be sold. He said data breaches occur even at organizations with tight security because data can be locked up, but it can also be hacked, so he would support deleting consumer data as soon as the underwriting decision has been made.

Birny Birnbaum (Center for Economic Justice—CEJ) said Dr. Ting is talking about data that is no longer needed while Mr. Peterson is talking about record retention. Ms. Kitt said the timeline for record retention varies by state, type, and purpose. Mr. Birnbaum said life insurers have to keep data longer due to the nature of their business. Ms. Kitt said such data should be put into a silent area like a black box so it can be pulled if it is needed, but it should also prevent the company’s marketing unit from seeing it. Mr. Wake said it is a privacy issue, except for specified purposes. Mr. Birnbaum said regarding the right to correct, he opposes the ACLI and the Coalition of Health Carriers’ position because it would mean that consumers would have the responsibility to track down and correct any inaccurate data. He said insurers should have to correct it, and they should have to refer consumers to third-party users to make such changes. He said consumers should have an absolute right to view, access, correct, and delete their data regardless of what the FCRA and HIPAA say. He said the requirement to investigate is
anti-consumer when referring to a third party. He also said the key under HIPAA is that the industry is saying they have no responsibility over their third-party affiliates’ data. He said the FCRA dispute model directs consumers to go to the furnisher of information to research and correct the data, as well as correct the credit reporting agencies.

Ms. Amann said she is hesitant to set a timeline for the completion of changes to the models, but she is okay with setting best practices for companies that indicate how long a company needs to keep underwriting information used for declination. When asked if there is a need to keep it at all, she said state market conduct examiners would need to be able to document the reason for a company’s declination during a market conduct examination many years after the declination occurs. Mr. Wake said there is a legal requirement to lock data for examinations, audits, arbitrations, litigation, record retention, and dispute situations. He said we have the technology to do so. Ms. Amann said the model would have to include this expectation. She said an FCRA requirement is that a letter of protest from a consumer must be kept by the insurer, and it must be sent with any future requests for data. She said she would put various parameters of these issues about the business practices of insurers in writing, and she would put forth data to correct but not change for edits but not comments.

Ms. Amann said during the next call on Oct. 25, the Working Group will discuss comments received by Oct. 18 on Segment Four – Right to Correct Information, as addressed in pages 36–39. She said the following schedule was posted to the web page:

- Comments received by Nov. 1 on Segment Five – Right of Data Portability, as addressed in pages 39–46, would be discussed at the Nov. 8 meeting.
- Comments received by Nov. 15 on Segment Six – Right to Restrict the Use of Data, as addressed in pages 46–50, would be discussed at the Nov. 22 meeting.

Having no further business, the Privacy Protections (D) Working Group adjourned.
The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Sept. 27, 2021. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (KY); Damon Diederich (CA); Chris Aufenthie (ND); Martin Swanson (NE); Gary Jones (PA); and Don Beatty (VA).

1. Received Comments on Segment Two of the Exposure Draft

Ms. Amann said written comments were received on Segment Two from the American Council of Life Insurers (ACLI); the Coalition of Health Carriers; the American Property Casualty Insurance Association (APCIA); the Medical Professional Liability Association (MPLA); and NAIC consumer representative, Harry Ting (Health Consumer Advocate). She said comments received by the deadline are posted to the Working Group’s web page. She said comments received after the deadline would be posted soon. She said all comments received would be considered by the Working Group for incorporation into the exposure draft as it goes through the segments to complete its charges. She said the discussion at this meeting would be on comments received on Segment Two – the right to opt in to data sharing, as addressed in Pages 29–32.

Shelby Schoensee (ACLI) said her comments are on behalf of Kristin Abbott (ACLI) as well. Ms. Schoensee said certain situations regarding opt-in need to balance current laws with risk-based review. She said the consumer initiates transactions so it opts in under the **NAIC Insurance Information and Privacy Protection Model Act** (#670) and the **Privacy of Consumer Financial and Health Information Regulation** (#672) under the Gramm-Leach-Bliley Act (GLBA). She said there should not be just one choice for all situations, but it should be flexible, such that opt-out should be maintained in accordance with the GLBA.

Bob Ridgeway (America’s Health Insurance Plans—AHIP) said the Coalition of Health Carriers covered its comments. Chris Petersen (Arbor Strategies LLC), speaking on behalf of the Coalition of Health Carriers, objected to the use of the word “right” when used with opt-in/opt-out because it refers to the ability to place restrictions on data use, whereas the GLBA under Model #672 just refers to nonaffiliates and applies to joint marketing only. He suggested that the definition of opt-in/opt-out be tightened up going forward.

Angela Gleason (APCIA) said the exposure document lumped opt-in and opt-out together. She said a balanced, risk-based approach like that created in the past should be used, and what applies to the technology industry does not apply to the insurance industry. She said applying that type of privacy requirement could perpetuate fraud and hinder underwriting.

Dr. Ting said included with his comments was the Bessemer Venture Partners report on data privacy engineering. He said this report encouraged companies: 1) to not sell or share data unless the consumer consents to it, but it also indicated that most consumers would consent; 2) to allow the consumer’s choice; 3) that internet disclosure or privacy notice should not be allowed, as most consumers do not understand what happens once cookies are allowed; and 4) to allow opt-out through future or prospective data, not for retrospective data. He said regarding the right to opt out: 1) a notice should be provided; 2) there should be a method for tracking; 3) companies should take steps to ensure that consumers know what has been shared, with whom, for what purpose, and how it will be used, much like the California Consumer Privacy Act (CCPA) does. He said there are cases where Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules should go beyond what HIPAA requires because his personal experience as a secret shopper has shown that his personal data that was gathered by a health insurance lead generator resulted in the sharing of that data with 1,722 companies that had nothing to do with insurance.

Mr. Aufenthie asked Dr. Ting what parts of his personal data were shared or sold following his secret shopper experience. Dr. Ting said because he lives in California, the CCPA made it possible for him to obtain information about the companies that received his data and how those companies were using it. He said during an online search for individual health insurance that took him three rounds of inquiries before he was even allowed to get to any type of health insurance plan, the company asked for his name, address, health conditions, health status, age, and income. He said his information was sold but only to companies he would be completely comfortable with receiving his information. He said some of the companies on the list as having received his data were companies that sold windows and pet food, from whom he received lots of calls and emails trying to sell their products to him. He said lead generators pay lots of money to get listed at the top of search results, so those companies
must sell consumers’ data to accomplish that listing. He said companies have a choice of who they work with, so they should not be using companies that sell data.

Birny Birnbaum (Center for Economic Justice—CEJ) said there is a need for balance; consumer consent should be required for any action and be limited to only that which is necessary. He said industry should understand just how limited a consumer’s understanding of privacy really is, and there should be best practices like those in the CCPA. He said telematic companies that harvest data from phones, geo, and vocations also sell marketing programs based on the telematics being collected. He said he is sure that consumers do not know this is being done, and they have not consented to their data being shared or sold, so it is unreasonable for consumers to be knowledgeable or responsible for their own data privacy decisions. However, he said he disagrees with opt-in because the notices are too long, and the consumer does not understand what all the wording means. Mr. Petersen said such notices are required to attain a Flesch score of a high school level reader. Erica Eversman (Automotive Education & Policy Institute—AEPI) said consumer understanding does not have the level necessary. She said most readers are at a fourth- or fifth-grade level, as evidenced by a 1992 survey by the federal government, which indicated most readers were at a sixth-grade level.

Mr. Diederich said it is hard to know what companies will do, but he asked if allowing a consumer to opt in for marketing would help. Dr. Ting said yes, that is an appropriate approach. He suggested that the Working Group give examples in the privacy policy statement of how it would be used; otherwise, the default should be to not allow the sharing or selling of consumer data at all. Mr. Diederich asked if some type of nondiscrimination or nonretaliation disclosure needs to exist. Dr. Ting said yes, if limited to need certain information, but only if it were limited to what is really needed. Ms. Eversman said the concept is good, but her experience with lawyers is that it is impossible to obtain retaliatory evidence that leads to prosecution. Peter Kochenburger (University of Connecticut School of Law) said people do not read them, so the federal government puts most personal information as opt-in because opt-out pretty much guarantees that consumers will not do it. Mr. Diederich said opt-in should not hinder sales or legal compliance. He asked if, given state insurance regulator concerns, consumers should have to opt in for companies to share data for marketing to external parties.

Mr. Petersen said HIPAA does not allow the sharing of non-personal health information (PHI) data, but it has a safe harbor for sharing PHI. He also said HIPAA has a more stringent definition of PHI. Ms. Gleason said opt-in has spots to opt out of marketing.

Ms. Amann said this type of information is sort of in the exposure document, but it needs to be streamlined because people just click through privacy notices and disclosures; but insurance is not retail, so it needs to be considered more carefully. She said the selling of information is the crux of the problem, and the question is if there is a doable fix, perhaps some overt statement that a consumer cannot be retaliated against for their refusal to opt in. Brenda J. Cude (University of Georgia) said consumers need a reason to read a disclosure. She said consumers feel they have no power because they cannot get service without agreeing, so there is no real or perceived need to read any notices or disclosures.

Ms. Amann said during the next call on Oct. 11, the Working Group will discuss comments received by Oct. 4 on Segment Three – the right to correct information, as addressed in Pages 32–36, would be discussed at the Oct. 11 meeting.

She said:

- Comments received by Oct. 18 on Segment Four – the right to delete information, as addressed in pages 36–39, would be discussed at the Oct. 25 meeting.
- Comments received by Nov. 1 on Segment Five – the right of data portability, as addressed in pages 39–46, would be discussed at the Nov. 8 meeting.
- Comments received by Nov. 15 on Segment Six – the right to restrict the use of data, as addressed in pages 46–50, would be discussed at the Nov. 22 meeting.

Ms. Amann said this schedule had been posted to the web page.

Ms. Amann said the next Working Group meeting is scheduled for Oct. 11.

Having no further business, the Privacy Protections (D) Working Group adjourned.
The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Sept. 13, 2021. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (KY); Damon Diederich (CA); and Chris Aufenthie (ND). Also participating was: Robert Wake (ME).

1. Announced a Format Change to the Privacy Policy Statement Exposure Draft

On behalf of Ms. Amann, Lois E. Alexander (NAIC) announced a format change to the privacy policy statement exposure draft. She said the first exposure draft incorporated all comments received into one large document. Since all materials have been vetted by the Working Group in prior meetings, Ms. Alexander said the Working Group would separate comments into appendices to make the exposure document more manageable for discussion in future meetings.

2. Received Comments on Segment One of the Exposure Draft

Ms. Amann said comments were received on Segment One from the American Council of Life Insurers (ACLI); the Coalition of Health Carriers; and NAIC consumer representatives, Karrol Kitt (University of Texas at Austin) and Brenda J. Cude (University of Georgia). She said comments received by the deadline are posted to the Working Group’s web page. She extended the Working Group’s apologies to Ms. Kitt because her comments were received by the deadline but had not yet been posted. She said comments received after the deadline would be posted soon. She said all comments received would be considered by the Working Group for incorporation into the exposure draft as the Working Group goes through the segments to complete its charges. She said the discussion at this meeting would be on comments received on Segment One – the right to opt out of data sharing, as addressed in Pages 5–29.

Chris Petersen (Arbor Strategies LLC), speaking on behalf of the Coalition of Health Carriers, said the definition used for the opting out of data sharing should be defined in a way that industry, state insurance regulators, and consumers can have a serious discussion on it. He said he defined the exposure draft simply says that individuals should be able to control their data, which would mean that the definition would apply to several of the possible potential rights in the document. He recommended that the Working Group use the very specific definition of “opt out” that is used in the Privacy of Consumer Financial and Health Information Regulation (#672), which is based on the Gramm-Leach-Bliley Act (GLBA) and is the most recent privacy model that has been adopted in most states. He said if that definition is used, it will help guide the rest of the discussion as the Working Group goes into more detail regarding what that right is as well as how it is used. He said when consumers receive an opt-out notice now, it is referring to the right as set forth in Model #672, so that is the definition that should be used if the Working Group is going to talk about whether it should be changed, modified, or eliminated. He said the recommendation is overly broad in that it says consumers should be afforded a comprehensive right to control the use of all their personal information for purposes related or unrelated to the insurance transaction, which goes beyond the GLBA because it recommends an unfettered right to controlling one’s own information. He said in Model #672, there are restrictions, exceptions, and disclosures in nonpublic personal information for service providers, servicing agreements and marketing agreements. He said companies must comply with state record retention requirements and other laws indicating how companies can use and disclose information. He said consumers would not be notified, nor would they have any way of knowing if a law enforcement agency demanded their information. He said if an insurance department requires consumer information, companies have their operations and the rights in the Health Insurance Portability and Accountability Act of 1996 (HIPPA), which includes the right to request, but federal law still gives companies the ability to say yes or no if we must disclose the information. Therefore, he said this recommendation would be contrary to, and would probably be preempted by, HIPPA. He said the recommendation must be much more. He said HIPAA should not be disrupted because we do not want to get preempted by federal law. He said health care insurers should have a HIPAA safe harbor that is currently in Model #672, and that should be retained because something that might work for a technology company would not necessarily work for a health insurer. He said the health insurance industry must maintain records for future claims, issues, and future health care operations, so the Working Group cannot confuse technology with health care.

Mr. Diederich said the exposure draft reflects several of the concerns that have just been identified because it has a discussion that the right to opt out should not be construed to interfere with the transaction for which the information has been gathered;
i.e., it should not hinder legal compliance. He said the Working Group is very much in agreement on those points about a HIPAA exemption, as existing HIPAA regulations basically permit regulation that is not in conflict with HIPAA. He said there is no requirement that any privacy right’s regime necessarily follow all the contours of HIPAA, so long as it is not in conflict with them. HIPAA would allow a model, which affords additional privacy rights beyond HIPAA, so long as it does not conflict with existing mandates. Mr. Petersen said that is correct, and it would also be wise to allow additional protections, so long as one could operate the HIPAA privacy rule. He said if an individual had the unfettered right to say, “you cannot share my information with anyone,” which is sort of what the recommendation suggests that it would hamper the implementation of the HIPAA privacy rule, because health insurers have things they are mandated to do under that rule, and this would contradict those. He said he believes that is why we must be careful that it works within the confines of HIPAA. Mr. Diederich said he is very much in agreement with that.

Ms. Kitt said the Working Group cannot do the opt-out because it is so important, but for the last 15 years, it has had opt-in with health and she knows opt-in is the next topic. However, with all these problems, if they just did an opt-in, they would not have all these opt-out issues. Companies would not be able to sell a consumer’s data, but the amount of revenue that brings in for companies is not known. Ms. Kitt said interested parties said consumers benefit from opt-in as well as from opt-out, but she does not see a benefit for consumers that currently have the opt-out, because consumers must do extra work to protect themselves and why should they have to protect themselves from a cost. She said to begin with, opting in for a benefit that makes sense, but not having to opt out for one because it is sort of two negatives does not make sense. She said speaking as a consumer, privacy is very important, and she does not know what insurance personnel do if consumers opt out. She said consumers let their information be shared, but so much of the sharing of information is not appropriate. She asked why life insurance or health insurance need to know about her homeowners’ coverage, or auto coverage, yet they get all this access. She said her comments are mostly negative stating again that my support is for the opt-in and to forget about this opt-out.

Kristin Abbott (American Council of Life Insurers—ACLI) asked if the Working Group could include in the privacy policy statement the initial thoughts on the opt-out provisions that it submitted last week. She said the ACLI intended to provide further feedback throughout the process. She said the ACLI supports a balanced opt-out approach, taking into consideration consumer rights and companies’ needs to collect and share information for normal business practices.

Randi Chapman (Blue Cross Blue Shield Association—BCBSA) said the BCBSA’s comments were submitted with the Coalition of Health Insurers. She said Mr. Petersen’s status covered several points that they have in common, but she wanted to reiterate the BCBSA’s request that the Working Group consider preserving the HIPAA compliance exemption because the carve out established in Model #672 and the federal laws alike have created consistency in terms of compliance with consumers and industry knowing what to expect, and there are robust requirements under HIPAA.

Binry Birnbaum (Center for Economic Justice—CEJ) said the CEJ hopes that the activities under the Working Group will, in fact, go beyond current law. He said current law is truly outdated in terms of a privacy framework to protect consumers in an era of surveillance capitalism to go beyond both an opting in and an opting out approach. He said it assumes certain things; i.e., that consumers will have disclosure of the information that is being collected about them and what that means in an understandable way. Therefore, instead of presenting the types of information that may be collected, it would include how the information is being used and how it might be used as opposed to similar general concepts that do not mean much to the consumer. Mr. Birnbaum wanted to emphasize the whole aspect that now it assumes consumers have enough knowledge to make informed and rational decisions, and that may have been a reasonable assumption 20 years ago. He said a passive reasonable assumption today is to give consumers the amount of data that is collected, with and without consumers consent. For example, there may be a lot of information that insurers get from public sources to speed the underwriting process, which they then combine with information they had gotten from the consumer or through their insurance process. Then something is done to combine information based on some opt-in the consumer has made about their personal information, thinking that it is going to be dealt with in insurance practices.

Harry Ting (Health Consumer Advocate) said when he spoke last week about his nine principals for the privacy of consumer data regarding the transactions that consumers have with insurance companies, the insurance company should only collect the data that it needs. He said for that transaction, there is no reason for them to collect other data; and if we do that, then the opt-in, to opt-out discussion becomes somewhat unnecessary if companies only collect what they need. Of course, they would need to prove that that is the data they need. However, Dr. Ting said that is the approach that should be taken, and there is no reason for them to collect other data. He said that is what he would like to suggest. When talking about the six categories, he said these primarily put the burden on the consumer to take measures to protect the privacy of their data, while it seems that the companies themselves have much more information and understanding of what is being collected and how it is being used. He said there
should be greater emphasis on putting requirements on companies, as opposed to putting so much burden on the consumers. He said the document he sent to be shared with the Working Group members talks about data privacy engineering, and it explains in their research that most companies collect much more data than they need. He said it is something that has developed because memory costs are so low that companies collect whatever they can, so many of the companies are collecting much more than they need.

Mr. Wake said he would agree that more precision is needed, but being precise includes talking about it. The definitions of “opt out” and “opt in” are very simple, and they are not going to change over time. Mr. Wake said opt out means what the company has the right to do. He said we can be made a little more precise, but the definition of opt out is something that the company has the right to do. He said unless the consumer explicitly gets permission and what needs to be worked on is not those definitions, except perhaps phrasing them a little more elegantly, what needs to be worked on is what things should be subject to an opt-in regime, what should not be subject to an opt-out ratio, and what things the consumer should have no control over. Mr. Diederich said this understanding is consistent with what a lot of the Working Group understands those terms to mean as well. Mr. Petersen said that is not how the document defines it though.

Ms. Amann said during the next call on Sept. 27, the Working Group will discuss comments received by Sept. 20 on Segment Two – the right to opt in to data sharing, as addressed in Pages 29–32. She said comments received by Oct. 4 on Segment Three – the right to correct information, as addressed in Pages 32–36, would be discussed at the Oct. 11 meeting; comments received by Oct. 18 on Segment Four – the right to delete information, as addressed in Pages 36–39, would be discussed at the Oct. 25 meeting; comments received by Nov. 1 on Segment Five – the right of data portability, as addressed in Pages 39–46, would be discussed at the Nov. 8 meeting; and comments received by Nov. 15 on Segment Six – the right to restrict the use of data, as addressed in Pages 46–50, would be discussed at the Nov. 22 meeting. She said this schedule has been posted to the web page.

Ms. Amann said the next Working Group meeting is scheduled for Sept. 27.

Having no further business, the Privacy Protections (D) Working Group adjourned.
The Privacy Protections (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met Aug. 30, 2021. The following Working Group members participated: Cynthia Amann, Chair (MO); Ron Kreiter, Vice Chair (KY); Damon Diederich (CA); LeAnn Crow (KS); T.J. Patton (MN); Chris Aufenthie (ND); Martin Swanson (NE); Teresa Green (OK); Tricia Goldsmith for Raven Collins (OR); Paul Towsen for Gary Jones (PA); and Katie Johnson (VA). Also participating were: Rick Cruz (MN); and Don Beatty (VA).

1. **Adopted its July 12 Minutes**

The Working Group adopted its July 12 minutes as amended with the revision requested by Karrol Kitt (University of Texas at Austin) to change the phrase “credit card” to “debit card.” Mr. Kreiter made a motion, seconded by Mr. Swanson, to adopt the Working Group’s July 12 minutes (see NAIC Proceedings – Summer 2021, Market Regulation and Consumer Affairs (D) Committee, Attachment Six). The motion passed unanimously.

2. **Heard an Update from the Summer National Meeting**

Ms. Amann said consumer data privacy was one of the discussion topics during the Summer National Meeting in Columbus, OH. She said the Innovation and Technology (EX) Task Force discussed the ownership of consumer data prior to the update she gave to the Task Force on the activities of the Working Group. She said the discussion about the ownership of consumer data continued during her report to the Market Regulation and Consumer Affairs (D) Committee, which is the parent committee of the Working Group. She said there was also a discussion about possibly creating a new lettered committee that would be known as the (H) committee to oversee cybersecurity issues. However, she said the appointment of a new lettered committee and the assignment of the consumer data ownership issue as a charge were both delayed for further consideration and determination at a future date. She said the Working Group was praised for its work to date and encouraged to complete its charges as written by the assigned due date, even if it required an acceleration of its meeting schedule. Chris Petersen (Arbor Strategies LLC) said data ownership was last discussed following the most recent update to the *Privacy of Consumer Financial and Health Information Regulation (#670)*, which he said he would find and share with the Working Group. Ms. Amann said there was a discussion of data ownership along with some definitions for consideration by the Working Group in the National Institute of Standards and Technology (NIST).

3. **Heard an Update on State Privacy Legislation by NAIC Legal Staff**

Jennifer McAdam (NAIC) said many consumer privacy rights can be traced back to federal implementation of the Fair Credit Reporting Act (FCRA), to which the *NAIC Insurance Information and Privacy Protection Model Act (#670)* is most similar. She said each year since the FCRA was adopted, states have introduced similar legislation; and she noted that updated state legislation charts are posted to the Working Group’s web page under the documents tab. She said since California was the first, and seemed to be the most comprehensive thus far, it is also included under the documents tab within one of the two gap analysis comparison charts completed by the NAIC Legal team: 1) the Model #670 to the California Consumer Privacy Act (CCPA) Privacy Comparison; and 2) the Gramm-Leach-Bliley Act (GLBA) to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Comparison. She said trial lawyers supported a private right of action in the California bill, but industry opposed this position. She said the FCRA presumed compliance with the law when the entity is subject to HIPPA and other federal laws. She said some of the bills have gone even further than the California Consumer Protection Act (CCPA) to look more like the General Data Protection Regulation (GDPR). She said there was not much to report regarding movement on state privacy legislation, as most of the bills proposed were not adopted. However, she said Colorado and Virginia were the exceptions, as both passed consumer privacy legislation in 2021. She said the Virginia bill goes into effect Jan. 1, 2023; applies to companies doing business in Virginia or marketing to Virginia residents; and gives consumers the right to access, correct, delete, and opt out of the sale and processing for targeted advertising purposes. She said the Virginia bill is like the CCPA in some areas but like the GDPR in others. She said it also has no private right of action, so enforcement is under the state Attorney General. She said the Colorado bill goes into effect July 1, 2023. She said the Colorado bill is not as stringent as the California bill, but that it is more stringent than the Virginia bill in that the Colorado bill gives the Attorney General’s office the right to establish regulations. She said Ohio has pending legislation that is not as extensive as California, Colorado, or Virginia. She said it has no private right of action, but it has a safe harbor for industry. She said the
Uniform Law Commission (ULC) recently adopted a uniform personal data protection act that may be finding its way into state legislation. She said legal will continue to follow state data privacy legislation as a few states will still be having legislative sessions that run through the end of the year.

4. **Heard an Update on California Proposition 24**

Mr. Diederich, California’s Acting Privacy Officer, said Proposition 24 is a follow-up to the CCPA that was developed to counter proposed legislation that was perceived to weaken the CCPA by adding some protection rights to data subjects. He said when it becomes effective Jan. 1, 2023, it will add some additional data rights and protections for consumers. He said the bigger differences are a limitation on the collection and use of personal information to certain categories and specific uses, which are disclosed to the data subject at the time of collection. He said there is a requirement for specific disclosures relating to sensitive personal information as defined in the proposition and for retention periods for each category of personal information. He said it must be reasonably necessary and proportionate with respect to the purpose of data collection that are disclosed to the consumer. He said businesses selling or disclosing personal information are required to sign a legal contract with any recipients of that data, such that the recipient would adhere to these set disclosure limitations on data use in terms of the proposition generally. He said there is a requirement for the adoption of security procedures, so the right to limit use and the disclosure of personal information is a major addition, and a major set of rights, which are provided on top of the CCPA. He said this grants a consumer the right to instruct businesses to limit user disclosure of sensible, sensitive, personal information to perform services expected by the average consumer requesting those types of services. He said sensible, sensitive, personal information includes social security numbers; driver's licenses; passports; financial account information; account log ins; geo locations; ethnic origin; religious or philosophical beliefs; union membership; contents of mail, email, or text messages; genetic data; health information; and information about your sex life or sexual orientation. He said to the extent that businesses disclose a consumer’s sensible personal information to third-party users, companies are required to provide notice to the consumer of that disclosure to the third-party user and give the consumer notice of the right to limit disclosure to that user. He said there is also an existing right of non-retaliation that could be considered as a consumer right of non-discrimination. He said there is new protection to employees, job applicants, and independent contractors of the business; a clarification that the non-discrimination provisions do not prohibit loyalty or other rewards programs; an expanded right of deletion and correction of inaccurate information; a clarification for businesses disclosing personal information after informing recipients; and a clarification that information third parties and vendors. He said there is a requirement for a web-based registration of request to exercise privacy rights; and for any information disclosed, the consumer must be provided with a commonly used machine-readable format that is readily understandable and that applies to the insurance industry. Ms. Amann asked if there had been a lot of opposition to the proposition or if it is just working its way through the process. Mr. Diederich said California is still in the rule-making phase, so it is too soon to tell.

5. **Exposed the First Working Group Exposure Draft of the Privacy Policy Statement with Comments Incorporated**

Ms. Amann said the next item on the agenda is to walk through the exposure draft of the privacy policy statement that was distributed Aug. 26. She said the document begins with the Working Group’s 2021 charges and the work plan it has followed since the first Working Group meeting in November 2019. She said following an initial delay due to the pandemic, the six consumer data privacy protections identified as gaps per the analysis in the work plan were discussed by the Working Group during meetings in November 2020 and March, May, June, and July 2021. She said Page 1 of the exposure draft listed the rights identified in the NAIC Member-Adopted Strategy for Consumer Data Privacy Protections received through the Market Regulation and Consumer Affairs (D) Committee as:

1. The right to opt out of data sharing.
2. The right to opt in to data sharing.
3. The right to correct information.
4. The right to delete information.
5. The right of data portability.
6. The right to restrict the use of data.

Ms. Amann said a format template with separate outline sections for each of these six consumer categories has been posted, presented, and discussed at Working Group meetings. She said 18 sets of comments received from members, state insurance regulators, and interested parties were copied and pasted into the format template without labels, and in no order, for each of these rights. She said Pages 2 and 3 list the states that have adopted Model #670, Model # 672, and the Insurance Data Security Model Law (#668). She said the consumer privacy protections addressed in each of these models are also noted. She said Pages 3 and 4 include a review of privacy rights in the GDPR and the CCPA. She said Pages 4 and 5 review state privacy legislation.
Links to comparison charts identify gaps in current state and federal laws and rules between the GLBA and HIPAA, as well as between Model #670 and the CCPA. Ms. Amann also said since this material had already been vetted by the Working Group in prior meetings, the Working Group was asking members, interested parties, and interested state insurance regulators to review the combined material and submit comments in the following manner as the Working Group proceeded to meet on a bi-weekly basis going forward:

- Segment One: The right to opt out of data sharing, as addressed in Pages 5–29 by Sept. 7, to be discussed during the Sept. 13 Working Group meeting.
- Segment Two: The right to opt in to data sharing, as addressed in Pages 29–32 by Sept. 20, to be discussed during the Sept. 27 Working Group meeting.
- Segment Three: The right to correct information, as addressed in Pages 32–36 by Oct. 4, to be discussed during the Oct. 11 Working Group meeting.
- Segment Four: The right to delete information, as addressed in Pages 36–39 by Oct. 18, to be discussed during the Oct. 25 Working Group meeting.
- Segment Five: The right of data portability, as addressed in Pages 39–46 by Nov. 1, to be discussed during the Nov. 8 Working Group meeting.
- Segment Six: The right to restrict the use of data, as addressed in Pages 46–50 by Nov. 15, to be discussed during the Nov. 22 Working Group meeting.

Ms. Amann said this schedule would be posted to the Working Group’s web page. She said comments could be submitted on the entire draft, any part of the draft, or any of the segments at any time. She said comments received and discussed would be incorporated into the exposure draft, as needed, to complete the Working Group’s charges.

Shelby Schoensee (American Council of Life Insurers—ACLI) said she and Kristen Abbott (ACLI) want to thank the chair and the Working Group for the exposure document. She said the document was very helpful; it was clear how much work went into it and how many years of history were involved. She wanted to confirm that the exposure document was a draft that included historical considerations, input received from interested parties and state insurance regulators, and recommendations introduced and discussed at the end of the document and at the end of each section as the Working Group moves through its discussions during the accelerated meetings. She said it sounds like the Working Group was hoping to get more input on the exposure document throughout those meetings, and at the end of the process, the Working Group would make sure that the recommendations flow from the revised document. Ms. Amann confirmed this was the plan. Ms. Schoensee said the ACLI just wants to make sure that it could communicate that effectively to its members to get constructive feedback to the Working Group throughout the process. She said ACLI members were excited to work on the privacy policy statement. Ms. Amann said comments submitted do not have to be formal, but they can just be bullet points of items to discuss, as the Working Group is more interested in getting a good flow of discussion going than it is about the formality of comments.

6. Received Additional Comments from a Consumer Perspective of Data Privacy

Harry Ting (Health Consumer Advocate) said the nine principles he formulated were based upon review of the meeting materials and privacy materials used in the real world. He said he hoped the principles would help the Working Group when evaluating consumer data privacy models. He said he took a different perspective from that encompassed in the six categories identified by the Working Group as rights. For the right to delete, he said his principles would mandate the deletion of certain personal information when it is no longer needed rather than provide a right to delete that a consumer would have to request to activate. He said only insurance-related businesses that need unpublished personal consumer data to complete insurance transactions should be allowed to collect such data. He said lead generating companies that only collect such data to sell it should not be allowed to collect the data, especially when the data is being sold to other businesses that do not meet this criterion. He said he ran across this type of lead generating company last year when he was doing some secret shopping for health insurance online and logged in to search on health insurance. He learned that the company was sharing his information with over 1,700 different companies when he was given a link to the companies that had been given his data. He said most had nothing to do with health or any other insurance. He said insurers and related parties should only keep data for as long as it is needed for the transaction or to meet regulatory requirements; when that data is not needed anymore, it should be deleted. He said businesses should not transfer or sell data to other business entities, whether they are related or not. He said if such a transfer or sale is not essential for the insurance transaction, it should be the consumer's choice whether to be contacted and provided with that information and only if the consumer wants information on the services or products that she or he did not request. He said the fifth principle ensures the accuracy of data that has a material impact on the consumer's purchase or receipt of services because it ensures the consumer can verify whether the data being used is correct, as we all know errors in data can
Brenda J. Cude (University of Georgia) said she is not representing any other consumer representatives, and these are her own thoughts after going through the exposure document a couple of times over the weekend. She said she wants to talk briefly about some reactions to what is in the exposure document about opting in and opting out, consumer notices, and the right to delete information. She reminded everyone how difficult it is for consumers to understand the implications of that choice. She said if she were to have the option to opt out, she assumed that it would only be for sharing or selling data to third parties. She said consumers do not know the difference between company affiliates and third parties. Consumers also do not know what the costs and benefits to them are of sharing or not sharing because there is no research. Dr. Cude guessed that most consumers would have a default position. Either they would always opt out based on principle, or they would never opt out, probably because they do not know how a choice to opt out could limit their opportunities to work with a company. Dr. Cude said she does not know what the implication of this is, but it is a very difficult choice for consumers. She said whether a consumer chooses to opt in or opt out is not a decision consumers can make given the incomplete information one has. As it stands now, the other point she wanted to make about this is that, while we probably all see the HIPPA language as something very different than what would apply to car insurance, consumers do not necessarily think of it that way. To them, insurance is insurance; so why should there be one standard for one type of insurance (TOI) and a different standard for another TOI. However, even as Dr. Cude was saying this, she realized she was not saying the standards should apply exactly, but maybe the framework should apply. Therefore, if the default is that consumers opt out of data sharing for any purpose not linked to treatment, payment, or health care operations, or as otherwise required by law, she asked if there might be a parallel for other TOIs that we opt out of. Dr. Cude said she also was struck by what seemed to be industry arguments at the end; therefore, it would be too difficult to implement an opt-out standard. She said the health insurance industry has obviously figured it out, and there might be a lot of protocols from the consumer reporting industry that could be transferred to insurance (e.g., how a consumer would verify the identity of an individual who is requesting their own credit).

Dr. Cude reminded the Working Group to resolve the issue of consumer notices by utilizing research guided by professionals with expertise about notices or modifications regarding their use by consumers, but she does not think state insurance regulators have the legal authority to change them. If they do, she said she would like to see that same research-driven approach because she believes a conversation about sample clauses has value. She asked the Working Group to remember that its key strengths are listening and being heard and sample language is helpful to industry; however, it is also helpful to consumers if it provides consistency to consumer communications. She said sample language needs to continue to be used and should be adopted widely so it benefits consumers as well as industry. She said there is some conversation about consumer use of electronic sources; and while she agrees that much has changed in the intervening years since the NAIC first started talking about this, she also agrees with the value of just-in-time communications that are likely to be delivered electronically. However, she does not want the Working Group to forget that not all consumers have the option to receive information electronically, and some consumers just prefer not to. She said she wants to make sure that the Working Group keeps that in mind and allows, or maybe even requires, that consumers have the choice to continue to receive paper copies. She said if the Working Group goes in the direction of allowing electronic delivery, she does not know why that should be available to consumers only after they become policyholders. She said the option should be posted to the website for consumers to consider as they select an insurance company. She said she spent some time thinking about what it means in the context of insurance to have the right to delete...
Ms. Amann said this portability discussion is helpful, and the example that comes to mind on the commercial side is when a consumer gets a loss run form that can be taken from carrier to carrier. She said the Working Group would make sure to have some good examples of what portability means in the context of consumer data privacy protections. Biriny Birnbaum (Center for Economic Justice—CEJ) thanked Dr. Ting for the principles that he set out, and he asked whether those principles were informed by any principles that were developed by consumer or privacy organizations like the World Privacy Forum (WPF), the Electronic Frontier Foundation (EFF), or the CEJ or if he relied on any other parties to develop those principles. Dr. Ting said the nine principles were purely his own reactions to reading about the materials that were submitted to the Working Group and thinking about his own personal values about the use of personal data. Therefore, he said it is not based upon any other sources.

Mr. Petersen said what is viewed as portability in the exposure document is an issue that needs to be resolved. He said portability in the health insurance world is the ability to go from one insurance company to another with no new pre-authorization, even though the term is just used but has not been defined. He said it would be helpful if everyone discussing it in this Working Group were using the same definition for portability. He said Dr. Cude referred to not knowing what retention was, but that she had probably read some materials on it. He said retention is different than authorizing an insurance company to transfer a consumer’s information over to another for either underwriting or claims processing. He said that is a totally different sort of transfer of information that is done for completely different reasons. He said the company transfers the information so it can be used to underwrite or pay a claim while keeping it in the company’s records. Ms. Amann said for the purpose of the exposure draft, a succinct definition will need to be developed, or perhaps it must be determined that portability may not be the best term to use. However, she said this has been a good conversation because it helps to clarify that it is not only about portability from the health perspective, but from a consumer’s general perspective, who has collected all necessary information that the consumer now wants to share with various insurers with a request for a quote. The consumer does not want to fill out 18 different forms to get those quotes. Dr. Cude said it relates to who owns the data, with the concept being it is my own personal data, and I should have access to it. Mr. Diederich said portability is seen as a subset of the right of access because access is the overarching right. He said it is information about you personally and you have a right to access it, which means portability would mean how that data is given to you. It should be in an easily machine-readable format that is understandable because consumers like it that way. Mr. Diederich said the right of access is what the Working Group is trying to define, and portability refers to certain aspects of that right. Ms. Amann said that is how she had always understood portability, but it is good to know that it needs some work. She said the Working Group wants to be clear about its intention, which is to not be specific by line of business, while recognizing that health has a great deal of guidance through HIPAA and other provisions. Mr. Petersen said that is a good reminder that the health insurance industry is heavily regulated by the HIPAA privacy rule, and that rule preempts state law. He said he believed people were leaning towards an exemption if the company complies with HIPAA, and he believed it might be easier if companies have that exemption because then the Working Group could make rules that are not as complicated for the rest of the industry, while leaving health insurers to tackle the extensive HIPAA privacy role to which they are already subjected.

Angela Gleason (American Property Casualty Insurance Association—APCIA) said the APCIA’s comments and observations include high level examples about how the restrictions and requirements for data align with the relationships of the parties and the products, as well as how that works together. She said the APCIA did not like use of the word “right” in discussions, but it looks forward to working through discussions about that during the Working Group process. Ms. Amann asked everyone to remember that the Working Group was instructed to focus on the six consumer rights and use them to provide recommendations along with the basis for the recommendations for consideration by the Market Regulation and Consumer Affairs (D) Committee. She also asked the Working Group to recognize that the recommendation would not be the conclusion, but there would still be model work to do in 2022. She said once the Committee has blessed the definitions and recommendations, the Working Group would pick up where it left off with revisions to Model #670 and Model #672 if that ends up being the will of the group, or it will develop a new model if so directed. Therefore, she said there would still be plenty of opportunities to
comment on whatever is concluded or recommended going forward. Wes Bissett (Independent Insurance Agents and Brokers of America—IIABA) asked if the Working Group’s goal is that the deliverable to the parent committee by the end of the year will essentially be plain language recommendations on these six issues, and not necessarily proposed statutory or regulatory language that would effectuate whatever outcomes the Working Group recommends. Ms. Amann said when Model #670 and Model #672 were last revised, several items were identified as outdated from a business or technology perspective, but the Working Group did not want to spend a lot of time wordsmithing the function or right. Lois E. Alexander (NAIC) said the expectation is that the deliverable will be the privacy policy statement with a comprehensive report about what was discussed, as well as the reasons why the Working Group supports the recommendations given. She said the report will not be just a paragraph with Working Group recommendations because that is something that could be done any time. She said the reason why the Working Group is going through this entire process is to get feedback from all stakeholders so a comprehensive report could be formulated for the parent company. Mr. Bissett said that explanation helps because stakeholders have struggled to understand the purpose of the privacy policy statement and how to respond to it, but it sounds like the privacy policy statement is ultimately the center of gravity for recommendations on the six issues or rights on which stakeholders can focus their efforts. Ms. Amann said Working Group discussions going forward will be used to tweak the privacy policy statement and recommendations report based on the better understanding and clarification obtained through consensus on the document. She said the document is long and it will probably get a little longer, but due to an ambitious schedule, she recognized that everybody would not be able to make conference calls as frequently as they are scheduled. However, she asked stakeholders who have questions or comments to submit, but who are unable to make the call, to please let Ms. Alexander or himself know, and they would be glad to raise the points on your behalf. She said if anyone misses a call and has questions, to please reach out and call either of them as they are always glad to bring anybody up to speed on what was discussed, as well as how or why a decision was made. Ms. Amann said the next Working Group meeting is scheduled for Sept. 13.

Having no further business, the Privacy Protections (D) Working Group adjourned.
The Antifraud (D) Task Force met Nov. 12, 2021. The following Task Force members participated: Trinidad Navarro, Chair (DE); Judith L. French, Vice Chair, represented by Michelle Brugh Rafeld (OH); Alan McClain represented by Crystal Phelps and Paul Keller (AR); Evan G. Daniels represented by Paul Hill (AZ); Ricardo Lara represented by Shawn Conner (CA); Andrew N. Mais represented by Kurt Swan (CT); Karima M. Woods represented by Michael Press (DC); Doug Ommen represented by Benjamin Olejnik (IA); Dean L. Cameron represented by Kyle Cammack (ID); Vicki Schmidt represented by Tate Flott (KS); Sharon P. Clark represented by Juan Garrett (KY); James J. Donelon represented by Matthew Stewart (LA); Anita G. Fox represented Michele Riddering (MI); Grace Arnold represented by Chris Ness and Devin Chapman (MN); Chlora Lindley-Myers represented by Carrie Couch and Jeana Thomas (MO); Mike Chaney represented by John Hornback (MS); Troy Downing and Troy Smith (MT); Mike Causey represented by Angela Hatchell, Della Shepherd and Tracy Biehn (NC); Jon Godfread represented by Dale Pittman and Jennifer Middlestead (ND); Eric Dunning represented by Martin Swanson (NE); Chris Nicolopoulos represented by Edwin Pugsley and Heather Silverstein (NH); Glen Mulready represented by Rick Wagnon (OK); Andrew R. Stolfi represented by Dorothy Bean (OR); Raymond G. Farmer represented by Gwen Fuller McGriff (SC); Jonathan T. Pike represented by Armand Glick (UT); Scott A. White represented by Mike Beavers (VA); and Allan L. McVey represented by Greg Elam (WV). Also participating was: John Haworth (WA).

1. **Adopted its Oct. 27 and Summer National Meeting Minutes**

   The Task Force met Oct. 27 and took the following action: 1) adopted its 2022 proposed charges.

   Mr. Swan made a motion, seconded by Mr. Stewart, to adopt the Task Force’s Oct. 27 (Attachment One) and July 26 (*see NAIC Proceedings – Summer 2021, Antifraud (D) Task Force*) minutes. The motion passed unanimously.

2. **Received an Update from the Antifraud Education Enhancement (D) Working Group**

   Ms. Rafeld said the Working Group is currently in the process of setting up webinars for the state fraud directors and staff. The first is the annual investigator safety webinar, which will be offered in December. Ms. Rafeld said the webinar is consistently being updated, and she encourage everyone to attend even if they have already due to the new information being added. Ms. Rafeld said the next webinar that is being worked on is an open-source webinar series. She said in 2019 at the Insurance Fraud Management (IFM) Conference, Michele Stuart (JAG Investigations) provided training, and the Working Group is looking to host this in a segmented portion with two to three sessions. Ms. Rafeld said the Working Group is always looking for new training topics, and she encouraged state insurance regulators or industry representatives to send in topics to the NAIC.

   Ms. Rafeld said moving forward, the Working Group will continue to monitor emerging issues for new fraud schemes and provide the necessary training to assist with education on the various types of insurance fraud.

3. **Received an Update from the Antifraud Technology (D) Working Group**

   Mr. Glick said the Working Group has continued to work on the creation of an Antifraud Plan Repository. Mr. Glick said the Working Group has previously reviewed the antifraud plan guideline in 2020. He said the Working Group created a subject matter expert (SME) group to develop an antifraud template and workflow. Mr. Glick said the SME group is finalizing its work on this project and expects to have it finalized by end of year. Mr. Glick said the final draft will be presented to the Working Group for its consideration and then will refer it to the Task Force for review.

4. **Received an Update from the Improper Marketing of Health Insurance (D) Working Group**

   Mr. Pyle said the Working Group has continued increase the size of its Working Group members and is currently at 15 members. He said the Working Group has continued to meet monthly in regulator-to-regulator session. Mr. Pyle said the Working Group has had participation from federal agencies including the Federal Bureau of Investigations (FBI), the U.S. Department of Labor (DOL), and the federal Centers for Medicare & Medicaid Services (CMS). Mr. Pyle said due to the discussions during these meetings and the added support from these federal agencies, the Working Group has been able to act on some of the bad actors that are improperly marketing health insurance.
Mr. Pyle said the Working Group will continue meet monthly in regulator-to-regulator session, but it is working to hold open meetings as well. Mr. Pyle said the Working Group will hold its first open meeting on at the Fall National Meeting, to hear presentations from the Alliance of Health Care Sharing Ministries, America’s Health Insurance Plans (AHIP), and the NAIC consumer representatives on the efforts they are making to fight against the improper marketing of health insurance. Mr. Pyle said the Working Group plans to meet next on Dec. 2 in regulator-to-regulator session.

5. **Heard a Report from the Coalition**

Matthew Smith (Coalition Against Insurance Fraud) said the Coalition will be on the keynote address kicking off the Global Insurance Fraud Summit. He said during the Summit, the Coalition will be releasing the first ever study completed on the globalization of insurance fraud. The data has been complied in Denmark over the last couple of months. Mr. Smith said the Coalition has closed its study, which is completed every two years on the state of insurance fraud technology, reviewing how insurers are using technology to identify fraud. Mr. Smith said this data can also be used to see areas of weaknesses, what the concerns are, and what needs to improve. He said the Coalition will be releasing that study and a joint presentation with Statistical Analysis Systems (SAS). Mr Smith said SAS is the Coalition’s partner in Washington, DC. He said the study will also be presented at the Coalition’s annual meeting on Dec. 7 and will then be available, starting Dec. 8, on its website.

Mr. Smith said the Coalition’s annual meeting will take place Dec. 6–7 in Washington, DC. He said at this time, they have 130 people registered to attend. Mr. Smith said during this meeting, they will discuss towing fraud and staged automobile accidents in addition to looking into 2022. He said they will be presenting the Prosecutor of Year Award and the 2021 Fraudster Hall of Shame. Mr. Smith said they will be updating their bylaws, encouraging other associations and companies around the world to join the Coalition.

Mr. Smith said the Coalition’s amicus program or friend of the court judicial program has two new briefs. The first is in the Supreme Court for Colorado dealing with individual insurance company employees being named as defendants in bad faith claims. Mr. Smith said the second is in New Jersey with a case of Liberty Mutual vs. Tech-Dan. The Coalition has filed a brief concerning whether if someone is found culpable for civil damages for committing insurance fraud, there should be joint liability where the damages can be collected against any one of them.

Ms. Smith said as the Coalition looks toward 2022, it is compiling a list of 22 legislative priorities, which will be adopted at the upcoming annual meeting. He said the Coalition has partnered with California to get criminal statute passed. Mr. Smith encourages states to reach out to the Coalition for assistance with getting new laws passed.

Ms. Rafeld said she would encourage other state fraud directors to get involved with the Coalition and use the numerous resources they have available. Commissioner Navarro said he agrees with her comments and encourages states to use the Coalition and each other to work toward the same goal of fighting against insurance fraud.

Having no further business, the Antifraud (D) Task Force adjourned.

*AFTF 11.12.21 Minutes*
The Antifraud (D) Task Force conducted an e-vote that concluded Oct. 27, 2021. The following Task Force members participated: Trinidad Navarro, Chair, represented by Frank Pyle (DE); Tynesia Dorsey, Vice Chair, represented by Michelle Brugh Rafeld (OH); Lori K. Wing-Heier represented by Alex Romero (AK); Evan G. Daniels represented by Paul Hill (AZ); Ricardo Lara represented by George Mueller (CA); Michael Conway represented by Damion Hughes (CO); Andrew N. Mais (CT); Karima M. Woods represented by Brian Bressman (DC); Sharon P. Clark (KY); James J. Donelon represented by Matthew Stewart (LA); Kathleen A. Birrane represented by James Wright (MD); Grace Arnold represented by Michael Marben (MN); Chlora Lindley-Myers represented by Carrie Couch (MO); Mike Chaney represented by John Hornback (MS); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by Dale Pittman (ND); Eric Dunning represented by Martin Swanson (NE); Chris Nicolopoulos represented by Heather Silverstein (NH); Marlene Caride represented by Richard Besser (NJ); Russel Toal (NM); Tanji J. Northrup represented by Armand Glick (UT); Scott A. White represented by Mike Beavers (VA); and Allan L. McVey (WV).

1. **Adopted its 2022 Proposed Charges**

The Task Force considered adoption of its 2022 proposed charges. Its 2022 proposed charges remain consistent with 2021, except for the change to the Antifraud Technology (D) Working Group charge to work with the NAIC to develop an Antifraud Plan Repository to be used by insurers to create and store an electronic fraud plan for distribution among the states/jurisdictions.

A majority of the Task Force members voted in favor of adopting its 2022 proposed charges (see *NAIC Proceedings – Fall 2021, Executive (EX) Committee and Plenary, Attachment Three*). The motion passed unanimously.

Having no further business, the Antifraud (D) Task Force adjourned.
MARKET INFORMATION SYSTEMS (D) TASK FORCE

Market Information Systems (D) Task Force Nov. 23, 2021, Minutes.................................................................9-124
Artificial Intelligence (AI) Subject Matter Expert (SME) Recommendations (Attachment Two)..............................9-128
The Market Information Systems (D) Task Force met Nov. 23, 2021. The following Task Force members participated: Mike Kreidler, Chair (WA); Chlora Lindley-Myers, Vice Chair, and Brent Kabler (MO); Evan G. Daniels represented by Maria Ailor (AZ); Ricardo Lara represented by Pam O’Connell (CA); Michael Conway represented by Damion Hughes (CO); Andrew N. Mais represented by Kurt Swan (CT); Trinidad Navarro represented by Frank Pyle (DE); Doug Ommen represented by Kim Cross (IA); Dana Popish Severinghaus represented by Erica Weyhenmeyer (IL); Vicki Schmidt represented by Tate Flott (KS); James J. Donelon represented by Jeff Zewe (LA); Troy Downing represented by Troy Smith (MT); Marlene Caride represented by Ralph Boeckman (NJ); Judith L. French represented by Rodney Beetch (OH); Cassie Brown represented by Rachel Cloyd (TX); Mark Afable represented by Rebecca Rebholz (WI); and James A. Dodrill represented by Jeannie Tincher (WV).

1. **Adopted its Oct. 29 and Summer National Meeting Minutes**

Commissioner Kreidler said the Task Force conducted an e-vote that concluded Oct. 29 to adopt its 2022 proposed charges.

Ms. Rebholz made a motion, seconded by Ms. O’Connell, to adopt the Task Force’s Oct. 29 minutes (Attachment One). The motion passed unanimously.

Director Lindley-Myers made a motion, seconded by Mr. Flott, to adopt the Task Force’s July 28 minutes (see NAIC Proceedings – Summer 2021, Market Information Systems (D) Task Force). The motion passed unanimously.


Mr. Kabler said the Working Group met Nov. 5 and Oct. 15 in regulator-to-regulator session, pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings. During these meetings, the Working Group reviewed the progress of the implementation of the Market Information Systems (MIS) Metric Report recommendations and methods to improve metric result reporting and data quality. He emphasized the metric report is not a scorecard on how states are using the MIS and is not meant to indicate that any state is doing anything wrong. He said the metric report is simply a tool to identify consistency, timeliness, and accuracy concerns. He said there may be good reasons that a metric may be moving in a positive or negative direction, but the report does not capture those reasons. He said the purpose of the report is to allow states to identify concerns and address them, if necessary. Mr. Kabler noted there was one error in the metric report that needs to be corrected. He said the comparison of the counts of market conduct examinations in the Insurance Department Resources Report (IDRR) and the Market Actions Tracking System (MATS) are incorrect, and NAIC staff are trying to determine the correct numbers.

Mr. Kabler said the Working Group approved two new Uniform System Enhancement Request (USER) forms. The first USER form is to create a Personalized Information Capture System (PICS) event for Market Conduct Annual Statement (MCAS) waiver and extension requests that will allow users to specify they want to receive regular reminders of waivers and extensions not acted upon. The second USER form is to create a telehealth code in the Complaint Database System (CDS).

Mr. Kabler said the Working Group adopted the artificial intelligence (AI) subject matter expert (SME) group’s recommendations (Attachment Two).

Mr. Flott made a motion, seconded by Ms. O’Connell, to adopt the Market Information Systems Research and Development (D) Working Group report. The motion passed unanimously.

3. **Considered AI Recommendations**

Commissioner Kreidler said one of the Task Force’s charges for 2021 was to develop recommendations for the incorporation of AI abilities in the NAIC MIS. The Task Force tasked the Market Information Systems Research and Development (D) Working Group to conduct the research and draft recommendations by the Fall National Meeting.
Commissioner Kreidler said the report was distributed to the Task Force and interested parties on Oct. 20 and posted to the Task Force web page at the same time. He said if the report is adopted, it will be forwarded it to the Market Regulation and Consumer Affairs (D) Committee in completion of the Task Force’s charge.

Mr. Kabler said that as background, he is skeptical of AI techniques. He said he was trained in classical statistical methods. He noted that AI was not developed in the statistics departments of universities, but in the computer sciences. He said he kept an open mind during the Working Group’s research, and he sees potential in AI that should be investigated.

Mr. Kabler said the report recommends moving ahead slowly in the consideration of incorporating AI in the NAIC MIS because there are issues with the data in the MIS. He said the first recommendation of the report is to analyze the data in the MIS to ensure the data collected from companies is accurate. He noted definitional and reporting issues in the MCAS as an example of potentially inaccurate data. He said AI techniques require more data than is currently being collected. He said the report recommends moving slowly into incorporating AI and that after analyzing the data needs and accuracy, analysts should incorporate more traditional statistical methodologies first. He said this would be a multiyear process requiring lots of resources from the states.

Commissioner Kreidler said there is reason to be cautious, and the report outlines a good plan for moving forward.

Ms. Cloyd said the report recommends a slow approach, but AI is a fast-moving field and the state insurance regulators will be outpaced. Ms. Cloyd said the report does not include NAIC feedback on the current MIS capabilities and the costs, resources, time required, and competing priorities.

Ms. Cloyd also said NAIC membership is forming the Innovation, Cybersecurity and Technology (H) Committee. She noted the report and the recommendations overlap with the charge to the Big Data and Artificial Intelligence (EX) Working Group to “assess data needs and required tools for state insurance regulators to appropriately monitor the marketplace, and evaluate the use of big data and intelligent algorithms, including AI in underwriting, rating, claims and marketing practices.” She said it should be determined whether this Task Force or the (H) Committee should be exploring the incorporation of AI in MIS. Commissioner Kreidler acknowledged there is a question as to which committee this charge belongs to, but he said any consideration of AI in MIS would involve the Task Force. He said he was afraid these considerations may fall through the cracks if the Task Force did not do this exploratory work.

Ms. Cloyd asked if these recommendations should be a narrow and well-defined proof-of-concept including an analysis of costs and benefits rather than being as broad as it is. Mr. Kabler said a proof-of-concept is a good idea. He said the financial regulatory department at the NAIC investigated this, and it was not clear that traditional statistical techniques were inferior to AI techniques for predicting insolvencies.

Andrew Pauley (National Association of Mutual Insurance Companies—NAMIC) said recommendations on incorporating AI in the NAIC MIS is premature given that the NAIC is not finished with its work of implementing regulation of the insurance industry regarding AI, machine learning (ML), and predictive analytics. He said this may lead to redundancies and the need to revisit many concepts later. He said it is still not clear that using AI will be superior to current analytical methods. He said NAMIC supports some of the recommendations of the report, such as analyzing the data currently in the MIS regarding the data’s quality and then re-evaluating the analytical tools. He said NAMIC is concerned with the collection of transactional-level data if it is not necessary to perform regulatory activities. He said this could subject sensitive, proprietary data to cyber risk and confidentiality breaches.

Birny Birnbaum (Center for Economic Justice—CEJ) noted the inconsistency in the statements from Texas and NAMIC that AI is moving swiftly, but the work of the Task Force regarding AI should slow down. He said the Market Analysis Procedures (D) Working Group and the Task Force are already doing the work of the first two recommendations in the report to assess the quality of the MIS data and analysis techniques, so no cost benefit analysis is necessary for those recommendations. The work would be the same, but more targeted. Mr. Birnbaum said some of the other recommendations should be made into charges for the Task Force or the Market Analysis Procedures (D) Working Group.

Mr. Birnbaum said he disagreed that there is a stark contrast between AI and classic statistical analyses. He said they can be used in conjunction. He did, however, agree that to be most effective, AI needs a large amount of data. He said it is understandable that financial state insurance regulators would not find AI particularly useful for predicting financial insolvencies since there are not many instances of insolvency to begin with, so any regression analysis would not be helpful. Mr. Birnbaum suggested a charge related to the fifth recommendation to begin exploring the types of data needed to implement more robust statistical methods including AI. He said this would not be expensive to do since it is merely a charge to explore
what type of data is needed. Ms. Cloyd said the Task Force should first determine what its end goal is before exploring data needs. The Task Force needs to determine if AI is feasible within the existing systems. She said to fulfill any charge will take time and resources, and the NAIC should provide feedback on the time and cost prior to the creation of a charge. Mr. Birnbaum said the purpose is clear—it is to improve market analysis and focus regulatory resources. The charge would be to determine the types of data needed to enable the use of robust statistical methods, including AI. He said the NAIC is ready and willing to assist and have the capabilities. He said the charge would not be a large resource commitment and would only be continuing what the Task Force and the Market Analysis Procedures (D) Working Group are already doing, but in a more focused way. Ms. Cloyd said she did not say the NAIC was not willing or capable but was only asking for written feedback on the costs and resources. Mr. Birnbaum said the Task Force needs the charge to keep learning about AI, its capabilities, and the data type needs.

Commissioner Kreidler asked for additional comments and said the discussion will continue during the Task Force’s next meeting.

Having no further business, the Market Information Systems (D) Task Force adjourned.

MISTF 2021 Fall National Meeting Minutes
The Market Information Systems (D) Task Force conducted an e-vote that concluded Oct. 29, 2021. The following Task Force members participated: Mike Kreidler, Chair (WA); Chlora Lindley-Myers, Vice-Chair (MO); Lori K. Wing-Heier (AK); Peni Itula Sapini Teo (AS); Evan G. Daniels (AZ); Ricardo Lara (CA); Michael Conway (CO); Andrew N. Mais (CT); Trinidad Navarro (DE); Doug Ommen (IA); Dana Popish-Severinghaus (IL); Vicki Schmidt (KS); James J. Donelon (LA); Grace Arnold (MN); Troy Downing (MT); Marlene Caride (NJ); Russell Toal (NM); Barbara D. Richardson (NV); Judith L. French (OH); Glen Mulready (OK); Andrew R. Stolfi (OR); Cassie Brown (TX); Michael S. Pieciak (VT); Mark Afable (WI); and Allan L. McVey (WV).

1. **Adopted its 2022 Proposed Charges**

   The Task Force considered adoption of its 2022 proposed charges. The Task Force’s 2022 proposed charges remain consistent with 2021, except for the removal of the charge to make recommendations for the incorporation of artificial intelligence (AI) abilities in the NAIC market information systems.

   A majority of the Task Force members voted in favor of adopting its 2022 proposed charges (see *NAIC Proceedings – Fall 2021, Executive (EX) Committee and Plenary, Attachment Three*).

   Having no further business, the Market Information Systems (D) Task Force adjourned.
Executive Summary

This report fulfills the Market Information Systems Research and Development (D) Working Group charge to evaluate the potential benefits of artificial intelligence (AI) in relation to market analysis. After careful consideration, the Working Group concluded that there may be possible benefits to improve analysis techniques. Several caveats are discussed as well. AI may not be suitable for data currently available to state insurance regulators. In addition, some of the techniques perform complex data mining operations, which can produce results that lack a clear interpretation. Lastly, AI techniques are designed for, and many require, very large datasets. As such, AI should be contemplated in the context of a long-range plan, beginning with repairing known issues with existing data, and employing more rigorous traditional statistical techniques to assess predictive accuracy of analytical tools. Subsequently, state insurance regulators can consider the acquisition of data appropriate to AI.

Introduction

In early 2021, the Market Information Systems Research and Development (D) Working Group received a charge from the Market Information Systems (D) Task Force to explore possible applications of artificial intelligence (AI) methods in market analysis. An early difficulty encountered by the Working Group is that the term “AI” itself has a variety of contested meanings. In addition, private sector entities have adopted the term as a marketing concept and inappropriately apply the label to products simply as a selling point. As such, the term has come to acquire a variety of meanings and is an “essentially contested concept.”

At its most general level, the term “AI” implies machine capacities that mimic or are analogous to processes of human reasoning and learning and entail some degree of machine autonomy in which learning occurs without significant human intervention. Beyond this general description, the Working Group did not feel that an attempt to define the term more strictly would be fruitful. Rather, the term is employed simply as a shorthand reference for a collection of various techniques that algorithmically seek patterns in data that are predictive of some future outcome. Common methods include machine learning, neural networks, and decision tree analysis. These processes are often contrasted to the traditional hypothetical-deductive methods of model specification associated with classical statistics. However, there does not appear to be a bright line of demarcation so that a particular technique can be firmly fixed within either category.

In addition, the Working Group focuses on what is commonly called “narrow AI,” in which machine algorithms are employed for narrowly defined and limited tasks. More advanced systems, called

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1 The term “essentially contested concept” was coined by W.B. Gallie in the seminal presentation to the Aristotelian Society in 1956.
“general AI,” possess generalized autonomous problem-solving capacities that are comparable to the processes of the human brain, and they are able to adapt to novel situations or information (Macnish et al., 2019).

It is important to emphasize the ways in which AI modeling techniques contrast to the standard scientific model employed in classical or traditional statistics:

**Classical Statistics:** Method of hypothetical-deductive reasoning in which hypotheses are clearly and narrowly specified prior to data testing, often with a prior understanding of the underlying causal nature of the relationships between variables. **Purpose:** To further causal understanding.

**AI:** Often employs a type of “data mining” in which a machine pattern-seeking algorithm is released “into the wild” to identify possible correlations between variables that may be predictive of some independent variable. Hypotheses are not specified prior to data analysis, and the algorithm may very well identify correlations that would not have occurred to an analyst and whose causal relationship is constructed post-hoc (to the degree that AI users are concerned with causality at all). **Purpose:** Predict future outcomes or events.

The difference between these two approaches is not trivial, and significant disagreements about the advantages and disadvantages of AI remain. It is of note that AI did not emerge principally from university statistics departments, but rather from the field of computer science. Many statisticians remain skeptical of the techniques and have offered up a variety of caveats for their use. For example, recently the American Statistical Society (ASA) reacted to the “reproducibility crisis” afflicting some disciplines that have discovered, with much consternation, that a large volume of published works could not be replicated. The concern was that increasingly less rigorous statistical methods departing from the hypothetical-deductive approach were becoming more prominent in a variety of fields, undermining confidence on research findings. Remarkings on departures from a rigorous hypothetical-deductive approach with “data mining” and like methods in which pattern seeking is largely ceded from a researcher to a machine, the ASA warned about improper inferences that might result from such techniques. The ASA centered its discussion on the p-value, related to the probability that some observed relationship occurred by chance along. A low p-value is often employed to minimize the probability that chance relationships will be misinterpreted as a relationship that is a meaningful, non-random outcome:

“Conducting multiple analyses of the data and reporting only those [analyses] with certain p-values...renders the reported p-values essentially uninterpretable. Cherry-picking promising findings, also known by such terms as data dredging, significant chasing, significance questions, selective inference and a ‘p-hacking’ leads to a spurious excess of statistically significant results...and should be vigorously avoided” (Wasserstein & Lazar, 2016).

To translate the ASA’s statement into more easily understood and less technical terms, the ASA is warning against false positives in which an analysis produces random or chance correlations between items that are not meaningfully related—that is, where a chance relationship is mistaken for a true causal relationship. That AI largely jettisons causal understanding as its primary goal (to the degree that causality is a concern at all) increases the probability that statistical results may be uninterpretable in any meaningful sense. This is clearly evinced by the increasing debate among state insurance...
Adopted by the Market Information Systems Research and Development (D) Working Group, Oct. 14, 2021

regulators and insurers regarding the meaning of statistical relationships appearing in predictive models that lack intuitive or, in many cases, even plausible explanations. See Appendix A for further discussion of the ASA statement.

The discussion above is not intended to sway state insurance regulators one way or the other with respect to AI. The purpose is simply to proffer some caveats shared by many statisticians. A final caveat is the AI techniques were developed to analyze very large data sets consisting of millions of records and possibly thousands or tens of thousands of variables. It is said to have an advantage in that algorithms can perform a large volume of analyses across different constellations of variables in a way that would be highly impractical employing traditional (and manual) model building. For small data sets, such as the limited data currently available to market analysts, it is unclear whether the expense associated with developing AI techniques can be justified, nor whether AI is at all superior to traditional model building methods. This is not an unimportant point and is discussed in more depth elsewhere in this recommendation.

Current Status of Market Analysis

Quantitative market analysis relies on just a handful of data sources:

**The Complaint Database System (CDS):** The NAIC compiles complaints against insurers received by state insurance regulators. Thus, each state has access to a national-level database. Complaint indices are “normalized” by expressing the volume of complaints to premium, compared with the overall industry total.

**The Regulatory Information Retrieval System (RIRS):** Regulatory actions in relation to insurance entities are captured in the RIRS database. Actions range from intervention in financially troubled entities to violations of producers and insurance carriers. Each record identifies the cause of the action, as well as any orders, fines, or restitution amounts. The RIRS database is currently being substantially revised to capture significantly more detail.

**The Market Actions Tracking System (MATS):** The MATS database captures information pertaining to market conduct exams, as well as actions short of exams. Data captured include area of scrutiny (claims, underwriting, etc.) and the outcome of the market action (order, fine, etc.). By matching MATS actions with RIRS, additional detail about the nature of the violation can be assessed.

**The Market Conduct Annual Statement (MCAS):** The MCAS was developed to capture data with the primary purpose of assessing an insurer’s market performance and identify potential market irregularities. The data focus primarily on claims handling and underwriting, and data are scrutinized with respect to claims processing times and denials, nonrenewal and cancellation practices, and overall turnover in a book of business. Data are captured by line and coverage. To date, MCAS data are collected for life and annuities, private automobile, homeowners, health (both on and off the federally facilitated marketplace [FFM]), long-term care (LTC), lender-placed insurance, disability income, and private flood.
Miscellaneous Data Sources: Some financial data has been incorporated into market information systems. Insurers that are under financial stress, or that rapidly expand into or contract out of a line of business, or that exhibit high defense or other adjudication costs, may be subjected to additional analysis. While financial indicators are only indirect or proxy measures of potential market issues, and by themselves may have no clear market-based interpretation, interpretation within the context of a host of other indicators may be reflective of the present of a market-relevant issue.

The NAIC, in conjunction with state insurance regulators, has developed a broad scope “market score” that incorporates much of the data referenced above, which is made available to regulators via the Market Analysis Prioritization Tool (MAPT). One such data are “normalized” by the premium volume and scope of company operations as necessary. For example, several RIRS-based ratios express the volume of RIRS actions in relation to premium volume, the number of states in which they have significant premium, and a composite ratio that incorporates both premium and scope. Each ratio is given a score, and their contribution to the overall score weighted according to their perceived predictive relevance. For example, financial ratios are accorded significantly less weight than complaints, as their relationship to market misconduct is considered more speculative and indirect.

An important caveat is that predictive analytics is not well developed in market regulation. The ratios employed in the Market Analysis Review System (MARS) have not been subjected to rigorous statistical tests that demonstrate their analytic utility. While some work has been performed in this regard, such work is significantly hampered by a dearth of appropriate data. For example, future RIRS actions are often employed as the dependent variable (the outcome of interest to be predicted). However, this presents all manner of statistical challenges. While it is certainly reasonable to use prior outcomes (past RIRS actions) to predict future outcomes (the RIRS actions to be predicted), employing RIRS actions as both dependent and independent variable introduces significant complexities in the interpretation of any observed relationship between the two. One can imagine, for example, that the use of RIRS actions in market analysis invites greater scrutiny to a given insurer, and that in turn generates future regulatory actions precisely because the company received additional scrutiny. Companies that have no “prior offenses” fail to attract regulatory scrutiny, so that any infractions may escape regulatory action for precisely that reason. This problem is certainly not insurmountable, but it must be explicitly recognized in any model building exercise, whether with AI or with more conventional statistical techniques.

In general, the paucity of rich data sources has significantly hampered the adoption of more rigorous analytical techniques. To return to RIRS, these data are not rich sources of detailed information. Schematics are not well designed “from the ground up.” Essential data are missing, such as line of business.

Any consideration of AI or any other analytical techniques must necessarily view the utility of such techniques within the context of available data. Regardless of the validity of a technique in general, it will have limited utility if data are themselves limited. Any recommendation to employ such methods must therefore at the same time recommend a thorough review of available data.

Importantly, results of quantitative analysis are always treated as merely suggestive and tentative and are regarded as at most a precursor to more qualitative analysis. It currently is employed to prioritize...
entities that may merit additional scrutiny and to narrow focus on a much more limited subset of companies out of a larger pool of companies. It therefore primarily prioritizes limited regulatory resources.

State insurance regulators avail themselves of the formal analytical processes adopted by the NAIC. Quantitative or “baseline” analysis identifies entities with anomalous indicators that significantly depart for industry-wide values. A “level 1” analysis may be pursued, in which an analyst devotes additional scrutiny to such things as complaint trends, common reasons complaints are lodged against an insurer, similarities in RIRS actions, etc. If concern still remains (or additional concerns are identified) subsequent to level 1 analysis, a structured level 2 analysis may be performed. A level 2 analysis requires a much greater commitment of time and resources. For example, rather than just manually reviewing complaint data to identify patterns, an analyst may manually review actual complaint documentation to garner a more detailed understanding of the nature of complaints.

As a preliminary to the following discussion, AI/statistical analysis may have two primary functions within the context of the current market analysis structure:

1. More accurately identify companies that merit the additional expenditure of resources necessary to perform the more labor-intensive level 1 and level 2 analyses. Analysis processes that more efficiently identify problem companies for this purpose are by definition more effective and more effectively target resources by avoiding “false positives” (for lack of a better word).

2. Potentially, AI methods could assume many of the functions that are currently performed manually. For example, many of the pattern-seeking analysis performed by analysts in a level 1 review could conceivably be more efficient if automated. Potentially, AI could identify patterns that might elude a human analysis. A very advanced level of AI could perhaps assume complex analysis involved with manually reviewing complaint files and documents. However, while the possibility is raised here, it is not further pursued. That level of AI suitable for tasks may not even exist as yet, or if it does, it may be so specialized that it may not be available to state insurance regulators. Even if available, the likely enormous costs themselves would render them highly impractical.

Whether such AI exists, is available at a practical cost, and can actually out-perform more conventional analyses are questions that the Market Information Systems Research and Development (D) Working Group is simply unable to satisfactorily address. The Working Group merely suggests initially limiting the scope of ambitions to a few methods that are commonly, if not universally, recognized as AI, such as machine learning or neural networks. More expansive or ambitious efforts may result in a fruitless search for “unobtainium.”

Given very large data sets, well beyond what is currently available to market analysts, AI may have clear advantages to more conventional approaches. The slow, methodical, hypothetical-deductive

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2 A tongue-in-cheek term originating among engineers in the 1950s. It is defined by Wikipedia as “… any hypothetical, fictional, or impossible material, but it can also mean a tangible but extremely rare, costly, or reasonably unobtainable material. Less commonly, it can refer to a device with desirable engineering properties for an application, but which are exceedingly difficult or impossible to achieve.”
approach that forms the core of conventional statistics may have advantages in terms of generating valid causal conclusions. However, AI may have certain advantages with respect to confronting the enormity of modern data. As AI is well-suited to performing much more expansive analysis and pattern-seeking routines over vast quantities of data, it may well identify predictive patterns that would have escaped conventional analysis or that are counterintuitive such that some hypotheses may never have occurred to an analyst employing a standard hypothetical-deductive approach. However, there are distinct disadvantages as well, and they are shared by other approaches often termed “data mining.” The fact is that patterns may lack an intuitive meaning, and the manner in which such patterns are identified and render interpretation may be unclear. Additionally, patterns may generate numerous “false positives,” apparent patterns or correlations that are purely random and possess no meaning or any real predictive power whatsoever. This is not fatal for AI techniques, but it introduces much in the way of caveats and requires significant remedial measures to be employed. This problem is so significant that it merits a much fuller discussion in a separate section below.

The Work of Market Information Systems Research and Development (D) Working Group

The Working Group solicited input from various parties. Two parties delivered presentations to the Working Group:

1. On June 16, 2021, the Working Group discussed a presentation regarding AI methods currently being explored by NAIC staff to predict which insurers are likely to experience financial stress, including insolvency. Beginning in January 2021, an outside consulting group was retained to develop both AI as well as more traditional statistical techniques to construct predictive models of insolvency risk. The efforts are ongoing at the time of writing. Presenters believed the methods were promising and could significantly advance financial risk surveillance. Among AI and statistical models explored were decision tree analysis, generalized linear models (GLMs), and logistic regression.

2. During the Working Group’s June 21, 2021, meeting, Birny Birnbaum (Center for Economic Justice—CEJ) encouraged the Working Group to adopt a long-term perspective and develop a multiyear plan to explore AI techniques that might be beneficial to market analysis. He also indicated that state insurance regulators have to date failed to acquire granular transactional data that could be exploited by AI methods to afford a much more robust surveillance system to reduce consumer harm to the extent possible.

After the meeting, the Working Group convened a subject-matter expert (SME) group with the intent of creating a draft recommendation to be submitted to the Working Group.

Recommendations

The Working Group recommends developing a long-range plan, in a sequence of five steps.

1. **Existing Market Analysis Data**
   As noted above, market analysis suffers from a paucity of detailed data. Some movement in expanding data and remedying deficiencies was made with a complete redesign of the RIRS data, which will facilitate analysis of factors related to an entity sanctioned by state insurance regulators. If
implemented, RIRS will also capture much more detailed data related to the specific misconduct that garnered a regulatory response. The RIRS proposal is currently under discussion with the Market Information Systems (D) Task Force, to which Working Group reports.

The remainder of available data also suffers from significant deficiencies. Insurers employ a variety of definitions to produce MCAS data. Even such a fundamental concept as a “claim” is reported differently by different insurers, making market-wide analysis challenging. For example, the MCAS defines a claim in the conventional sense of “a demand for payment.” Investigation by the Missouri Department of Commerce & Insurance (DCI) has determined that the definition is interpreted in wildly divergent ways across the industry that simply makes meaningful comparison impossible and renders key market indicators or ratios largely meaningless. Some insurers set up a claim on a coverage that is reasonably related to the facts of the incident as relayed by a claimant. Other insurers set up all possible coverages on a policy as a claim in their internal systems regardless of whether those coverages might be reasonably implicated in a claim. As might be imagined, those carriers have significantly higher ratios of claims closed without payment. This and other issues remain with the MCAS and significantly impair market analysis.

**Recommendation 1:** Survey currently available market analysis data, and identify substantive deficiencies based on the nature and substance of the data elements collected. Ensure that all data are consistently reported across insurers to the degree practical and ensure adherence to definitions of data elements.

**II. Existing Methods of Market Analysis**

Current quantitate methods of market analysis are large based on ad hoc and intuitive understanding of how data indicators might be related to market misconduct. For example, one of the earliest indicators developed are complaints received by state insurance regulators regarding insurers. It is probably not unreasonable to interrogate complaint data to identify trends over time, as well as just overall complaint volume, to attempt to identify potential problems in a market. Similar indices consider the volume of RIRS actions, as well as the gravity of infractions in terms of potential consumer harm. It is the opinion of many state insurance regulators that such indicators possess a rational relationship to market misconduct and are relevant to identify market actors that might benefit from a heightened level of regulatory scrutiny.

While the Working Group agrees with the rationale behind such market indicators, analytical tools have not to date been subjected to more rigorous statistical methods to clearly identify the predictive power and assess their relative importance or weight. For example, the MAPT, maintained by the NAIC and available to state insurance regulators, employs overall insurer scores based on various indicators. However, the weight of these indicators employed in the score were assigned by state insurance regulators based on experience, as well as assessment of whether a likely relationship have a clear rational meaning. For example, complaint ratios are weighted significantly more heavily than things like financial indicators. The Working Group believes subjecting the scoring system to rigorous statistical analysis could yield significant benefits in identifying problem market actors.
Recommendation 2: In conjunction with recommendation 1 (assess data quality), state insurance regulators should adopt a much more rigorously statistical approach to identify the predictive power of market scoring systems, assess how each variable should be weighted in terms of its unique contribution to productiveness, and drop those that lack analytic utility. In addition, effort should be made to integrate data into a single overall analysis. For example, the MAPT does not incorporate MCAS data, which is typically subject to a separate analysis. The Working Group believes that a “piecemeal” approach is likely less effective than a more integrated approach.

It is noted that the current state of data will likely prove limiting and that such efforts may not make much progress until additional data are made available (such as the proposed revisions to the RIRS data, currently subject to NAIC discussion).

III. Available Approaches: Exploring AI

In addition to more traditional statistical tools, such as various types of regression models and correlation analyses, AI may offer additional benefits. Some commercial statistical packages have incorporated AI methods. The statistics package SAS, which is widely used in both the private and public sectors, makes some AI techniques available in its standard statistical module. In addition, SAS has developed a module called Enterprise Miner, which incorporates both data mining and some lower-level AI routines. (For those familiar with the terms, it performs such things as decision-tree analysis, neural networks, and like forms of analyses). Other modules make machine learning available—a potentially powerful type of analysis that modifies prior predictive algorithms as new data become available.

Recommendation 3: In undertaking recommendation 2, incorporate various promising AI modes of analyses, as well as traditional statistical modeling. Constantly assess the precision of model outcomes relative to objectives such as identifying potential market issues.

IV. Qualitative Analysis

The current model of market analysis incorporates a multistage hierarchical structure. First, quantitative analysis such as that produced by the MAPT identifies potential market problems and narrows focus to entities that appear to exhibit potential areas of regulatory concern. Having narrowed down the focus of analysis to a much more limited pool of candidates, market analysts in the states engage in more manual or qualitative analysis of additional information sources. For example, an analyst may review a selection of complaint files to identify additional patterns of market behavior to better understand their nature and substance.

SAS is markets in “modules,” each consisting of a different suite of capabilities that can be tailored to a user’s need. For example, “base SAS” provides standard data handling programs. A “statistics module” provides a wide-ranging set of analytical routines.
Adopted by the Market Information Systems Research and Development (D) Working Group, Oct. 14, 2021

As noted above, AI techniques such as text analysis could potentially expand such exercises and improve the identification of concerning patterns at a deeper level, as well as assess ways to improve the efficiency of other qualitative tasks.

**Recommendation 4:** Assess ways AI can improve both the efficiency of qualitative analysis and facilitate pattern recognition across larger volumes of textual evidence, including most especially complaints, but perhaps other textual sources. For example, the “level 1” analysis formalized in NAIC market system may include a review of the “management discussion and analysis” of the financial annual statement.

V. Longer-Range Planning

As noted above, data mining and AI techniques were developed primarily as tools to analyze large volumes of data. For data past a certain magnitude, including especially those containing many hundreds or even thousands of variables, the traditional hypothetical-deductive cornerstone that is the cornerstone of traditional statistical inference may be ill-suited as well as cost-prohibitive in terms of time and resources. If the purpose is solely prediction as opposed to causal understanding, AI can fine-tune predictive algorithms by testing relationships that may be unlikely to occur to a statistician employing causal modeling.

Currently, such large volumes of data are unavailable to market analysts, though they could potentially be obtained. More granular data pertaining to claims, underwriting, and other areas of company operations are routinely collected via the “standard data requests” adopted as a supplement to the Market Regulation Handbook and commonly employed in market conduct exams.

However, AI and data mining can churn up counterintuitive statistical relationships that defy ready interpretation. In addition, it is likely to detect proxy relationships that are not understood. Proxy relationships, in which a third variable is substituted for an underlying variable of interest, are often employed in statistical models. This is often due to the accessibility or cost of obtaining data of the actual causal variable of interest. However, when employed in traditional statistical analysis, the nature of the relationship between the proxy variable and the actual variable of interest is generally well understood. This is not true of AI techniques that employ or resemble data mining.

The techniques are also likely to generate some number of purely chance relationship, where a correlation is generated by random chance. Inferential statistics seek to minimize mistaking a chance relationship for a meaningful association. Typically, the use of a p-value requirement of 0.05 or less limits the probability of accepting a random relationship to no more than 5% of occurrences. However, a 5% threshold means that over time, false, or chance relationships will be misinterpreted of a true correlation.

This fact is not fatal for the use of AI in market analysis, but it does represent a strong caveat for those employing the techniques, at least those that share elements with data mining. Careful interpretations of p-values should recognize an increased possibility of false positives. Observed relationships should be assessed and validated over time to ensure correlations are stable. In addition, once relationships
are identified via AI and found useful, standard statistical models should also be employed to test whether different techniques yield superior predictive power. Additional discussion of caveats is presented in the appendix.

That said, there is much potential of AI in market analysis, assuming that additional, more granular, data are available. As noted, such techniques are most suited for large datasets whose very size would make a standard statistical approach impractical just given the sheer number of possible correlations available for testing.

**Recommendation 5:** Systematically explore potential data sources suitable for AI techniques, with an eye for discovering patterns and relationships in relation to some well-defined outcome one is attempting to predict. This may be identifying entities that may merit additional regulatory scrutiny in a way that is currently done by the less sophisticated methods employed in the MAPT or with the MCAS. Larger volumes of data, such as the standard data requests, can be subjected to AI to identify problematic claims handling, underwriting, and other insurer practices.

**Summary of Recommendations**

**Recommendation 1:** Survey currently available market analysis data, and identify substantive deficiencies based on the nature and substance of the data elements collected. Ensure that all data are consistently reported across insurers to the degree practical, and ensure adherence to definitions of data elements.

**Recommendation 2:** In conjunction with recommendation 1 (assess data quality), state insurance regulators should adopt a much more rigorously statistical approach to identify the predictive power of market scoring systems, assess how each variable should be weighted in terms of its unique contribution to productiveness, and drop those that lack analytic utility. In addition, effort should be made to integrate data into a single overall analysis. For example, the MAPT does not incorporate MCAS data, which is typically subject to a separate analysis. The Working Group believes that a “piecemeal” approach is likely less effective than a more integrated approach.

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a way that is currently done by the less sophisticated methods employed in the MAPT or with the MCAS. Larger volumes of data, such as the standard data requests, can be subjected to AI to identify problematic claims handling, underwriting, and other insurer practices.
Appendix: Caveats

Recently, some fields of scientific inquiry have experienced much consternation and hand-wringing due to the so-called “replicability crisis” resulting from the realization that many studies published in top-tier journals could not be replicated. In 2015, Open Science Collaboration published research into the replicability of psychological studies. Of the 100 studies that were subjected to testing, replications yielded statistically significant results in only 36% compared to 97% of the original publications (Open Science Collaboration, 2015). Similar reproducibility issues were found in other fields.

Attention was directed at quantitative methods, particularly those made possible by modern computing power. Researchers can run countless variations of models, including multiple different variables, cross-effects, and other tweaks, until they eventually produce positive or statistically significant results. The inevitable outcome of the lack of rigor of such methods is that many chance correlations will be mistaken for meaningful relationships.

Think of it this way. The probability of obtaining all heads from 10 flips of a fair coin is 1/1024. So, if a researcher actually performed the experiment 1,024 times and obtained 10 heads at least once, it would obviously be improper to infer that the coin was a two-headed coin. Without knowledge of the total number of trials, one might reject the “null hypothesis” that the coin is fair, and results would be “statistically significant” with a p-value of (1/1,024) = 0.00098, well below the 0.05 maximum threshold to establish statistical significance. But the true p-value can only be calculated with knowledge of the total number of trials prior to obtaining the recorded result, such that the true p-value is well above the maximum threshold.

There are no allegations of willful misconduct so much as careless and sloppy methods, producing much introspection about how statistics methods are taught to scientists at colleges and universities. The problem is so significant that the following year, the American Statistical Association (ASA) released a statement regarding misuse of p-values and practices known as “p hacking” or “data dredging.” A letter from the ASA is reprinted below, with a link to the full statement (used with permission).

Really, this is a warning for state insurance regulators not to adopt a casual attitude about apparent relationships turned up by the methods. When such methods are employed, modelers should be on constant guard against mechanical interpretations of model outputs. It is important to fully understand what is going on in the “black box” of an AI algorithm, the results of all statistical tests performed, and the totality of processes generating final results.

A high number of false positives that prompt regulatory follow-up can risk draining away regulatory resources going down blind allies.
AMERICAN STATISTICAL ASSOCIATION RELEASES STATEMENT ON STATISTICAL SIGNIFICANCE AND P-VALUES

Provides Principles to Improve the Conduct and Interpretation of Quantitative Science

March 7, 2016

The American Statistical Association (ASA) has released a “Statement on Statistical Significance and P-Values” with six principles underlying the proper use and interpretation of the p-value. The ASA releases this guidance on p-values to improve the conduct and interpretation of quantitative science and inform the growing emphasis on reproducibility of science research. The statement also notes that the increased quantification of scientific research and a proliferation of large, complex data sets has expanded the scope for statistics and the importance of appropriately chosen techniques, properly conducted analyses, and correct interpretation.

Good statistical practice is an essential component of good scientific practice, the statement observes, and such practice “emphasizes principles of good study design and conduct, a variety of numerical and graphical summaries of data, understanding of the phenomenon under study, interpretation of results in context, complete reporting and proper logical and quantitative understanding of what data summaries mean.”

“The p-value was never intended to be a substitute for scientific reasoning,” said Ron Wasserstein, the ASA’s executive director. “Well-reasoned statistical arguments contain much more than the value of a single number and whether that number exceeds an arbitrary threshold. The ASA statement is intended to steer research into a ‘post p<0.05 era.’”

“Over time it appears the p-value has become a gatekeeper for whether work is publishable, at least in some fields,” said Jessica Utts, ASA president. “This apparent editorial bias leads to the ‘file-drawer effect,’ in which research with statistically significant outcomes are much more likely to get published, while other work that might well be just as important scientifically is never seen in print. It also leads to practices called by such names as ‘p-hacking’ and ‘data dredging’ that emphasize the search for small p-values over other statistical and scientific reasoning.”

The statement’s six principles, many of which address misconceptions and misuse of the p-value, are the following:

1. **P-values can indicate how incompatible the data are with a specified statistical model.**

2. **P-values do not measure the probability that the studied hypothesis is true, or the probability that the data were produced by random chance alone.**

3. **Scientific conclusions and business or policy decisions should not be based only on whether a p-value passes a specific threshold.**
4. Proper inference requires full reporting and transparency.

5. A p-value, or statistical significance, does not measure the size of an effect or the importance of a result.

6. By itself, a p-value does not provide a good measure of evidence regarding a model or hypothesis.

The statement has short paragraphs elaborating on each principle.

In light of misuses of and misconceptions concerning p-values, the statement notes that statisticians often supplement or even replace p-values with other approaches. These include methods “that emphasize estimation over testing such as confidence, credibility, or prediction intervals; Bayesian methods; alternative measures of evidence such as likelihood ratios or Bayes factors; and other approaches such as decision-theoretic modeling and false discovery rates.”

“The contents of the ASA statement and the reasoning behind it are not new—statisticians and other scientists have been writing on the topic for decades,” Utts said. “But this is the first time that the community of statisticians, as represented by the ASA Board of Directors, has issued a statement to address these issues.”

“The issues involved in statistical inference are difficult because inference itself is challenging,” Wasserstein said. He noted that more than a dozen discussion papers are being published in the ASA journal The American Statistician with the statement to provide more perspective on this broad and complex topic. “What we hope will follow is a broad discussion across the scientific community that leads to a more nuanced approach to interpreting, communicating, and using the results of statistical methods in research.”

About the American Statistical Association

The ASA is the world’s largest community of statisticians and the oldest continuously operating professional science society in the United States. Its members serve in industry, government and academia in more than 90 countries, advancing research and promoting sound statistical practice to inform public policy and improve human welfare. For additional information, please visit the ASA website at www.amstat.org.

For more information:

Ron
Wasserstein

Citations


Adopted by the Market Information Systems Research and Development (D) Working Group, Oct. 14, 2021

PRODUCER LICENSING (D) TASK FORCE

Producer Licensing (D) Task Force Nov. 29, 2021, Minutes ................................................................. 9-144
  Producer Licensing (D) Task Force Oct. 29, 2021, Minutes (Attachment One) ........................................ 9-147
  Producer Licensing Uniformity (D) Working Group Nov. 3, 2021, Minutes (Attachment Two) ................. 9-148
  Producer Licensing Uniformity (D) Working Group Oct. 6, 2021, Minutes (Attachment Three) ............... 9-149

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The Producer Licensing (D) Task Force met Nov. 29, 2021. The following Task Force members participated: Elizabeth Kelleher Dwyer, Co-Chair (RI); Larry D. Deiter, Co-Chair (SD); Jim L. Ridling represented by Jimmy Gunn (AL); Alan McClain represented by Peggy Dunlap (AR); Ricardo Lara represented by Charlene Ferguson (CA); Michael Conway represented by Steven Giampaolo (CO); Doug Ommen represented by Andria Seip (IA); Vicki Schmidt represented by Monica Richmeier (KS); Sharon P. Clark (KY); James J. Donelon represented by Lorie Gasior (LA); Judith L. French represented by Tynesia Dorsey (OH); Jessica K. Altman represented by Katelin Hunt and Adriane Force (PA); and Jeff Rude represented by Bryan Stevens (WY). Also participating were: Rachel Chester (RI) and Maggie Dell (SD).

1. **Adopted its Oct. 29 and Summer National Meeting Minutes**

The Task Force conducted an e-vote that concluded on Oct. 29 to adopt its 2022 proposed charges.

Commissioner Clark made a motion, seconded by Ms. Ferguson, to adopt the Task Force’s Oct. 29 (Attachment One) and Aug. 4 (see NAIC Proceedings – Summer 2021, Producer Licensing (D) Task Force) minutes. The motion passed unanimously.

2. **Adopted the Report of the Producer Licensing Uniformity (D) Working Group**

Ms. Chester said the Producer Licensing Uniformity (D) Working Group met Nov. 3 and Oct. 6 and reviewed the results of its survey addressing the appropriate producer licensing standard for individuals to sell, solicit, and negotiate pet insurance. Seven states responded to the survey that the current uniform licensing standard for pet insurance is the correct policy direction; seven states responded that the major lines of authority of Property/Casualty (P/C) should be required; one state responded that pet insurance should become a core limited line; and one state responded that a license for any major line of authority should be required.

Superintendent Dwyer said the survey was done prior to the Property and Casualty Insurance (C) Committee adopting the Pet Insurance Model Act, which includes a training requirement for insurance producers who want to sell, solicit, or negotiate pet insurance. Ms. Ferguson questioned whether an additional survey is needed or if there should be updates made to the NAIC’s Producer Licensing Model Act (Attachment Two). Superintendent Dwyer suggested that the Task Force review the Pet Insurance Model Act after the Executive (EX) Committee and Plenary consider adoption of the model.

Mr. Baughman made a motion, seconded by Ms. Ferguson, to adopt the report of the Producer Licensing Uniformity (D) Working Group, including its Nov. 3 (Attachment Two) and Oct. 6 (Attachment Three) minutes. The motion passed unanimously.

3. **Adopted the Report of the Uniform Education (D) Working Group**

Ms. Dell said the Uniform Education (D) Working Group has not held an open conference call since the NAIC Summer National Meeting but is working on a survey regarding state requirements for the approval of continuing education (CE) course instructors. The Working Group is beginning its review of the survey results.

Mr. Baughman made a motion, seconded by Ms. Ferguson, to adopt the report of the Uniform Education (D) Working Group. The motion passed unanimously.

4. **Discussed Procedures for Amending NAIC Uniform Producer Licensing Applications**

Director Deiter said the draft procedures are being developed to ensure the consideration of changes to the uniform applications support the NAIC members’ goal of providing stable applications and encouraging the use of electronic technology for licensing. He said the initial draft procedures were dated Nov. 4, 2020. The Task Force solicited comments on the draft, and in response to those comments, the procedures were revised with a new draft date of June 10. The Task Force discussed the draft
during its Aug. 4 call and requested written comments after the call. Texas, Virginia, and the National Association of Professional Insurance Agents (PIA) submitted comments.

Mr. Tozer said the procedures indicate that there will be an e-mail distributed to request changes to the NAIC Uniform Producer Licensing Applications, and he asked whether the notice will be distributed to interested parties. He also asked if the form to request changes to the NAIC Uniform Producer Licensing Applications has been developed. He also inquired as to who will initially review a request to amend the NAIC Uniform Producer Licensing Applications. Lauren Pachman (PIA) said there is some overlap of the PIA comments with Virginia’s comments, and the PIA comments focus on more technical changes to clarify the intent of certain sections of the procedures.

Director Deiter said he and Superintendent Dwyer would work with NAIC staff to review the comments and circulate a revised draft for consideration.

5. Received Comments from the ACLI on Diversity and Inclusion

David Leifer (American Council of Life Insurers—ACLI) said diversity and inclusion is a priority for the ACLI membership. He suggested that best practices on 1033 waiver request required because of the Violent Crime Control and Law Enforcement Act of 1994s would be helpful. He said state mandates for specific hours of pre-licensing education can be a barrier to entry into the insurance industry. He said the ACLI supports processes that ensure people are qualified to be insurance producers, but prior work of the NAIC does not reflect a higher pass rate for licensing applicants in states that require pre-licensing education. He said the ACLI continues to support the use of remote examinations because this provides greater access to people seeking a producer license. Jim Hodges (National Alliance of Life Companies—NALC) said the NALC supports the elimination of mandatory pre-licensing education. Superintendent Dwyer said the Task Force would continue to review this issue.

Mr. Baughman said Washington requires pre-licensing education but may eliminate this requirement. He said this could decrease exam pass rates. Superintendent Dwyer said Rhode Island did not experience a decrease in exam pass rates after the elimination of required pre-licensing education. She said one reason Rhode Island eliminated required pre-licensing education is because experienced insurance producers who left the insurance industry were required to complete pre-licensing education if they returned to the insurance industry. Commissioner Richardson said Nevada experienced a change in exam pass rates after eliminating mandatory pre-licensing requirements but did notice more applicants with criminal background issues. Superintendent Dwyer said Rhode Island, similar to Pennsylvania, has a process where prospective applicants can request an informal review of their background prior to taking an examination.

6. Discussed the Elimination of Cultural Bias in Producer Licensing Exams

Superintendent Dwyer said the Task Force received a charge from the Special (EX) Committee on Race and Insurance to discuss the elimination of cultural bias in producer licensing exams. She said the Center for Insurance Policy and Research (CIPR) is conducting some research on the number and location of producers by company compared to demographics in the area.

Superintendent Dwyer said she and Director Deiter requested the three producer licensing examination vendors to provide information, and two exam vendors responded. One exam vendor said all content development staff participate in training on the Content and Editorial Policy, which is grounded in the following statements of principle: 1) respect human rights and strive to create content that is free from discrimination and is anti-bias; 2) develop content that embeds our commitments to diversity, equity, and inclusion (DE&I); 3) provide support for learning that is based on evidence and facts; and 4) create content that is ethical and adheres to legal requirements. The exam vendor also said all subject matter experts (SMEs) are trained to be mindful of these principles during test development meetings. After SME review, all items undergo an editorial review, during which items are reviewed for sensitivity and bias by a designated editor. The vendor also said they encourage their clients to nominate SMEs from diverse backgrounds, and they are always looking for SMEs from diverse backgrounds to participate in the test development process.

Superintendent Dwyer said the other exam vendor reported that their test development is guided by industry standards for Fairness (American Education Research Association [AERA], American Psychological Association [APA], National Council on Measurement in Education [NCME], Standards for Educational and Psychological Testing, Ch. 3, 2014). This includes the following components of the process:

- Item Writer Training: During the item authoring process, item writers are instructed to avoid language, stereotypes, and scenarios that might introduce bias in the assessment.
• Item Sensitivity Review: All test questions are reviewed by SMEs during the content validation process. During this phase, SMEs are trained and instructed to identify and eliminate language, stereotypes, and scenarios that could be construed to imply bias with respect to gender, race/ethnicity, or culture. Test items that are identified as such are either changed to eliminate potential bias or are dropped.

• Diversity in the Composition of SMEs: To the extent possible, item writing and review panels are intended to be diverse with respect to demographic group membership, along with other important characteristics (e.g., experience, area of practice, geographic location, work setting).

Superintendent Dwyer asked if there is more detail the Task Force would like to receive. She said she would follow up with the exam vendor that did not respond and compile the responses in a report to the Special (EX) Committee on Race and Insurance.

7. Received a Report from the NIPR Board of Directors

Director Deiter said he serves as the president of the 2021 National Insurance Producer Registry (NIPR) Board of Directors, and October marked the 25th anniversary for NIPR. NIPR was created as a unique public-private partnership (PPP) between the NAIC and the insurance industry to build a uniform producer licensing system to deliver a cost-effective, streamlined process. Director Deiter said NIPR is on track to have its highest transaction volume and revenue year, and it is forecasting more than $1 billion in fees moved to the state departments of insurance (DOIs). He said NIPR continues to implement the contact change request application for business entities. To date, NIPR has 28 states in production and has processed more than 7,300 transactions on behalf of those states. Kentucky is scheduled to be implemented on Dec. 10 and Kansas in January 2022. Director Deiter said NIPR recently implemented a chat feature, which gives NIPR’s customers another route for assistance with licensing questions. From January to October, NIPR’s customer service department handled over 162,000 calls, more than 70,000 emails, and 20,000 chats. NIPR is also on track to complete its transition to the cloud before the end of the year, which will enhance NIPR’s ability to provide services to the states and insurance industry.

8. Discussed Other Matters

Superintendent Dwyer said the Task Force will continue to monitor pass rates for in-person and remote exams and continue to work with exam vendors to receive updates.

Superintendent Dwyer said she and Director Deiter were approached by the leadership of the Cannabis Insurance (C) Working Group, who would like to collaborate with the Task Force to study whether cannabis-related convictions are preventing individuals from being licensed as an agent or broker in states where cannabis is legalized for medical and/or recreational use. She said she and Director Deiter would be providing more detail on this request at the next Task Force call.

Mr. Tozer said Virginia and other states routinely receive applications with errors or misstatements completed by authorized third-party submitters, and he would like for the Task Force or Producer Licensing Uniformity (D) Working Group to discuss this issue and develop a national solution. He suggested that authorized submitters who have multiple violations could be barred from acting as authorized submitters, or additional communication could be made to producer applicants that they will be penalized for incorrect information provided. Ms. Ferguson said California said the NAIC Uniform Producer Licensing Applications could include an attestation that the authorized third-party submitter has communicated with the applicant regarding the answers being submitted. Superintendent Dwyer said the Task Force could issue a statement to authorized third-party submitters informing them that they are responsible for confirming answers with the applicant. Director Deiter said South Dakota rarely has issues with authorized submitters and can take the necessary regulatory action if issues arise. Superintendent Dwyer suggested that the Working Group could review this issue.

Ms. Ferguson asked about the status of the NAIC Uniform Producer Licensing Applications amendments the Task Force adopted in 2018. Superintendent Dwyer said the Executive (EX) Committee and Plenary did not consider adoption of these amendments, and the Task Force needs to review the amendments. Director Deiter suggested that the Task Force review the amendments after it adopts the new procedures for amending the NAIC Uniform Producer Licensing Applications. Ms. Ferguson suggested that the Producer Licensing Uniformity (D) Working Group review the amendments from 2018 because this would help inform the state licensing directors on what amendments would move forward and whether additional requests for new amendments should be submitted. Superintendent Dwyer said the proposed amendments from 2018 should be reviewed in the first quarter of 2022, and any additional requests for amendments could be submitted toward the end of 2022.

Having no further business, the Producer Licensing (D) Task Force adjourned.

ProdLic Min 11.29.21
The Producer Licensing (D) Task Force conducted an e-vote that concluded Oct. 29, 2021. The following Task Force members participated: Elizabeth Kelleher Dwyer, Co-Chair (RI); Larry D. Deiter, Co-Chair (SD); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Jimmy Gunn (AL); Ricardo Lara represented by Charlene Ferguson (CA); Trinidad Navarro represented by Robin David (DE); David Altmaier represented Matt Tamplin (FL); Dean L. Cameron represented by Lisa Tordjman (ID); Sharon P. Clark (KY); Grace Arnold represented by Peter Brickwedde (MN); Mike Causey represented by Angela Hatchell (NC); Eric Dunning (NE); Chris Nicolopoulos represented by Christie Rice (NH); Russell Toal (NM); Barbara D. Richardson represented by Stephanie McGee (NV); Judith L. French represented by Tynesia Dorsey (OH); Glen Mulready represented by Erin Wainner (OK); Jessica K. Altman represented Adriane Force (PA); Jonathan T. Pike represented by Randy Overstreet (UT); Scott A. White represented by Mike Beavers and Richard Tozer (VA); Mike Kreidler represented by Jeff Baughman (WA); Mark Afable represented by Rebecca Rebholz (WI); Allan L. McVey (WV); and Jeff Rude represented by Bryan Stevens (WY).

1. **Adopted its 2022 Proposed Charges**

   The Task Force considered adoption of its 2022 proposed charges, which remained consistent with its 2021 charges.

   The following 2021 charges were deleted from the 2022 proposed charges:

   - Finalize the white paper on the role of chatbots and artificial intelligence (AI) in the distribution of insurance and the regulatory supervision of these technologies by the 2021 Spring National Meeting.
   - Draft procedures for amending the NAIC’s uniform producer licensing applications and uniform appointment form to ensure consistency with the NAIC membership’s goal of maintaining uniform and stable applications that encourage the efficient use of electronic technology.

   The discussion on role of chatbots and AI will be incorporated into the work of the Innovation and Technology (EX) Task Force or the new Innovation, Cybersecurity, and Technology (H) Committee, which may be appointed in 2022. The charge regarding the development of procedures for amending the NAIC uniform producer licensing applications was deleted due to the anticipated completion of this charge in 2021.

   The following new charges were added to the 2022 proposed charges:

   - Coordinate with the Special (EX) Committee on Race and Insurance on referrals affecting insurance producers.
   - Discuss how criminal convictions may affect producer licensing applicants, and review the NAIC’s *Guidelines for State Insurance Regulators to the Violent Crime Control and Law Enforcement Act of 1994* to create a more simplified and consistent approach in how states review 1033 waiver requests.

   A majority of the Task Force members voted in favor of adopting its 2022 proposed charges (see *NAIC Proceedings – Fall 2021, Executive (EX) Committee and Plenary, Attachment Three*).

   Having no further business, the Producer Licensing (D) Task Force adjourned.
The Producer Licensing Uniformity (D) Working Group of the Producer Licensing (D) Task Force met Nov. 3, 2021. The following Working Group members participated: Rachel Chester, Chair, Elizabeth Kelleher Dwyer, and Matt Gendron (RI); Courtney Khodabakhsh, Vice Chair (OK); Crystal Phelps, Peggy Dunlap, and Teri Ann Mecca (AR); Charlene Ferguson (CA); Matt Guy (FL); Lisa Tordjman (ID); Lorelei Brilliante and Shelley Taylor-Barnes (MD); Karin Gyger and Michele Riddering (MI); Kevin Schlautman (NE); Victoria Baca (NM); Hermoliva Abejar and Stephanie Kerry (NV); Karen Vourvopoulos (OH); Maggie Dell (SD); Mike Beavers and Richard Tozer (VA); Jeff Baughman (WA); Melody Esquivel (WI); and Bryan Stevens (WY).

1. Discussed the Pet Insurance Licensing Standards

Ms. Chester said the Working Group’s last conference call took place on Oct. 6. She said the Working Group discussed the status of reviewing the pet insurance licensing standards in order to determine a recommendation for changes that should be made. She said the Working Group will pick up where it left off, discussing the pet insurance licensing standards. She said the direction from the Producer Licensing (D) Task Force was to review the current pet insurance licensing standards and provide a recommendation on whether changes should be made. She said the Working Group members were notified that the materials can be found on the Working Group’s web page. These materials include a discussion document that summarizes the work that has been completed in addition to the status of the pet insurance licensing standards.

Ms. Chester said the survey had four options: 1) confirm that current uniform licensing standards for pet insurance is the correct policy direction; 2) recommend that pet insurance become a core limited line all states shall adopt; 3) recommend that the major lines of authority of property/casualty (P/C) be required to sell pet insurance; and 4) recommend that a full license with any major line of authority be required to sell pet insurance. She said seven states voted to confirm that current uniform licensing standards for pet insurance is the correct policy direction; seven states voted to recommend that the major lines of authority of P/C be required to sell pet insurance; one state voted to recommend that pet insurance become a core limited line all states shall adopt; and one state voted to recommend that a full license with any major line of authority be required to sell pet insurance. She said the results show that there is a draw with how the states are voting on what to do with the pet insurance licensing standards. She said prior to the survey being sent out, the Working Group members, interested state insurance regulators, and interested parties were solicited for any comments; that resulted in a survey being distributed. The Working Group discussed confirming each option from the survey and agreed that the information compiled should be sent up to the Task Force for it to determine the direction.

Birny Birnbaum (Centers for Economic Justice—CEJ) said his recommendation at this point would be to take everything the Working Group has done and send it to the Task Force for it to determine what should be done. He said the Working Group has fulfilled its task on collecting the necessary information.

Ms. Chester said she agrees that the best course of action would be to take the information that the Working Group has compiled and send it to the Task Force.

Mr. Stevens made a motion, seconded by Ms. Khodabakhsh, to take the pet insurance licensing standards survey results and present them to the Task Force. The motion passed unanimously.

Having no further business, the Producer Licensing Uniformity (D) Working Group adjourned.

PLUWG Minutes 11.3.21
Producer Licensing Uniformity (D) Working Group
Virtual Meeting
October 6, 2021

The following Working Group members participated: Rachel Chester, Chair, Elizabeth Kelleher Dwyer, and Matt Gendron (RI); Courtney Khodabakhsh, Vice Chair, and Landon Hubbart (OK); Crystal Phelps, Peggy Dunlap, and Teri Ann Mecca (AR); Charlene Ferguson, Dianne Cooper, Troy Dickinson, and Tyler McKinney (CA); Matt Guy (FL); Lisa Tordjman (ID); Lorelei Brilliante and Shelley Taylor-Barnes (MD); Karin Gyger and Michele Riddering (MI); Kevin Schlautman (NE); Victoria Baca (NM); Hermoliva Abejar and Stephanie Kerry (NV); Karen Vourvopoulos, Holly Stran, and Patty Black (OH); Maggie Dell (SD); Mike Beavers and Richard Tozer (VA); Jeff Baughman (WA); and Melody Esquivel and Rebecca Rebholz (WI). Also participating was: Bryan Stevens (WY).

1. Discussed the Pet Insurance Licensing Standards

Ms. Chester said with Chris Murray departed from the Alaska Department of Insurance (DOI), she has been asked to step in as the new chair of the Working Group. She said the Working Group will pick up where it stopped last, discussing the pet insurance licensing standards. She said the direction from the Producer Licensing (D) Task Force was to review the current pet insurance licensing standards and provide a recommendation on whether changes should be made. She said notice was sent out notifying everyone that the materials can be found on the Working Group web page. These materials include a discussion document that summarizes the work that has been completed in addition to the status of the pet insurance licensing standards.

Ms. Chester said the Working Group’s task is not to discuss the pet insurance product but to focus on licensing related to pet insurance. She said as a quick recap to bring everyone up to speed, the Working Group discussions thus far concerning pet insurance began in 2010, and they were picked back up in 2017 by the Task Force. Industry trades came forward and expressed some concerns with the direction pet insurance was moving specific to the licensing standards. The Task Force has discussed pet insurance, but it did not have enough information about the product to make an informed decision. The Task Force asked the Property and Casualty Insurance (C) Committee to look at pet insurance. The Committee formed a Pet Insurance (C) Working Group, which has been working on this topic. The Pet Insurance (C) Working Group created a white paper on pet insurance, which was referred to the Task Force. The Pet Insurance (C) Working Group is also working towards the creation of a model law for pet insurance, which will deal with consumer protection and aspects related to policy. Ms. Chester said the Pet Insurance (C) Working Group web page has the exposure drafts and any comments submitted.

Ms. Chester said the comments submitted from Superintendent Dwyer offers a fourth option for the Working Group to review. She said this provides four different options for the Working Group to determine as the best option. The options are: 1) confirm that current uniform licensing standards for pet insurance is the correct policy direction; 2) recommend that pet insurance become a core limited line all states shall adopt; 3) recommend that the major lines of authority of property/casualty (P/C) be required to sell pet insurance; and 4) recommend that a full license with any major line of authority is required to sell pet insurance.

Mr. Baughman said in Washington, pet insurance is filed under property line of authority, and requirements and training would need to match what they currently have in place not to cause additional issues within the state. Mr. Guy said Florida would be in the same situation; if it would follow along with its current business rules, there would not be an issue. Ms. Ferguson said California would agree. She said even though it is pet health insurance, it deals with a broker agent that would need to go through training to sell this type of insurance (TOI).

Mr. Tozer said Virginia covers this line under P/C. He said Virginia has thousands of P/C licenses, and it would be a difficult process to determine which of them only hold the P/C to sell pet insurance only.

Mr. Gendron said the Pet Insurance (C) Working Group is working to complete a model law. He said it is important to recognize that pet insurance is different than a homeowner or other type of property license, and it covers the maintenance of your pet and not the value. He said it is more of an accident and wellness of the property, but it does not operate the same as basic property insurance.
Mr. Gendron said the creation of the model act tries to define what the rules are going to be for pet insurance, and there will be standard cancellation provisions that apply, which will not be defined in the model law, but it will be determined on that type of line of business in your state.

Cari Lee (Steptoe & Johnson LLP) said the problem is pet insurance is sold online, and most of the agents selling pet insurance are only selling that product. She said the North American Pet Health Insurance Association (NAPHIA) is working to get the correct training for these individuals. She said the easiest way to do this would be to make this a core limited line.

Briny Birnbaum (Center for Economic Justice—CEJ) said it sounds as though state insurance regulators are asking which of the existing licensing “boxes” this fits into. He said the hurdle is this is something new, and it does not fit into one specific structure. He said the questions arise concerning the type of consumer protection necessary. This is a complex product, and it is more complicated than the traditional limited lines. Mr. Birnbaum said structure needs to be in place to protect consumers, including the type of training needed. He said the CEJ would support Superintendent Dwyer’s recommendation for the fourth option to “recommend that a full license with any major line of authority be required to sell pet insurance” if it is paired with relevant training.

Ms. Chester said it is important for the Working Group to recognize that a substantive training product is a function of market conduct and not specifically licensing.

Mr. Stevens said several good points have been made for pet insurance; however, changing this to a core limited line would be much more difficult to get widespread adoption. He said a specific training requirement for pet insurance may satisfy a lot of the state and industry concerns.

Ms. Lee said NAPHIA would agree with Wyoming; however, if an agent only sells pet insurance and is required to go through all the P/C licensing requirements, it would be beyond the scope of pet insurance. Mr. Stevens said Wyoming would be in support of training, and it believes training would be the key item to take away that is considered necessary for pet insurance.

Mr. Birnbaum said the logical extension of any requirement becoming a burden is not a legitimate concern, and an argument could be made that any regulation or requirement could be removed that would set the lowest possible premiums; however, that would not be a legitimate argument to reflect consumer protection. He said he would agree with necessary training, but he would object to the characterization of getting a license having no value to a seller of pet insurance.

Mr. Gendron said in Rhode Island, there is 5–15% of the P/C exam questions, which cover the general responsibility/subject matter question. Mr. Birnbaum said there are four states that deem this line important to make it a limited line. He said to make this a core limited line, it would take several states to agree and a vote, which would make it a difficult process.

Ms. Chester said the Working Group’s goal is to review the current pet insurance licensing standards and provide a recommendation based on the options presented. She said a survey will be sent out to the Working Group members to collect votes on the preference of each member state. She said all responses are due by Oct. 29 so the Working Group can discuss the results of the survey and finalize the recommendation to the Task Force.

Having no further business, the Producer Licensing Uniformity (D) Working Group adjourned.
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The Financial Condition (E) Committee met in San Diego, CA, Dec. 13, 2021. The following Committee members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair, (CO); Dana Popish Severinghaus represented by Kevin Fry and Susan Berry (IL); Amy L. Beard represented by Roy Eft (IN); Eric A. Cioppa, Robert Wake and Vanessa Sullivan (ME); Chlora Lindley-Myers and John Rehagen (MO); Mike Chaney represented by Vanessa Miller (MS); Marlene Caride represented by David Wolf (NJ); Russell Toal represented by My Chi To (NY); Judith L. French (OH); Raymond G. Farmer (SC); Cassie Brown represented by Doug Slape and Jamie Walker (TX); Mark Afable and Amy Malm (WI); and Jeff Rude (WY).

1. Adopted its Nov. 19 and Summer National Meeting Minutes

Commissioner White said the Committee met Nov. 19 and took the following action: 1) adopted a response to the Financial Regulation and Accreditation Standards (F) Committee related to captive insurers; 2) received a response from the Valuation Analysis (E) Working Group chair related to a specific recommendation from the recent Financial Sector Assessment Program (FSAP); 3) received a memorandum from the Capital Adequacy (E) Task Force chair with respect to a new charge for a new Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group; and 4) adopted the Committee’s 2022 proposed charges.

Commissioner Conway made a motion, seconded by Commissioner Rude, to adopt the Committee’s Nov. 19 (Attachment One) and Aug. 14 (see NAIC Proceedings – Summer 2021, Financial Condition (E) Committee) minutes. The motion passed unanimously.

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

Commissioner White stated that the Committee usually takes one motion to adopt the Committee’s task force and working group reports that are considered technical, noncontroversial, and not significant by NAIC standards—i.e., they do not include model laws, model regulations, model guidelines, or items considered to be controversial. He reminded Committee members that subsequent to the Committee’s adoption of its votes, all the technical items included within the reports adopted will be sent to the NAIC members for review shortly after the conclusion of the Fall National Meeting as part of the Financial Condition (E) Committee Technical Changes report. Pursuant to the Technical Changes report process previously adopted by the NAIC Plenary, the members will have 10 days to comment. Otherwise, the technical changes will be considered adopted by the NAIC and effective immediately. With respect to the task force and working group reports, Commissioner White asked the Committee: 1) whether there were any items that should be discussed further before being considered for adoption and sent to the members for consideration as part of the Financial Condition (E) Committee Technical Changes report; and 2) whether there were other issues not up for adoption that are currently being considered by task forces or working groups reporting to this Committee that require further discussion. The response to both questions was no.

In addition to presenting the reports for possible adoption, Commissioner White also noted that the Financial Analysis (E) Working Group met Dec. 11, Nov. 3, and Oct. 13 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss letter responses and financial results. Additionally, the Valuation Analysis (E) Working Group met Nov. 30, Nov. 10, Sept. 27, and July 26 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss valuation items related to specific companies.

Mr. Rehagen made a motion, seconded by Commissioner Conway, to adopt the following task force and working group reports: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Financial Stability (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; Valuation of Securities (E) Task Force; Group Capital Calculation (E) Working Group (Attachment Two); Group Solvency Issues (E) Working Group (Attachment Three); Mutual Recognition of Jurisdictions (E) Working Group (Attachment Four); NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group (Attachment Five); National Treatment and Coordination (E) Working Group (Attachment Six); Restructuring Mechanisms (E) Working Group (Attachment Seven); and Risk-Focused Surveillance (E) Working Group (Attachment Eight). The motion passed.
3. **Adopted the Process for Evaluating Jurisdictions that Recognize and Accept the GCC**

Mr. Wake reminded the Committee that in late 2020, the NAIC adopted revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). These revisions implemented group capital calculation (GCC) filing requirements for insurance groups at the level of the ultimate controlling person. They also incorporate the requirements for a group-wide capital calculation as addressed under the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement).

Mr. Wake stated that Section 4L(2) of Model #440 provides two ways a non-U.S. jurisdiction may meet the standards for its insurance groups to be exempted from the GCC: 1) if the jurisdiction has been determined to be a reciprocal jurisdiction for purposes of credit for reinsurance; and 2) if the jurisdiction has otherwise been determined to recognize and accept the GCC by procedures specified in regulation. The Mutual Recognition of Jurisdictions (E) Working Group was charged by the Financial Condition Committee with creating a process to determine whether other jurisdictions “recognize and accept” the NAIC GCC. Mr. Wake noted that during the drafting process, the GCC Recognize and Accept Process was exposed for a public comment period on July 21 and on Sept. 22, and the Working Group believed that all comments received were appropriately addressed. Additionally, NAIC staff communicated with staff from the Federal Insurance Office (FIO) during the drafting process. The Working Group incorporated some minor revisions that were suggested by the FIO into the Nov. 8 draft, which the Working Group unanimously adopted on Nov. 18.

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

4. **Adopted the ReFAWG Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers**

Mr. Rehagen said that the ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers was created to aid in the implementation of the 2019 revisions to the *Credit for Reinsurance Model Law* (#785) and *Credit for Reinsurance Model Regulation* (#786). Under this process, the Reinsurance Financial Analysis (E) Working Group will assist the states in reviewing reinsurers to determine whether they have met the requirements to be recognized as a certified reinsurer and/or a reciprocal jurisdiction reinsurer. He noted that the Working Group normally meets in regulator-to-regulator session, but state insurance regulators, U.S. ceding insurers, and other interested parties all believed that it was important to have a public process to provide specific guidance with respect to the review of reciprocal jurisdiction reinsurers.

Mr. Rehagen said that during the drafting process, the *ReFAWG Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers* was exposed for a public comment period on June 17 and again on Sept. 17. The comments received were discussed by the Task Force at the Summer National Meeting and by the Working Group on Aug. 25 in regulator-to-regulator session. He stated the Task Forces believed that all comments received were appropriately addressed. He noted that NAIC staff communicated with staff from the FIO during the drafting process. He stated that non-substantive revisions suggested by the FIO were incorporated into the final draft, which was exposed on Nov. 11 for a 21-day public comment period, and no comments were received. He stated that the *ReFAWG Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers* was then unanimously adopted by the Reinsurance (E) Task Force earlier in the day.

Mr. Rehagen made a motion, seconded by Mr. Eft, to adopt the *ReFAWG Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers* (Attachment Ten). The motion passed unanimously.

5. **Discussed Other Matters**

a. **Request from the CEJ**

Commissioner White indicated he had a couple of matters he wanted to bring to the attention of the members of the Committee. Specifically, he noted that a couple of days before the Fall National Meeting, he and Commissioner Conway received a letter from the Center for Economic Justice (CEJ) (Attachment Eleven). He summarized the key points to the letter, including that Birny Birnbaum (CEJ) was asking the Committee to undertake work already at the Special (EX) Committee on Race and Insurance. He noted that the specific request made was for the 2022 charges be expanded to look at the impact of insurer investments on communities of color. Commissioner White noted this appeared to be part of a larger effort on Mr. Birnbaum’s part to take some of the work that is currently being conducted at the Special Committee and place it instead in those committees that have subject matter expertise.
Commissioner White noted that without getting into the merits of that approach, he did want to share a few thoughts about the proposal itself, which is to have this Committee look into the impacts of insurer investments on communities of color. First, he said he spoke with members of his staff, NAIC staff, and some members of the Committee to think about the merits of this recommendation. He noted that the comments he heard were similar from everyone he spoke with. He stated the biggest question both in his mind and those he spoke with was whether it is something that makes sense for the Financial Condition (E) Committee to look at. He noted that the purpose of the Committee is solvency oversight, first and foremost, and this request does not touch on issues of solvency. He stated another issue is what this would look like and how this would be accomplished. For example, what metrics the Committee would use to determine whether there is a material impact? Assuming the Committee could develop metrics, is it possible that it might adversely affect the Committee’s primary goal of solvency protection? Commissioner White noted there are questions about whether this analysis could be done using just Schedule D data for bonds and stocks.

Commissioner White said that these were just a few of the examples of thinking as he reviewed the request. He stated he does not want to rule out the possibility that at some point, the Committee would be tasked with looking at the issue. Commissioner White noted, however, that having just looked at this for the first time just before the Fall National Meeting, and given the unusual nature of the request given it does not deal with solvency protection, he is not comfortable with suggesting the charge be added at this time. He noted that he suspects several other members of the Committee were hearing about this request for the first time. He stated that the work being requested, addressing issues of disparity based on race, are being undertaken at the Special Committee, and in his opinion, until the Committee receives direction from that Committee or from the officers, it seems appropriate for those discussions to continue to occur at that Committee instead. Support for Commissioner White’s reaction and recommendation was provided by Commissioner Conway, Director Lindley-Myers and Superintendent Cioppa. No other members disagreed with Commissioner White.

b. RBC Methodology for Structured Securities and Other ABS

Commissioner White reminded the Committee of one of its deliverables from the last year dealing with revised risk-based capital (RBC) bond factors for life insurers. He described how that adoption was the completion of a multiyear endeavor that resulted in the big change where the Committee went from six NAIC designations to basically 20 different levels within those six designations, thereby reducing the “cliffs” that could exist between the factors before. He also noted how the changes also incorporated more recent bond performance, with the result that some factors went up and some went down. He noted that while the American Academy of Actuaries (Academy) did most of the work on that project, Moody’s did a parallel analysis of the bond factors, and it was their recommended changes that were ultimately adopted by the Committee. Commissioner White said that the reason he is bringing this up is to remind the Committee of that work and also, more specifically, the work done by Moody’s, which was characterized as Phase I in what it envisioned to be a two-part project. This second phase of the project would address the need to differentiate capital charges for asset classes, including structured securities and other asset-backed securities (ABS).

Commissioner White explained that he would like the Committee to consider the possibility of moving forward on the second phase of this project, whether it be Moody’s or some other vendor. He noted how his support for this idea at this time was driven by the fact that the Committee has been engaged in the past two years and longer, which is a focus on this sustained low interest rate environment and the impact it has had on the industry, particularly the life industry. He described how state insurance regulators are aware that insurers’ investment strategies and asset allocations are increasingly in search of higher-yielding investments. For example, a shift away from senior corporate debt holdings towards structured securities and other ABS, in particular collateralized loan obligations (CLOs). These investments tend to offer a more attractive yield and may provide some relative regulatory capital advantages to more traditional asset types, such as fixed-rate corporate bonds. He noted the concern that this creates incentives for insurers to invest in higher-yielding and riskier assets, such as certain structured credit instruments, where risk is inconsistent with capital charges.

Commissioner White said that the idea was for the Committee to examine whether the RBC charges for insurer investment concentrations are appropriately calibrated to safeguard insurers against losses in these types of investments. He said the next steps would include having the NAIC hire a consultant to provide the resources the Committee needs to address this issue. He proposed using the same model for this project as was used for variable annuities and mortgage guaranty insurers, where most of the funding comes from the industry. He stated he was hopeful that since the American Council of Life Insurers (ACLI) supported the Moody’s work, the NAIC can get enough members of the life industry to help fund the second phase of this analysis. He noted that during the Committee’s Nov. 19 meeting, a discussion led by Tom Botsco resulted in the creation of the new Risk-Based Capital (RBC) Investment Risk and Evaluation (E) Working Group. He suggested that the new Working Group take on this project and make it an immediate priority. He also suggested that the new Working Group make it another immediate priority to put the necessary structural changes in place for RBC, and because those are due soon, that a joint meeting
of the new Working Group and the Committee occur in early January to get that work started. He suggested joint meetings with that new Working Group so that the Committee can be informed about the work occurring and provide any direction needed.

Having no further business, the Financial Condition (E) Committee adjourned.

December 13 E min.docx
Financial Condition (E) Committee
Virtual Meeting
November 19, 2021

The Financial Condition (E) Committee met Nov. 19, 2021. The following Committee members participated: Scott A. White, Chair (VA); Michael Conway, Vice Chair, (CO); Dana Popish Severingham represented by Kevin Fry (IL); Amy L. Beard represented by Roy Eft (IN); Eric A. Cioppa (ME); Chlora Lindley-Myers and John Rehagen (MO); Mike Chaney represented by David Browning (MS); Marlene Caride (NJ); Russell Toal represented by Leatrice Geckler (NM); Adrienne A. Harris represented by My Chi To (NY); Judith L. French and Tom Botsko (OH); Raymond G. Farmer (SC); Cassie Brown represented by Doug Slape (TX); Mark Afable (WI); and Jeff Rude represented by Linda Johnson (WY).

1. **Adopted a Response to the Financial Regulation and Accreditation Standards and Accreditation (F) Committee**

Commissioner White described how the Committee had received a referral from the Financial Standards and Accreditation (F) Committee subsequent to the Spring National Meeting. He said the Financial Standards and Accreditation (F) Committee was reviewing the preamble to its manual and updating it for changes as a result of changes to a new NAIC model regulation on reinsurance. He said a question was raised whether some of the other aspects of the preamble needed to be updated. Commissioner White described how there had been a placeholder in that preamble for years for variable annuities and long-term care (LTC), pending potential changes to the standards for those lines of business. He stated that the referral specifically asked for an update on the actual usage of such captives, which he indicated he sent directly to the Financial Analysis (E) Working Group since obtaining that type of information would involve gathering specific company information from domestic states. He said the Committee received a response from that Working Group and met Oct. 14 in regulator-to-regulator session as questions regarding specific companies were expected to be raised. He stated the Committee prepared a response back to the Financial Standards and Accreditation (F) Committee, included in the materials, which captured what he and his staff think is appropriate.

Commissioner Conway made a motion, seconded by Superintendent Cioppa, to adopt the proposed response (Attachment One-A). The motion passed unanimously.

2. **Received a Response to the FSAP Recommendation**

Commissioner White stated the second agenda item was a follow-up to the report issued by the International Monetary Fund (IMF) related to the Financial Sector Assessment Program (FSAP) report from 2020. He stated that one of the recommendations dealt with actuarial resources. He stated that Mike Boerner (TX), chair of the Valuation Analysis (E) Working Group, sent a letter to the Committee (Attachment One-B) describing the actuarial support that group currently receives from the NAIC. Commissioner White noted that it was his understanding that the NAIC has added seven actuaries to its staff to help with principle-based reserving (PBR). Commissioner White described how he believes the letter seems to indicate appreciation for the resources provided thus far, but it also implies that if more resources are needed, the Valuation Analysis (E) Working Group will let those within the NAIC leadership know that such additional resources are also needed. He noted no action was needed on the letter other than just suggesting the Committee members stay attuned to the ongoing implementation of PBR.

3. **Discussed a Memorandum From the Capital Adequacy (E) Task Force**

Commissioner White said that an issue was brought up during the Committee’s Oct. 14 regulator-to-regulator meeting. He stated during that meeting, a request was made for the Committee to provide assurances that the Statutory Accounting Principles (E) Working Group, Valuation of Securities (E) Task Force, and Capital Adequacy (E) Task Force are coordinating their work on the current work with *Statement of Statutory Accounting Principles (SSAP) No. 43—Loan-Backed and Structured Securities*.

Mr. Botsko summarized his request (Attachment One-C) to the Committee. The request includes a new working group to evaluate proposed changes to the risk-based capital (RBC) formula. He discussed some of the primary reasons for the new group including describing how RBC was a minimum standard and that the NAIC needs to find a balance between the detail of reporting and the appropriateness of a risk charge. He described how the group would be a formal group, which he stated he believes was important to provide transparency and documentation for important considerations. He noted the working group would also evaluate other investment charges for the appropriateness and accuracy given some of the factors had not been updated since their development in the early 1990s. He also described an informal affiliated RBC drafting group and how he believes a number of changes could be made related to that work to improve some consistency in these areas of RBC. He noted...
he sees the group as having a more holistic view, and it will be important for the group to stay current with new investment products, as well as international approaches.

Commissioner White asked Mr. Botsko if the coordination with the Statutory Accounting Principles (E) Working Group would continue. Ms. To stated her support for the work and the charge.

Director French made a motion, seconded by Commissioner Afable, to incorporate the proposed charge included in the letter into the Committee’s 2022 proposed charges. The motion passed unanimously.

4. **Adopt its 2022 Proposed Charges**

Commissioner White noted that the Committee had previously exposed its 2022 proposed changes for a 30-day public comment period and received no comments.

Commissioner Conway made a motion, seconded by Ms. Geckler, to adopt its 2022 proposed charges (Attachment One-D), including the charge included in the previous agenda item. The motion passed unanimously.

Having no further business, the Financial Condition (E) Committee adjourned.

*Attachment One-Nov 19 E min.docx*
MEMORANDUM

TO: Superintendent Elizabeth Kelleher Dwyer, Chair of the Financial Regulation Standards and Accreditation (F) Committee

FROM: Commissioner Scott A. White, Chair of the Financial Condition (E) Committee

DATE: Nov. 19, 2021

RE: Use of Captives to Reinsure Variable Annuity and Long-Term Care Business

I received your April 14 memo requesting information on the extent the referenced captives are used, any trends on the use of the captives, reasons for such trends, and any relevant updates on work done in the areas of variable annuities and long-term care insurance (LTCI). Upon receiving your memo, I referred your request to the Financial Analysis (E) Working Group. Since the Working Group ultimately collected the information on the use of captives by surveying domestic states using the states’ confidentiality standards, the Working Group’s response memo will be submitted to the Financial Regulation Standards and Accreditation (F) Committee as a separate regulator-only document. However, for the purposes of this memo, I would note that one of the key takeaways from the Working Group is that the current impact to the risk-based capital (RBC) of the domestic insurers utilizing these captives is minimal.

I would also like to provide you with updates on work done on variable annuities and LTCI. In 2018, the Financial Condition (E) Committee adopted a revised framework for variable annuities, which became effective Jan. 1, 2020. The changes were specifically designed to remove the non-economic volatility within the previous framework, therefore removing the major reason for the use of captives for variable annuities. The Committee believes it is an appropriate time to remove the to be determined (TBD) effective date in the Accreditation Preamble and replace it with a reference to VM-21, Requirements for Principle-Based Reserves for Variable Annuities.

For LTCI, the Financial Condition (E) Committee has not developed any new standards that could be used to justify the removal of the TBD status. Although the impact of the use of captives for LTCI still appears to be minimal, the Committee recommends that this aspect of the Accreditation Preamble be retained and that the Financial Regulation Standards and Accreditation (F) Committee continue to monitor the use of captives for LTCI.

In summary, the Financial Condition (E) Committee recommends a replacement of the TBD in the Accreditation Preamble for variable annuities with VM-21 and retaining the TBD for LTCI.
MEMORANDUM

TO: Commissioner Marlene Caride, Chair of the NAIC Life Insurance and Annuities (A) Committee
Commissioner Scott A. White, Chair of the NAIC Financial Condition (E) Committee

FROM: Mike Boerner, Chair of the NAIC Life Actuarial (E) Task Force and Valuation Analysis (E) Working Group

DATE: Oct. 8, 2021

RE: Financial Sector Assessment Program (FSAP) Recommendation

In late 2020, the International Monetary Fund (IMF) completed its technical note as part of its assessment of U.S. insurance supervision in connection with its FSAP. The IMF made a number of recommendations in completing its technical note, one of which relates to life insurance reserving. Specifically, the following recommendation was made:

*The NAIC and state insurance regulators should significantly expand their in-house supervisory actuarial capability to supervise principle-based reserving (PBR) effectively. Consider the formation of a shared center of expertise in addition to the NAIC resources already available to the Valuation Analysis (E) Working Group.*

A reference is made in the recommendation to existing NAIC resources available to the Valuation Analysis (E) Working Group, which has been appropriately built up by the NAIC since the adoption of PBR. To date, these NAIC resources have been quite valuable in helping both the Working Group and the Life Actuarial (A) Task Force meet state insurance regulators’ needs. As chair of both groups, I can personally attest to both the Working Group and Task Force’s appreciation for the assistance provided by these NAIC resources. While more resources for such efforts would certainly always be appreciated, we believe the resources provided to date, along with the use of consultants for very specific projects, have collectively met the needs of state insurance regulators within those groups, and we support the prudent approach taken by the NAIC thus far in meeting our needs.

I appreciate the intent of the IMF consideration, and to the extent that our need for resources becomes more pronounced, we stand prepared to initiate the NAIC protocol for requesting those resources. Please let me know if you have any questions.
MEMORANDUM

TO: Scott A. White (VA), Chair of the Financial Condition (E) Committee
    Michael Conway (CO), Vice Chair of the Financial Condition (E) Committee

FROM: Tom Botsko (OH), Chair of the Capital Adequacy (E) Task Force

DATE: Nov. 1, 2021

RE: Request for a New Working Group

In recent years, there have been a significant number of investment-focused proposals that have been received by the Financial Condition (E) Committee or initiated or received by one of its task forces or working groups. Regardless of which group initially vets the proposal, these proposals may have risk-based capital (RBC) impacts, and in many of these proposals, the RBC impact is the driving force. The Capital Adequacy (E) Task Force, along with the RBC working groups, are requesting a new working group be formed to review these investment-related proposals that affect many different areas of the annual statement and financial reporting. When necessary, other groups will be contacted for their expertise. This new working group (RBC Investment Risk and Evaluation (E) Working Group) would be charged with performing a comprehensive review of the RBC investment framework for all business types, which could include: 1) identifying and acknowledging uses that extend beyond the purpose of the Risk-Based Capital (RBC) for Insurers Model Act (#312); 2) assessing the impact and effectiveness of potential changes in contributing to the identification of weakly capitalized companies (i.e., those companies at action level); and 3) documenting the modifications made over time to the formulas, including, but not limited to an analysis of the costs in:

- Study and development.
- Implementation (internal and external).
- Assimilation.
- Verification.
- Analysis and review of the desired change to the RBC formulas and facilitate the appropriate allocation of resources.

This request recognizes the Committee’s recent request for the chairs, vice chairs, and supporting NAIC staff of the Capital Adequacy (E) Task Force, Statutory Accounting Principles (E) Working Group, and Valuation of Securities (E) Task Force to meet on a routine basis to discuss topics pertaining to the bond project that have cross-functional implications. While those meetings may be informative to our pursuit, this is a more holistic endeavor to review appropriate NAIC consideration not limited to one investment area but with a focus on process to maximize efficiency in achieving the NAIC’s collective goals.

Since the inception of the RBC formulas in the early 1990s, many of the risk factors have not been evaluated/updated for the appropriateness of the initial risk charge.
We believe that having a regularly scheduled analysis of these investment risk charges is necessary to maintain accuracy of the formula and to stay current with economic conditions. We also understand that the Insurance Core Principles (ICPs) speak to the periodic review of the solvency framework. This proposed working group would work in parallel with these principles to review and maintain appropriate RBC charges.

One other important aspect of this working group would be to maintain documentation of the analysis and the background of the charge. At various times, the RBC working groups have reached out to the original members of the group that created the RBC formulas to better understand the thought process/reasons for some of the original charges.

As the insurance environment evolves both domestically and internationally, it is imperative that our organization stays current. The development of group capital within the NAIC is an indicator that our organization needs to maintain appropriate and current methodology.

Thank you for taking the time to review this request. We are available to discuss this with you at your convenience.

Please contact Jane Barr, NAIC staff support for the Capital Adequacy (E) Task Force, at jbarr@naic.org with any questions.

Cc: Dan Daveline; Eva Yeung; Crystal Brown; Dave Fleming; Julie Gann
FINANCIAL CONDITION (E) COMMITTEE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Financial Condition (E) Committee will:
   B. Appoint and oversee the activities of the following: Accounting Practices and Procedures (E) Task Force; Capital Adequacy (E) Task Force; Examination Oversight (E) Task Force; Receivership and Insolvency (E) Task Force; Reinsurance (E) Task Force; Risk Retention Group (E) Task Force; and Valuation of Securities (E) Task Force.
   C. Oversee a process to address financial issues that may compromise the consistency and uniformity of the U.S. solvency framework, referring valuation and other issues to the appropriate committees as needed.
   D. Use the Risk-Focused Surveillance (E) Working Group to address specific industry concerns regarding regulatory redundancy, and review any issues industry subsequently escalates to the Committee.

2. The Financial Analysis (E) Working Group will:
   A. Analyze nationally significant insurers and groups that exhibit characteristics of trending toward or being financially troubled; determine if appropriate action is being taken.
   B. Interact with domiciliary regulators and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods, and action(s).
   C. Support, encourage, promote, and coordinate multistate efforts in addressing solvency problems, including identifying adverse industry trends.
   D. Increase information-sharing and coordination between state insurance regulators and federal authorities, including through representation of state insurance regulators in national bodies with responsibilities for system-wide oversight.

3. The Group Capital Calculation (E) Working Group will:
   A. Continually review and monitor the effectiveness of the group capital calculation (GCC), and consider revisions, as necessary, to maintain the effectiveness of its objective under the U.S. solvency system.
   B. Develop regulatory guidance related to the GCC. Complete by the 2021 Summer National Meeting.
   C. Liaise, as necessary, with the International Insurance Relations (G) Committee on international group capital developments, and consider input from participation of U.S. state insurance regulators in the International Association of Insurance Supervisors (IAIS) monitoring process.

4. The Group Solvency Issues (E) Working Group will:
   A. Continue to develop potential enhancements to the current regulatory solvency system as it relates to group solvency-related issues.
   B. Critically review and provide input and drafting to the IAIS, Insurance Groups Working Group or on other IAIS material dealing with group supervision issues.
   C. Continually review and monitor the effectiveness of the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450), and consider revisions, as necessary, to maintain effective oversight of insurance groups.
   D. Assess the IAIS Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame), and make recommendations on its implementation in a manner appropriate for the U.S.
5. The Own Risk and Solvency Assessment (ORSA) Implementation (E) Subgroup of the Group Solvency Issues (E) Working Group will:
   A. Continue to provide and enhance an enterprise risk management (ERM) education program for state insurance regulators in support of the ORSA implementation.
   B. Continually review and monitor the effectiveness of the Risk Management and Own Risk and Solvency Assessment Model Act (#505) and its corresponding NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual; consider revisions as necessary.

6. The Mortgage Guaranty Insurance (E) Working Group will:
   A. Develop changes to the Mortgage Guaranty Insurance Model Act (#630) and other areas of the solvency regulation of mortgage guaranty insurers, including, but not limited to, revisions to Statement of Statutory Accounting Principles (SSAP) No. 58—Mortgage Guaranty Insurance, and develop an extensive mortgage guaranty supplemental filing. Finalize Model #630 by the 2021 Spring National Meeting.

7. The Mutual Recognition of Jurisdictions (E) Working Group will:
   A. Develop a process for evaluating jurisdictions and jurisdictions and maintain a listing of jurisdictions that meets the NAIC requirements for recognizing and accepting the NAIC Group Capital Calculation (GCC).
   B. Maintain the NAIC List of Qualified Jurisdictions and the NAIC List of Reciprocal Jurisdictions in accordance with the Process for Evaluating Qualified and Reciprocal Jurisdictions.

8. The NAIC/American Institute of Certified Public Accountants (AICPA) (E) Working Group will:
   A. Continually review the Annual Financial Reporting Model Regulation (#205) and its corresponding implementation guide; revise as appropriate.
   B. Address financial solvency issues by working with the AICPA and responding to AICPA exposure drafts.
   C. Monitor the federal Sarbanes-Oxley (SOX) Act of 2002, as well as rules and regulations promulgated by the U.S. Securities and Exchange Commission (SEC), the Public Company Accounting Oversight Board (PCAOB), and other financial services regulatory entities.
   D. Review annually the premium threshold amount included in Section 16 of Model #205, with the general intent that those insurers subject to the Section 16 requirements would capture at least approximately 90% of industry premium and/or in response to any future regulatory or market developments.

9. The National Treatment and Coordination (E) Working Group will:
   A. Increase utilization and implementation of the Company Licensing Best Practices Handbook.
   B. Encourage synergies between corporate changes/amendments and rate and form filing review and approval to improve efficiency.
   C. Continue to monitor the usage and make necessary enhancements to the Form A Database.
   D. Maintain educational courses in the existing NAIC Insurance Regulator Professional Designation Program for company licensing regulators.
   E. Make necessary enhancements to promote electronic submission of all company licensing applications.

10. The Restructuring Mechanisms (E) Working Group will:
    A. Evaluate and prepare a white paper that:
        1. Addresses the perceived need for restructuring statutes and the issues those statutes are designed to remedy. Also, consider alternatives that insurers are currently employing to achieve similar results.
        2. Summarizes the existing state restructuring statutes.
        3. Addresses the legal issues posed by an order of a court (or approval by an insurance department) in one state affecting the policyholders of other states.
        4. Considers the impact that a restructuring might have on guaranty associations and policyholders that had guaranty fund protection prior to the restructuring. Complete by the 2021 Summer National Meeting.
    B. Identifies and addresses the legal issues associated with restructuring using a protected cell. Complete by the 2021 Summer National Meeting.
    C. Consider requesting approval from the Executive (EX) Committee on developing changes to specific NAIC models as a result of findings from the development of the white paper. Complete by the 2021 Summer National Meeting.
11. The Long-Term Care Insurance Restructuring (E) Subgroup of the Restructuring Mechanisms (E) Working Group will:
   A. Identify and assess potential legal and regulatory issues arising from a corporate transaction that would seek to legally separate certain long-term care (LTC) policies from the general account of the issuing insurer. Report on the Subgroup’s consideration of the issue, including a recommendation as to merits of an existing regulatory framework (e.g., Insurance Business Transfers state statutes) or a new regulatory framework, as contemplated by Workstream #2 of the Long-Term Care Insurance (EX) Task Force.

12. The Restructuring Mechanisms (E) Subgroup of the Restructuring Mechanisms (E) Working Group will:
   A. Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer, along with the adequacy of long-term liquidity needs. Also, develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for its consideration. Complete by the 2021 Summer National Meeting.
   B. Consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff. Complete by the 2021 Fall National Meeting.
   C. Review the various restructuring mechanisms and develop, if deemed needed, protected cell accounting and reporting requirements for referring to the Statutory Accounting Principles (E) Working Group. Complete by the 2021 Fall National Meeting.

13. The Risk-Focused Surveillance (E) Working Group will:
   A. Continually review the effectiveness of risk-focused surveillance, and develop enhancements to processes as necessary.
   B. Continually review regulatory redundancy issues identified by interested parties, and provide recommendations to other NAIC committee groups to address as needed.
   C. Oversee and monitor the Peer Review Program to encourage consistent and effective risk-focused surveillance processes.
   D. Continually maintain and update standardized job descriptions/requirements and salary range recommendations for common solvency monitoring positions to assist insurance departments in attracting and maintaining suitable staff.

14. The Valuation Analysis (E) Working Group will:
   A. Respond to states in a confidential forum regarding questions and issues arising during the course of annual principle-based reserving (PBR) reviews or PBR examination, and which also may include consideration of asset adequacy analysis questions and issues.
   B. Work with NAIC resources to assist in prioritizing and responding to issues and questions regarding PBR and asset adequacy analysis, including actuarial guidelines or other requirements making use of or relating to PBR, such as Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation (AG 38), Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued Under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48), and the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).
   C. Develop and implement a plan with NAIC resources to identify outliers/concerns regarding PBR/asset adequacy analysis.
   D. Refer questions/issues, as appropriate, to the Life Actuarial (A) Task Force that may require consideration of changes/interpretations to be provided in the Valuation Manual.
   E. Assist NAIC resources in the development of a standard asset/liability model portfolio used to calibrate company PBR models.
   F. Make referrals, as appropriate, to the Financial Analysis (E) Working Group.
   G. Perform other work to carry out the Valuation Analysis (E) Working Group procedures.

NAIC Support Staff: Dan Daveline/Julie Gann/Bruce Jenson
2022 Proposed Charges

ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Accounting Practices and Procedures (E) Task Force will:

2. The Blanks (E) Working Group will:
   A. Consider improvements and revisions to the various annual/quarterly statement blanks to:
      1. Conform these blanks to changes made in other areas of the NAIC to promote uniformity in reporting of financial information by insurers.
      2. Develop reporting formats for other entities subject to the jurisdiction of state insurance departments.
      3. Conform the various NAIC blanks and instructions to adopted NAIC policy.
      4. Oversee the development of additional reporting formats within the existing annual financial statements as needs are identified.
   B. Continue to monitor state filing checklists to maintain current filing requirements.
   C. Continue to monitor and improve the quality of financial data filed by insurance companies by recommending improved or additional language for the Annual Statement Instructions.
   D. Continue to monitor and review all proposals necessary for the implementation of statutory accounting guidance to ensure proper implementation of any action taken by the Accounting Practices and Procedures (E) Task Force affecting annual financial statements and/or instructions.
   E. Continue to coordinate with other task forces of the NAIC to ensure proper implementation of reporting and instructions changes as proposed by these taskforces.
   F. Coordinate with the Life Actuarial (A) Task Force to use any special reports developed and avoid duplication of reporting.
   G. Review requests for investment schedule blanks and instructions changes in connection with the work being performed by the Capital Adequacy (E) Task Force and its working groups.
   H. Review changes requested by the Valuation of Securities (E) Task Force relating to its work on other invested assets reporting for technical consistency within the investment reporting schedules and instructions.

3. The Statutory Accounting Principles (E) Working Group will:
   A. Maintain codified statutory accounting principles by providing periodic updates to the guidance that address new statutory issues and new generally accepted accounting principles (GAAP) pronouncements. Provide authoritative responses to questions of application and clarifications for existing statutory accounting principles. Report all actions and provide updates to the Accounting Practices and Procedures (E) Task Force.
   B. At the discretion of the Working Group chair, develop comments on exposed GAAP and International Financial Reporting Standards (IFRS) pronouncements affecting financial accounting and reporting. Any comments are subject to review and approval by the chairs of the Accounting Practices and Procedures (E) Task Force and the Financial Condition (E) Committee.
   C. Coordinate with the Life Actuarial (A) Task Force on changes to the AP&P Manual related to the Valuation Manual VM-A, Requirements, and VM-C, Actuarial Guidelines, as well as other Valuation Manual requirements. This process will include the receipt of periodic reports on changes to the Valuation Manual on items that require coordination.
ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE (continued)

C.D. Obtain, analyze and review information on permitted practices, prescribed practices or other accounting treatments suggesting that issues or trends occurring within the industry may compromise the consistency and uniformity of statutory accounting, including, but not limited to, activities conducted by insurers for which there is currently no statutory accounting guidance or where the states have prescribed statutory accounting that differs from the guidance issued by the NAIC. Use this information to consider possible changes to statutory accounting.

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

Ongoing Support of NAIC Programs, Products or Services

1. The Capital Adequacy (E) Task Force will:
   A. Evaluate emerging “risk” issues for referral to the risk-based capital (RBC) working groups/subgroups for certain issues involving more than one RBC formula. Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
   B. Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).
   C. Evaluate relevant historical data and apply defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to the current asset risk structure and factors in each of the RBC formulas.

2. The Health Risk-Based Capital (E) Working Group, Life Risk-Based Capital (E) Working Group, and Property and Casualty Risk-Based Capital (E) Working Group will:
   A. Evaluate refinements to the existing NAIC RBC formulas implemented in the prior year. Forward the final version of the structure of the current year life and fraternal, property/casualty (P/C), and health RBC formulas to the Financial Condition (E) Committee by June.
   B. Consider improvements and revisions to the various RBC blanks to: 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity; and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified. Any proposal that affects the RBC structure must be adopted no later than April 30 in the year of the change, and adopted changes will be forwarded to the Financial Condition (E) Committee by the next scheduled meeting or conference call. Any adoptions made to the annual financial statement blanks or statutory accounting principles that affect an RBC change adopted by April 30 and results in an amended change may be considered by July 30 for those exceptions where the Capital Adequacy (E) Task Force votes to pursue by super-majority (two-thirds) consent of members present no later than June 30 for the current reporting year.
   C. Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the revised Accounting Practices and Procedures Manual (AP&P Manual) to ensure that model laws, publications, formulas, analysis tools, etc., supported by the Task Force continue to meet regulatory objectives.
   D. Review the effectiveness of the NAIC’s RBC policies and procedures as they affect the accuracy, audit ability, timeliness of reporting access to RBC results and comparability between the RBC formulas. Report on data quality problems in the prior year RBC filings at the summer and fall national meetings.

3. The Longevity Risk (E/A) Subgroup, a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force, will:
   A. Provide recommendations for the appropriate treatment of longevity risk transfers by the new longevity factors.

4. The Variable Annuities Capital and Reserve (E/A) Subgroup, a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force, will:
   A. Monitor the impact of the changes to the variable annuities reserve framework and RBC calculation, and determine if additional revisions need to be made.
   B. Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.

5. The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group will:
   A. Recalculate the premium risk factors on an ex-catastrophe basis, if needed.
   B. Continue to update the U.S. and non-U.S. catastrophe event list.
   C. Continue to evaluate the need for exemption criteria for insurers with minimal risk.
D. Evaluate the RBC results inclusive of a catastrophe risk charge.
E. Refine instructions for the catastrophe risk charge.

CAPITAL ADEQUACY (E) TASK FORCE (continued)

F. Continue to evaluate any necessary refinements to the catastrophe risk formula.
G. Evaluate other catastrophe risks for possible inclusion in the charge.

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

NAIC Support Staff: Jane Barr
EXAMINATION OVERSIGHT (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Examination Oversight (E) Task Force will:
   A. Accomplish its mission using the following groups:
      5. Information Technology (IT) Examination (E) Working Group.

2. The Electronic Workpaper (E) Working Group will:
   A. Monitor and support the state insurance departments in using electronic workpaper software tools to conduct and document solvency monitoring activities.
   B. Provide ongoing oversight to the transition of electronic workpaper work to the TeamMate+ application NAIC’s Electronic Workpaper Hosting Project.
   C. Monitor state insurance regulator use of TeamMate+ to proactively identify best practices and improvements to the application, as necessary. Develop a framework to meet the long-term hosting and software needs of state insurance regulators in using electronic workpapers to conduct and document solvency monitoring activities. Ensure that solutions developed consider various state insurance regulator uses, as appropriate.

3. The Financial Analysis Solvency Tools (E) Working Group will:
   A. Provide ongoing maintenance and enhancements to the Financial Analysis Handbook and related applications for changes to the NAIC annual/quarterly financial statement blanks, as well as enhancements developed to assist in the risk-focused analysis and monitoring of the financial condition of insurance companies and groups. Monitor the coordination of analysis activities of holding company groups, and coordinate and analyze input received from other state regulators.
   B. Provide ongoing development maintenance and enhancements to the automated financial solvency tools developed to assist in conducting risk-focused analysis and monitoring the financial condition of insurance companies and groups. Prioritize and perform analysis to ensure that the tools remain reliable and accurate.
   C. Coordinate with the Financial Examiners Handbook (E) Technical Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.
   D. Adjust the Financial Analysis Handbook and current financial analysis solvency tools for life insurance companies based on any recommendations as requested from the Life Actuarial (A) Task Force to incorporate principle-based reserving (PBR) changes.
EXAMINATION OVERSIGHT (E) TASK FORCE (continued)

4. The Financial Examiners Coordination (E) Working Group will:
   A. Develop enhancements that encourage the coordination of examination activities regarding holding company groups.
   B. Promote coordination by assisting and advising domiciliary regulators and exam coordinating states as to what might be the most appropriate regulatory strategies, methods and actions regarding financial examinations of holding company groups.
   C. Facilitate communication among regulators regarding common practices and issues arising from coordinating examination efforts.
   D. Provide ongoing maintenance and enhancements to the Financial Examination Electronic Tracking System (FEETS).

5. The Financial Examiners Handbook (E) Technical Group will:
   A. Continually review the Financial Condition Examiners Handbook and revise, as appropriate.
   B. Coordinate with the Risk-Focused Surveillance (E) Working Group to monitor the implementation of the risk-assessment process by developing additional guidance and exhibits within the Financial Condition Examiners Handbook, including consideration of potential redundancies affected by the examination process, corporate governance and other guidance as needed to assist examiners in completing financial condition examinations.
   C. Coordinate with the Financial Analysis Solvency Tools (E) Working Group and the Risk-Focused Surveillance (E) Working Group, as appropriate, to develop and maintain guidance in order to provide effective solvency monitoring.
   D. Coordinate with the IT Examination (E) Working Group and the Financial Examiners Coordination (E) Working Group to maintain specialized areas of guidance within the Financial Condition Examiners Handbook related to the charges of these specific working groups.
   E. Adjust the Financial Condition Examiners Handbook based upon any recommendations as requested from the Life Actuarial (A) Task Force to incorporate PBR changes.

6. The Information Technology (IT) Examination (E) Working Group will:
   A. Continually review and revise, as needed, the “General Information Technology Review” and “Exhibit C—Evaluation of Controls in Information Systems” sections of the Financial Condition Examiners Handbook.
   B. Monitor cybersecurity trends, including emerging and/or ongoing vulnerabilities, and develop guidance within the Financial Condition Examiners Handbook or other tools, if deemed necessary, to support IT examiners.

NAIC Support Staff: Bailey Henning
2022 Proposed Charges

FINANCIAL STABILITY (E) TASK FORCE

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

Ongoing Support of NAIC Program, Products or Services

1. The Financial Stability (E) Task Force will:

   A. Consider issues concerning domestic and global financial stability as they pertain to the role of state insurance regulators and make recommendations to the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council and/or the Executive (EX) Committee, as appropriate.

      1. Analyze existing post-financial crisis regulatory reforms for their application in identifying macroeconomic trends, including identifying possible areas of improvement or gaps, and propose to the Financial Condition (E) Committee or other relevant committee enhancements and/or additions to further improve the ability of state insurance regulators and the industry to address macroprudential impacts; consult with such committees on implementation, as needed.

   B. Consider state insurance regulators’ input to national and international discussions on macroeconomic vulnerabilities affecting the insurance sector.

      1. Monitor international macroprudential activities at forums like the International Association of Insurance Supervisors (IAIS).
      2. Implement the Macroprudential Initiative (MPI) domestically, which includes enhancements to the U.S. regulatory toolkit as part of the State Ahead initiative.

   C. Serve as a forum to coordinate state insurance regulators’ perspectives on a wide variety of issues arising from the designation of a U.S. insurance group as “systemically important” and “internationally active” both pre- and post-designation, including:

      1. Where appropriate, develop policy recommendations and/or guidance regarding the role, responsibilities and activities of state insurance regulators in the context of consolidated supervision resulting from designation.
      2. Analyze proposed rules by the federal agencies that relate to financial stability.
      3. Analyze proposed policy measures regarding supervisory standards for global systemically important insurers (G-SIIs) and internationally active insurance groups (IAIGs).
      4. Develop comment letters on such analysis for further consideration by the International Insurance Relations (G) Committee, the Government Relations (EX) Leadership Council, and/or the Executive (EX) Committee, as appropriate.

2. The Macroprudential (E) Working Group will:

   A. Oversee the implementation and maintenance of the liquidity stress testing framework for 2020 data as well as future iterations.

   B. Assist with the remaining MPI projects related to counterparty disclosures and capital stress testing as needed.

   C. Continue to develop and administer data collection tools as needed, leveraging existing data where feasible, to provide the Financial Stability (E) Task Force with meaningful macroprudential information regarding how the insurance sector is navigating the prevailing market conditions.

   D. Oversee the development, implementation, and maintenance process for a new Macroprudential Risk Assessment system (i.e., policies, procedures, and tools) to enhance regulators’ ability to monitor industry trends from a macroprudential perspective.

   E. Oversee the documentation of the NAIC’s macroprudential policies, procedures, and tools.

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

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

Ongoing Support of NAIC Programs, Products or Services

1. The Receivership and Insolvency (E) Task Force will:
   A. Monitor and promote efficient operations of insurance receiverships and guaranty associations.
   B. Monitor and promote state adoption of insurance receivership and guaranty association model acts and regulations, and monitor other legislation related to insurance receiverships and guaranty associations.
   C. Provide input and comments to the International Association of Insurance Supervisors (IAIS), the Financial Stability Board (FSB) or other related groups on issues regarding international resolution authority.
   D. Monitor, review and provide input on federal rulemaking and studies related to insurance receiverships.
   F. Monitor the work of other NAIC committees, task forces and working groups to identify and address any issues that affect receivership law and/or regulatory guidance.
   G. Perform additional work as directed by the Financial Condition (E) Committee and/or received through referral by other groups.

2. The Receiver’s Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force will:
   A. Review the Receiver's Handbook to identify areas where information is outdated, updates are required, or additional guidance is needed. Based on this review, draft and propose recommended edits to the Receiver’s Handbook. Complete by the 2022 Fall National Meeting.

2.3. The Receivership Financial Analysis (E) Working Group will:
   A. Monitor receiverships involving nationally significant insurers/groups to support, encourage, promote and coordinate multistate efforts in addressing problems.
   B. Interact with the Financial Analysis (E) Working Group, domiciliary regulators, and lead states to assist and advise as to what might be the most appropriate regulatory strategies, methods and/or action(s) regarding potential or pending receiverships.

3. The Receivership Law (E) Working Group will:
   A. Review and provide recommendations on any issues identified that may affect states’ receivership and guaranty association laws (e.g., any issues that arise as a result of market conditions; insurer insolencies; federal rulemaking and studies; international resolution initiatives; or as a result of the work performed by or referred from other NAIC committees, task forces and/or working groups).
   B. Discuss significant cases that may impact the administration of receiverships.

1. Complete work as assigned from the Receivership and Insolvency (E) Task Force to address recommendations from the Financial Stability (E) Task Force’s Macroprudential Initiative (MPI) referral:
   A. Complete work related to qualified financial contracts (QFCs), including: 1) explore if bridge institutions could be implemented under regulatory oversight pre-receivership to address an early termination of QFCs and, if
appropriate, develop applicable guidance; 2) develop enhancements to the Receiver's Handbook guidance on QFCs; and 3) identify related pre-receivership considerations related to QFCs and, if necessary, make referrals to other relevant groups to enhance pre-receivership planning, examination and analysis guidance.

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

C. Consult with and/or make referrals to other NAIC working groups, as deemed necessary, as the topic relates to affiliated intercompany agreements and pre-receivership considerations. Complete by the 2021 Fall National Meeting.

— The Receiver's Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force will:

   A. Review the Receiver's Handbook to identify areas where information is outdated, updates are required, or additional guidance is needed. Based on this review, draft and propose recommended edits to the Receiver's Handbook. Complete by the 2022 Fall National Meeting.

NAIC Support Staff: Jane Koenigsman
2022 Proposed Charges

REINSURANCE (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Reinsurance (E) Task Force will:
   A. Provide a forum for the consideration of reinsurance-related issues of public policy.
   C. Monitor the implementation of the 2011, 2016 and 2019 revisions to the Credit for Reinsurance Model Law (#785); and the 2011 and 2019 revisions to the Credit for Reinsurance Model Regulation (#786) and the Term and Universal Life Insurance Reserve Financing Model Regulation (#787).
   D. Communicate and coordinate with the Federal Insurance Office (FIO), other federal authorities, and international regulators and authorities on matters pertaining to reinsurance.
   E. Consider any other issues related to the revised Model #785, Model #786 and Model #787.
   F. Monitor the development of international principles, standards and guidance with respect to reinsurance. This includes, but is not limited to, monitoring the activities of various groups within the International Association of Insurance Supervisors (IAIS), including the Reinsurance and Other Forms of Risk Transfer Subcommittee, the Reinsurance Mutual Recognition Subgroup and the Reinsurance Transparency Group.
   G. Consider the impact of reinsurance-related federal legislation, including, but not limited to, the federal Nonadmitted and Reinsurance Reform Act (NRRA) and the Federal Insurance Office Act, and coordinate any appropriate NAIC action.
   H. Continue to monitor the impact of reinsurance-related international agreements, including the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance” (UK Covered Agreement).

2. The Reinsurance Financial Analysis (E) Working Group will:
   A. Operate in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings and operate in open session when discussing certified reinsurance topics and policy issues, such as amendments to the Uniform Application for Certified Reinsurers.
   B. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.
   C. Provide a forum for discussion among NAIC jurisdictions of reinsurance issues related to specific companies, entities, or individuals.
   D. Support, encourage, promote, and coordinate multistate efforts in addressing issues related to certified reinsurers, including, but not limited to, multistate recognition of certified reinsurers.
   E. Provide analytical expertise and support to the states with respect to certified reinsurers and applicants for certification.
   F. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.
   G. Ensure the public passporting website remains current.
   H. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective approaches for the financial solvency surveillance to assist the states in their work to protect the interests of policyholders.

NAIC Support Staff: Jake Stultz/Dan Schelp
2022 Proposed Charges

RISK RETENTION GROUP (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Becky Meyer/Sara Franson
2022 Proposed Charges

VALUATION OF SECURITIES (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Charles Therriault
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met Nov. 22, 2021. The following Working Group members participated: John Rehagen, Chair (MO); Kathy Belfi, Vice Chair (CT); Susan Bernard (CA); Philip Barlow (DC); Ray Spudeck (FL); Carrie Mears (IA); Susan Berry (IL); Roy Eft (IN); Christopher Joyce (MA); Judy Weaver (MI); Kathleen Orth (MN); Jackie Obusek (NC); David Wolf (NJ); Bob Kasinow (NY); Dale Bruggeman and Tim Biler (OH); Greg Lathrop (OR); Melissa Greiner (PA); Trey Hancock (TN); Jamie Walker (TX); and Doug Stolte and David Smith (VA).

1. **Adopted its Nov. 8, Sept 13, and Summer National Meeting Minutes**

The Working Group met Nov. 8 and Sept. 13 and took the following action: 1) exposed a staff memorandum that includes possible group capital calculation (GCC) modifications for a public comment period ending Dec. 23; 2) exposed until some clarifying changes to the GCC instructions that were previously provided to the Working Group and the public as part of the GCC Trial Implementation for a public comment period ending Dec. 8; 3) discussed comments on maintenance documents and proposed revisions; 4) discussed comments on a draft referral to the Capital Adequacy (E) Task Force; 5) adopted recommended changes to the *Financial Analysis Handbook* that incorporate guidance on using the GCC and subsequently distributed it to the Financial Analysis Solvency Tools (E) Working Group.

Ms. Belfi made a motion, seconded by Mr. Eft, to adopt the Working Group’s Nov. 8 (Attachment Two-A), Sept. 13 (Attachment Two-B), and July 26 (see *NAIC Proceedings – Summer 2021, Financial Condition (E) Committee, Attachment Two*) minutes. The motion passed unanimously.

2. **Discussed Results of the GCC Trial Implementation**

Ned Tyrrell (NAIC) provided a summary of the GCC Trial Implementation (Attachment Two-C). He emphasized that the summary was focused on those particular data points that might be helpful in the Working Group’s decisions on whether to make modifications to the template and instructions as they relate to issues identified during its Nov. 8 meeting. He noted that the summary includes data that has been anonymized, which is important in making sure a reader of the information can understand the data but unable to determine a specific company’s results. He described the different groupings used through the presentation, including by ownership type or sector, where composite represents an insurance that has a mixture of life and property/casualty (P/C) business. Mr. Tyrrell described the graphs used to provide the distribution of data, including the points used to provide averages and percentiles. He noted that the summary slides are all at the level of 200% of authorized control level risk-based capital (RBC). He also noted the large dominance of U.S. insurance business in most of the participants. Additionally, Mr. Tyrrell noted the relative low number of insurers that are affected by the debt limits, the other debt category and even the stress test, which was extreme and was intended to test the sensitivity of the debt limits.

Mr. Tyrrell discussed the data on non-risk jurisdictions, noting there as well that few of the insurers were affected by these types of insurers within their groups under both the Trial Implication use of 100% charge on the book value, or essentially a zeroing out of available and required capital, or the Nov. 8 meeting proposal of a 50% charge on the book value of such entities. He also discussed how the senior debt reported in the slides represented the allowable senior debt in the companies’ specific GCC calculations. Finally, he discussed the current proposal discussed during the Working Group’s Nov. 8 meeting that suggests the charge for asset managers be changed to the capital requirement from their regulator and just showed how the issue may be material to some of the insurers just from a simple standpoint of the size of such operations in the makeup of the group, but that it is less material for other volunteers. He noted that additional data would be needed to dig into the impact more specifically.

Dave Neve (Global Atlantic) asked about the difference between the GCC ratios on slide 6 and slide 10. Mr. Tyrrell noted it was a good catch to see the differences, and he said the reason is because one is weighted (slide 10) while the other (slide 6) is not. More specifically, on slide 10, the ratio is calculated by adding up the available capital and the required capital, and the available capital is divided by the requirement capital. Mr. Neve also asked about the impact of scalars. Mr. Tyrrell noted this was looked at but not included in the summary since there is currently not a decision before the Working Group on the matter. He described that with the excess scalar method, for most volunteers it actually does not make much of a difference. He noted,
however, that the results are consistent with the intent, which is to capture the difference between those systems with less reserve conservatism versus more reserve conservatism.

3. **Discussed Other Matters**

Mr. Rehagen reminded the participants of the Working Group’s two current exposures and that his intent is meet in early January to consider comments from those two exposures.

Having no further business, the Group Capital Calculation (E) Working Group adjourned.

Attachment Two-A-11-8-21 Meeting Minutes (1).docx
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee met Nov. 8, 2021. The following Working Group members participated: John Rehagen, Chair (MO); Kathy Belfi, Vice Chair (CT); Kim Hudson (CA); Philip Barlow (DC); Ray Spudeck (FL); Carrie Mears (IA); Susan Berry (IL); Christopher Joyce (MA); Judy Weaver and Steve Mayhew (MI); Jackie Obusek (NC); Justin Schrader (NE); David Wolf (NJ); Bob Kasinow (NY); Dale Bruggeman and Tim Biler (OH); Greg Lathrop (OR); Melissa Greiner and Kimberly Rankin (PA); Trey Hancock (TN); Amy Garcia (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. **Discussed and Exposed a Staff Memorandum on Possible GCC Modifications**

Mr. Rehagen stated that the first two agenda items were related to the extent the Working Group wants to make any changes to the group capital calculation (GCC) before the template and instructions are effective for 2022. He described that the principle behind agenda item two was to make sure members of the industry have plenty of time to prepare for any changes made in the same year as the changes are effective. He described more specifically how agenda item two requires GCC template changes to be exposed by Jan. 31 of the effective year and then adopted by April 30, and that GCC instruction changes need to be exposed by April 30 and adopted by June 30. He said that the proposed maintenance procedures included in agenda item two had yet to be adopted. Therefore, he said perhaps the Working Group could be more lenient on some of those deadlines this year, but he wants to stick to the spirit of the dates in that agenda item. He stated the Working Group would come back to those dates in the next agenda item but wanted Working Group members to be aware of those before he asked NAIC staff to summarize each of the items in its staff memorandum (Attachment Two-A1). He asked that as NAIC staff summarize the items, Working Group members keep in mind his desire to expose the memorandum for 45 days, and then for the Working Group to meet in early January to discuss comments received.

Dan Daveline (NAIC) summarized each of the proposals in the staff memorandum. As it relates to the proposed change for foreign insurers, Mr. Wolf asked for an example of a jurisdiction that would not have a risk-based regime. Mr. Daveline responded that Barbados was one such example. Ned Tyrrell (NAIC) added some additional context for Mr. Wolf. He said that a non-risk-based regime could include, for example, a jurisdiction where it is simply a minimum capital requirement in dollars, such as $5 million, that does not go up or down based upon the amount of business written. He stated that Barbados was not quite this insensitive, but that it may not consider the type of business written or the type of assets owned. Mr. Wolf stated his appreciation for the example and stated he is still favoring a 100% factor on the book value of the entity because that is what they have at risk in that country. However, he said that he is not opposed to it being exposed and getting different viewpoints.

Michael DeBois (MassMutual) clarified that the life risk-based capital (RBC) formula actually requires a zero value for the carrying value of foreign insurers and, therefore, is excluded from both the numerator and denominator of the RBC. Mr. Daveline agreed with the statement from Mr. DeBois, indicating he was simply shortcutting for comparative purposes. Mr. Spudeck asked about the materiality of this issue, as well as the materiality of the issue dealing with other debt. Mr. Daveline and Mr. Tyrrell noted this was a good question and said that while neither are generally material to the industry as a whole based upon the trial implementation, it is more material to a small number of companies but not significant even in those cases. It was noted that during a future meeting, aggregate results from the trial implementation would be presented, which may be helpful in supplementing this response. Mr. Spudeck whether in those situations where its more material, would it show up in the financial analysis. Mr. Daveline responded that he believed spike in other debt likely would show up in the GCC analytics, but he does not believe the same could be said about the foreign insurer question. Mr. Tyrell responded he would look more closely at the data on both questions. With respect to the issue raised within the memorandum on modifying the reporting of some entities in Schedule 1, Ms. Belfi said she appreciates the issue being raised as they had seen some inconsistency in reporting, and they were struggling with the issue as well.

The Working Group agreed to expose the NAIC staff memorandum for a 45-day public comment period ending Dec. 23.

Mr. Rehagen also noted that included in the materials was the latest instructions that already included changes for items that were changed during the trial implementation. He noted all of those changes were intended to be clarifying.
The Working Group agreed to expose the instructions for a 30-day public comment period ending Dec. 8.

2. **Discussed Comments on Maintenance Documents and Proposed Revisions**

Mr. Rehagen discussed how the Working Group had previously exposed proposed documents that collectively provide the GCC with the same type of maintenance process as exists in RBC, including the change proposal forms, and the timeline he mentioned earlier in the meeting. He noted that the Working Group received one comment letter (Attachment Two-A2) from the American Council of Life Insurers (ACLI). Mr. Rehagen said NAIC staff tried to add language into a revised document to recognize the ACLI’s point, but at the same time, give the Working Group some flexibility. He asked if the ACLI could comment on whether it finds the changes proposed responsive to their concerns. Mariana Gomez-Vock (ACLI) stated that while her members have not had a chance to review and discuss the changes, she had, and she believes they could support the changes. She stated her appreciation for the Working Group and NAIC staff’s efforts to incorporate feedback from stakeholders around the potential need for more time on more complex issues. Mr. Rehagen asked the Working Group if it would like to adopt the revised procedures today or come back to it after the Working Group has received comments on the first exposure of the Working Group from earlier in the meeting. Ms. Belfi stated she would like to wait. Mr. Rehagen stated he does not believe there is a rush. Therefore, the Working Group will revisit the revised procedures during a future meeting.

3. **Considered Comments on a Draft RBC Referral**

Mr. Rehagen discussed how the Working Group had previously exposed a “draft” memorandum from the Working Group to the Capital Adequacy (E) Task Force. The memorandum highlighted some of the differences between the GCC and RBC. Mr. Rehagen reminded everyone that the Working Group discussion definitely emphasized that whether RBC made such changes was really up to those particular RBC groups. He noted the Working Group received comments on that memorandum and wanted to give each of those parties an opportunity to speak to their comment letters (Attachment Two-A3). Before doing so, he noted that he is open to having some discussions with the Task Force in the future, maybe just to explain why the GCC was constructed the way it was. He added that he suspects the Working Group may hear some of the same on why RBC was constructed the way it was. He stated the timing of such conversations may not be immediate but rather based upon the current priorities that both groups have. He asked the ACLI to summarize its letter. Ms. Gomez-Vock emphasized the ACLI’s support for the work, but also emphasized the GCC should reflect existing RBC and accounting rules. She said to the extent that the GCC causes those existing rules to be rethought, they should be done so under the existing processes in place at those groups.


Mr. Rehagen directed the Working Group to the comments received (Attachment Two-A4) on the Working Group’s previously re-exposed Financial Analysis Handbook guidance, as well as a revised draft of the same where NAIC staff modified the re-exposed guidance to address any comments that did not change the original intent. Tom Finnell, speaking on behalf of the interested party group consisting of the American Association of Health Insurance Plans (AHIP), the American Council of Life Insurers (ACLI), American Insurance Group, Anthem, Blue Cross and Blue Shield Association (BCBSA), Metropolitan Life Insurance Company, and UnitedHealth Group, stated their support for the revised guidance. He discussed how the group had provided some fairly significant comments during the Working Group’s first exposure, which they believe were needed to ensure that the guidance was consistent with the original purpose of the GCC. Mr. Finnell said those comments had been incorporated into the re-exposed version, so they have no further comments.

Mark Sagat (Liberty Mutual) said Liberty Mutual supports the current version and would recommend adoption. Chuck Feinen (State Farm) said State Farm has no further comments at this time. Jeff Martin (UnitedHealth Group) stated his appreciation for the Working Group’s incorporation of most of UnitedHealth Group’s edits into the revised guidance that it believes should improve the clarity and readability of the document. He did note that there was one reference on Page 169 of the materials that UnitedHealth Group believes required some action. Mr. Daveline acknowledged the comment was legitimate and could be resolved by either updating the cross reference to the other section of the Financial Analysis Handbook or by removal of the sentence. He indicated he would work with the NAIC staff support for the Financial Analysis Handbook to get it resolved before the document is distributed to the Financial Solvency Analysis Tools (E) Working Group.

Ms. Mears noted one other change on Page 172 and described how the section refers to guidance that is within an international consideration section, which she believes would apply to all groups. Mr. Daveline and Mr. Rehagen agreed that the guidance could pertain to all groups. Ms. Mears suggested renaming that international section to make it more generic to all holding companies.
Mr. Hudson made a motion, seconded by Ms. Mears, to adopt the revised GCC Financial Analysis Handbook guidance (see NAIC Proceedings – Fall 2021, Examination Oversight (E) Task Force, Attachment Two-D and Attachment Two-E) and send to the Financial Analysis Solvency Tools (E) Working Group for its consideration. The motion passed unanimously.

5. **Discussed Other Matters**

Mr. Rehagen stated that he expects the Working Group to meet in the coming weeks to receive a presentation from Mr. Tyrrell on the GCC trial implementation results.

Having no further business, the Group Capital Calculation (E) Working Group adjourned.

File 1a-11-8-21 Meeting Minutes.docx
MEMORANDUM

TO: Group Capital Calculation (E) Working Group
FROM: Dan Daveline, Ned Tyrrell, and Jane Ren
DATE: Nov. 8, 2021
RE: Staff Proposed Changes as a Result of Trial Implementation

While the 2019 GCC Field Test was invaluable in finalizing major changes to the GCC Template and Instructions before implementation, the 2021 Trial Implementation allowed preparers and reviewers of the GCC to focus more on the nuances of the GCC. As expected, a number of changes to the instructions were suggested during the completion of the template based upon comments and feedback from preparers, which the Working Group has been made aware of with each new release of the same during the trial period. Such changes are included in today’s materials, and we request the Working Group to expose these updated instructions with these modifications. The purpose of this memorandum however is to highlight more material changes, or potentially material changes to the extent the Working Group agrees with the staff recommendation. The following summarizes such changes.

Due to the fact that in accordance with draft procedures for the Working Group, template changes need to be adopted earlier in the year before instructional changes, we have listed those that require template changes first so they can be prioritized in discussions.

Template Changes

1. **Eliminate Stress Scenario**: While some Working Group members may want to consider adding informational stresses to the GCC in the future, the current sentiment among the Working Group seems to suggest that should only be considered after the GCC is fully implemented. Based upon that, it seems appropriate to remove the current stress from the template and the instructions.

2. **Debt Allowance**: One of the reasons the industry proposed the idea of including stress testing in the GCC for the Trial Implementation was to understand the sensitivity of the debt allowance after an economic downturn, therefore addressing its procyclicality. While it’s true that a 30% decline in the capital of a group can impact the debt allowance of the GCC in certain situations, thereby reducing the GCC ratio, NAIC staff does not believe this is a sufficient cause for increasing the debt allowance. As a reminder, the debt allowance is a proxy for the amount of subordinated capital embedded within the GCC and we believe the current allowance approximates this proxy well. A number of volunteers participating in the Trial Implementation suggested the 30% decline was generally not a very reasonable stress given past performance of the industry during previous financial crisis (e.g., 2008/2009 great
recession). However, some of those volunteers pointed to monetary policy during a financial crisis which actually encourages entities of all industries to increase debt as a means to push back against the negative impact. They pointed to the industry’s issuance of debt immediately after COVID and suggested the GCC should not go against these policies. NAIC staff does not disagree in principle, and would suggest a better way to address these points is through a simple annual 10% cap that enables the debt allowance to increase 10% from the prior year, but only during a period where the Federal Reserve has taken a public position of reducing the cost of borrowing through reducing interest rates either by lowering the Federal Funds rates or by purchasing debt instruments (additional if applicable). However, the 10% increase must be reversed once the Federal Reserve has taken action to reverse its trend (e.g., increase rates or reduce purchasing debt instruments). Perhaps this could be formally implemented only upon issuance of “guidance” by the Working Group that is posted to the Website. The details of whether this is appropriate and how it should be considered for adoption should first be determined by the Working Group. NAIC Staff would welcome proposed changes to the GCC instructions and template that could achieve this type of approach or any other similar approach that reduces the perceived procyclicality of the GCC limitation in this area.

3. **Eliminate Sensitivity Test Related to “Other Debt”** – We recognize that some members of the industry continue to believe that the debt allowance should include “other debt” beyond “senior debt” and “hybrid debt”. However, NAIC staff continues to believe that the approach already adopted by the Working Group to have an individual limit for each of those items (30% and 15% respectively) and the overall cap of those two is appropriate for the previous points made regarding how the debt allowance is a proxy for subordinated capital already within the insurance companies. With the previous consideration about adding an additional 10% annual change meeting the criteria, we further support no change to allow other debt. This should be further deliberated by the Working Group before taking action on this issue and input from interested parties may assist the Working Group in such a deliberation.

4. **Non-Risk Sensitive Foreign Jurisdictions** - One recommendation that has already been made by NAIC staff and regulators during the Trial Implementation is a different approach related to non-risk sensitive foreign jurisdictions. In summary, these are jurisdictions whose capital requirements are not responsive to the magnitude and/or nature of an insurer’s risk profile. During the Trial Implementation, a conservative approach was used on this matter, and the template included a capital charge equivalent to 100% of the carrying value of the non-U.S. insurer, which is similar in the life RBC formula today. However, to be clear, since 2010, the life formula has required companies to use a zero value for foreign affiliates statutory carry value is excluded from both total adjusted capital (the numerator) and RBC (the denominator) of the RBC ratio. This was done to level the playing field between stock and mutual insurers on the basis that most stock insurers where such entities are owned by a sister non-insurance holding company rather than the U.S. life insurance company.
NAIC staff suggestion during the Trial implementation was that groups with such entities consider using a lower factor, such as 50% of the carrying value, and be given the option to calculate the insurers capital requirement using RBC (with reasonable simplifications/estimates) if that is preferred to the 50% carrying value. At this point we have included this option in the revised instructions pending approval with exposure of such a substitute.

5. **Schedule 1 Related Questions/Considerations** The last item actually includes a number of separate questions or considerations, but they are all related to Schedule 1 and its purpose. More specifically, from the onset, the regulators have always stated they would like a way to make sure that the GCC includes all of the entities included in Schedule Y. Said differently, as drafted today, the Schedule 1 requires all entities to be listed in the Schedule Y, thereby providing that starting point the regulators requested. However, the instructions do provide one exception, and that is for Schedule A and BA entities, since those entities are already reflected in the RBC, and they don’t result in double counting of capital. Instead, these entities are listed in the Q&A tab, thereby having the effect of keeping the Schedule 1 cleaner, but still allowing a way for the regulator to reconcile back to the Schedule Y if they chose to do so. The question is whether similar exceptions in Schedule 1 should be provided for other entities. This would be for simplicity and to allow the regulator to focus on the entities more easily in the group on that matter. NAIC staff welcomes input on these considerations. The following presents such types of entities to the Working Group in a way to see if they would like a different approach:

a. **Other entities included in the RBC** The GCC does not require non-insurance/non-financial entities to be destacked, but they are required to be included in Schedule 1 and certain limited information included in the Inventory. The question is whether a listing of these entities could be included in the Q&A similar to the Schedule A and BA entities. The idea being that would keep the Schedule 1 cleaner, but for anyone wanting to reconcile back to the Schedule 1, they could do so with the listings in the Q&A. The NAIC raises this issue in case the current approach results in confusion by the preparer, or even for the reviewer since the inventory does not include any calculated capital amounts for these entities.

b. **Consideration of Entities “Not material” or “Excluded” from the GCC ratio** The GCC currently requires the group to list out its entities on Schedule 1, then mark each as either “Included” or “Excluded” for the purpose of calculating the GCC ratio. Specifically, for those that do not meet the GCC definition of material, the entity can “Exclude” them, however they have to be marked as such. The regulator then reviews the same listing and determines for themselves if each entity should be “Included” or “Excluded”. It’s likely that in the majority of situations, once a regulator determines an entity may be “Excluded” from the ratio, that they will likely be excluded in the future. This is based upon the fact that the general reason for exclusion tends to be driven by the nature of the entity and its risks, and not its size.
However, to clarify, not all entities that are once approved to be excluded always will be, and for that reason there will be a continued need for the GCC to provide information that allows the regulator to decide whether they can be excluded. The question is whether such information could be different than what is provided in Schedule 1, and, if so, whether perhaps such information could be reported elsewhere (e.g., Q&A tab). This would reduce the number of entities on Schedule 1 and perhaps help the regulator to focus on material entities in that schedule. The NAIC raises this issue for two reasons; 1) whether a different approach would allow for a more efficient review of the GCC by the regulator; 2) whether the current approach results in confusion by the preparer.

i. **Sensitivity Analysis** There is currently a sensitivity analysis related to “Excluded” entities to help the regulator understand the impact of the excluded entities on the GCC. The question is whether this should be removed. To the extent these excluded entities were no longer included in the Schedule 1 and Inventory, this sensitivity analysis could not be calculated, again, suggesting the need for some type of information to still be captured elsewhere in the GCC.

### Instruction Only Changes

6. **Asset Managers** – The GCC currently considers asset managers as financial entities, and therefore subject to a factor of either 2.5%, 5.0%, or 10% of 3-year average revenue (same as other financial entities) based upon the material risk principles defined in Section II of the instructions. Some members of the industry have suggested that asset managers should instead utilize the regulatory capital standards imposed by the Financial Industry Regulatory Authority (FINRA). NAIC staff have always believed that while the base GCC requirements should generally remain the same as the principles under which they have been developed by the Working Group, it’s only natural that it evolves over time to carve out new factors for specific industry’s where a different factor can be supported. As it relates to the current GCC, this would include either specific financial entities having a different factor than those noted above, or potentially even for non-insurance/non-financial industries, a different factor than is used for all other non-insurance/non-financial entities. Additionally, perhaps more specific to the point, one of the GCC principles is that it defers to the specific capital requirements of the regulator of the entity, which in this case may include FINRA to the extent they have specific capital requirements. NAIC staff attempted to gather information on such requirements through the review of FINRA 15c3-1, but it was unclear how such capital requirements practically work as they seem to be more principle-based. NAIC Staff would recommend the Working Group consider such a request, but only upon deliverance of documentation, including examples, that enable the regulators to understand. This does not need to be a full presentation to the Working Group unless the members indicate such is
needed but could instead be full documentation and time for the Working Group to ask questions.
September 24, 2021

Mr. John Rehagen, Chair
Missouri Department of Insurance
Division Director – Financial Institutions & Professional Registration
NAIC Group Capital Calculation Working Group
Via e-mail: ddaveline@naic.org

Re: Comments on NAIC Group Capital Calculation (GCC) Procedures

Dear Mr. Rehagen:

The American Council of Life Insurers appreciates the opportunity to comment on the Proposed Group Capital Calculation (“GCC”) Procedures (hereafter the “GCC Process”). We appreciate the significant and thoughtful work that has gone into the GCC framework and the NAIC’s ongoing commitment to developing a GCC that is fit-for-purpose.

ACLI is generally supportive of establishing a clear procedure for amending the GCC template and instructions, however, we are concerned that the proposed 30-day exposure period for additions or amendments, may be sufficient for routine maintenance, but may not provide regulators, consumer representatives and the industry enough time to fully evaluate or provide meaningful feedback on GCC amendments that impact fundamental elements of the GCC, are complex or may have a significant impact on a group’s GCC results.1 For example, should the GCC amendment process be identical for both annual scalar maintenance and the adoption of a scalar methodology? We believe that there may be circumstances when the nature of the proposed amendment/addition to the GCC will merit additional vetting prior to adoption, and a longer minimum exposure period, than what is currently provided in the current exposure.

We respectfully recommend that the Working Group consider adopting an approach to GCC amendments that differentiates between additions or changes that are (1) routine annual updates or technical corrections or clarifications; and (2) those that fall outside of the bucket of “routine annual updates or technical corrections” and may impact a fundamental element of the GCC, are particularly complex, or impactful to GCC results. The Working Group could consider developing two parallel tracks for GCC amendments. One track could allow routine annual updates and technical corrections or clarifications to be exposed and adopted after a 30-day exposure, while all other amendments or additions would be subject to greater rigor and opportunity for review.

1 As we note later in our letter, a GCC amendment may not impact GCC results on the aggregate, across the industry or line of business, but it could significantly impact a particular group’s GCC ratio. We would consider both scenarios as “impactful.”

American Council of Life Insurers | 101 Constitution Ave. NW, Suite 700 | Washington, DC 20001-2133

The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 280 member companies represent 94 percent of industry assets in the United States.

acli.com
ACLI comment letter on the GCC Amendment Process
09/24/2021

We believe that this topic merits further collaboration and conversation among Working Group members and stakeholders to identify and define the type of amendments or additions that would fall into the second bucket (e.g., issues that are connected to a fundamental element of the GCC or especially complex or impactful). Below, we have preliminarily identified several changes to the GCC amendments that we believe may fall into the category requiring a more rigorous process for adoption:

- **Scalar methodology.** It is likely that the GCC’s ultimate scalar methodology will likely be incorporated into the GCC as an amendment to the template and instructions. Scalar methodology – as opposed to routine updates to existing scalars – is an illustrative example of the type of an amendment that should necessitate greater analysis and exposure than what is currently provided in the proposed GCC Process. Scalars are a fundamental feature of an aggregation method, like the GCC and they will be relatively complex. We believe the adoption of a scalar methodology should require a longer exposure period than what is contemplated as the acceptable minimum in the exposed GCC Process. Scalars are a foundational element of any aggregation method, and they are highly complex. Any proposed scalar methodology change or addition should require careful vetting, and potentially a charge from the parent committee. We recognize that routine scalar maintenance may not require an elevated level of scrutiny and in most cases, could be conducted under the proposed GCC amendment process.

- **Senior/hybrid debt limit.** The cap on the amount of senior or hybrid debt that counts towards available capital is another complex and meaningful area in the GCC that we believe will necessitate a more robust process than the exposure provides.

- **Treatment of non-insurance entities.** Because the treatment of non-insurance entities is a fundamental element of a group capital calculation, we believe that non-technical corrections or clarifications to the treatment of non-insurance entities would benefit from additional review and analysis prior to exposure and adoption.

These examples are not exhaustive – indeed, we encourage the Working Group to consider where and how to draw the line between routine updates and technical amendments, and the type of amendments that may warrant a more rigorous exposure period and analysis.

We wish to raise an additional concern that we believe weighs in favor of having a longer minimum exposure period, and that is the fact that the GCC will apply to a large universe of heterogeneous groups of varying sizes and business models. It is possible that a change that may appear negligible to one type of group – or even most groups – may have a much greater impact on another type of group. The true impact of proposed amendments may not be immediately apparent unless, and until, the larger universe of affected groups are afforded the opportunity to

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2 We understand that once the scalar methodology has been adopted, the NAIC will need to perform regular scalar maintenance. In general, we would differentiate between scalar methodologies and scalar maintenance. The adoption of scalar methodologies would require robust engagement with stakeholders prior to adoption. However, it is likely that scalar maintenance may, in some cases, be a technical update as data sets are updated. Whether scalar maintenance is a routine technical update may depend on the methodology selected.

3 The Academy reported that scalars had an inverse relationship between simplicity and validity – the simpler the scalar, the less accurate it is. See Aggregating Regulatory Capital Requirements Across Jurisdictions: Theoretical and Practical Considerations (Executive Summary), American Academy of Actuaries Research Paper 2021, No. 1, available at https://www.actuary.org/sites/default/files/2021-04/Scalars.ExecSummary.pdf.
ACLI comment letter on the GCC Amendment Process
09/24/2021

evaluate it and provide feedback on its impact. We encourage the Working Group to keep this in mind as they evaluate the proposed GCC amendment process.

In addition, we encourage the Working Group to consider if the proposed GCC Process would benefit from adding language or steps that would increase the level of review or consensus required before a GCC addition or amendment is formally approved for exposure. One way to do that could be to require some form of collective action or consensus of the Working Group or a charge from the parent committee prior to the exposure of certain amendments or additions to the GCC. This additional step may also enhance the stability of the GCC.

Conclusion

Thank you for the opportunity to provide these comments. As always, we would be happy to discuss them with you or your staff at your convenience.

Regards,

[Signature]

Mariana Gomez-Vock

[Signature]

Gabrielle Griffith
October 25, 2021

Mr. John Rehagen, Chair
Missouri Department of Insurance
Division Director – Financial Institutions & Professional Registration
NAIC Group Capital Calculation Working Group
Via e-mail: ddaveline@naic.org

Re: Comments on the NAIC Group Capital Calculation Working Group’s exposed referral to the Capital Adequacy (“E”) Task Force (“CADTF”)

Dear Mr. Rehagen:

The American Council of Life Insurers (“ACLI”) appreciates the opportunity to comment on the Proposed Group Capital Calculation (“GCC”) Procedures. We appreciate the significant and thoughtful work that the Working Group has exercised throughout the development of the GCC.

ACLI agrees that it is desirable to align the GCC, RBC and broader statutory accounting frameworks, where appropriate. In general, the GCC should reflect existing RBC and statutory accounting rules, rather than re-writing them. If the implementation of the GCC causes regulators, the NAIC, or other stakeholders to rethink existing RBC and statutory accounting treatment/rules, then we would expect that regulators would respect and use the existing RBC and accounting governance process to propose potential changes to those regulatory frameworks. Once alignment between the frameworks is achieved, we would expect that the GCC would, where relevant, pull inputs from statutory financial statements and RBC calculations, with CADTF consistency across RBC formulas.

Thank you for the opportunity to comment. We look forward to continuing to support the efforts of the Working Group and staff as work continues on other GCC elements, like scalar methodology. As always, we would be happy to discuss our comments, or any other issue, with you or your staff at your convenience.

Regards,

Mariana Gomez-Vock

Mariana Gomez-Vock
October 25, 2021

John Rehagen, Chair
Group Capital Calculation (E) Working Group
National Association of Insurance Commissioners

Re: Proposed Referral to the Capital Adequacy (E) Task Force

Dear Mr. Rehagen:

The American Property Casualty Insurance Association (APCIA) appreciates the opportunity to comment on the Group Capital Calculation (E) Working Group’s proposed draft referral to the Capital Adequacy (E) Task Force regarding potential changes to the various risk-based capital (RBC) formulas for the treatment of insurance company subsidiaries and financial entities. APCIA is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA members represent all sizes, structures, and regions—protecting families, communities, and businesses in the U.S. and across the globe.

APCIA broadly agrees with the goal of aligning factors for the GCC with the comparable charges in the RBC formulas, and we agree that the GCC and RBC should treat similar assets similarly. However, we believe it would be premature at this time to consider changing RBC charges to make them consistent with the GCC factors for subsidiary non-U.S. insurance companies and other financial subsidiaries. We are concerned that reconciling differences in the way these subsidiaries are treated in the P/C, life, and health RBC formulas would make this task unpracticable at this time.

Instead, over the first years of the GCC’s implementation, APCIA recommends that the Group Capital Calculation (E) Working Group work together with the Capital Adequacy (E) Task Force and its working groups to study how the GCC and RBC can best be aligned. This can involve consideration, for example, of whether to move certain entities out of covariance in RBC formulas to make treatment of those entities more aligned with the GCC’s. In addition, the GCC introduced a new high/medium/low-risk concept for the capital charges for some financial affiliates, and further study will allow more time to collect data and refine guidance concerning how these new differentiated charges are applied. Finally, we believe further study is warranted to assess the relevant differences in the P/C, life, and health RBC formulas and the reasoning for those differences, because this analysis will better inform the decision of how the GCC and RBC can best be aligned.

APCIA appreciates the Working Group’s efforts to begin consideration of aligning the GCC and RBC, and we look forward to a continuing dialogue as this process continues.
Please contact us if you have any questions, and we look forward to discussing our comments with you and the Working Group.

Sincerely,

Stephen W. Broadie
Vice President, Financial & Counsel
steve.broadie@apci.org

Matthew Vece
Manager, Financial & Tax Counsel
matthew.vece@apci.org
October 29, 2021

Dan Daveline, Director, Financial Regulatory Services, NAIC
By e-mail at: ddaveline@naic.org


Mr. Daveline:

This submission is on behalf of a group of eight interested parties (IP Group) and in response to the September 14, 2021, re-exposure by the Group Capital Calculation (E) Working Group (GCCWG). The re-exposure relates to proposed guidance about the Group Capital Calculation (GCC) that has been drafted for inclusion in the NAIC’s Financial Analysis Handbook (FAH) for eventual use by financial analysts of state insurance departments.

As you know, the IP Group provided many comments and marked text suggestions to the initial exposure of revisions to the FAH text through our written submission of July 31, 2021. Those comments and suggestions were intended to help clarify the text, and in some cases to address concerns of the IP group about how analysts might use the GCC or interpret GCC results inappropriately.

The IP Group is very grateful to now see that many of the comments and suggestions it submitted on July 31, 2021, have apparently been accepted by the GCCWG as seen in the text of the re-exposure. Consequently, as a group, we are more comfortable that the re-exposure text fairly portrays the GCC and how it should be appropriately used and interpreted by regulatory analysts.

Moreover, we would like to express our satisfaction with the level of engagement that we have enjoyed with NAIC staff and the GCCWG, the way in which the GCCWG’s deliberative and exposure processes were handled, and that we were provided ample time to consider the proposals and to comment in a thoughtful manner.

With that, and as the IP Group, we have no further comments on the re-exposure. We understand that some of the undersigned members of the IP Group may separately provide additional comments intended to clarify certain portions of the FAH text so as to further improve its clarity and readability for the benefit of analysts. We encourage you to consider their comments in the same thoughtful manner as was afforded comments submitted earlier by the IP Group as a whole.

Sincerely, and on behalf of the IP Group:

America’s Health Insurance Plans – Bob Ridgeway
American Council of Life Insurers – Mariana Gomez
American International Group, Inc. – Marty Hansen
American Property Casualty Insurance Association – Steve Broadie
Anthem, Inc. – Doug Wright
Blue Cross and Blue Shield Association – Joseph Zolecki
MetLife Inc. – Martin Mair
UnitedHealth Group – Jeff Martin
Via Email

10/29/2021

Dan Daveline
Director – Financial Regulatory Services
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106

Re: Draft Group Capital Calculation Regulatory Guidance and Analyst Reference Guide

Dear Mr. Daveline:

Liberty Mutual Insurance Company (hereinafter “Liberty Mutual”) appreciates the opportunity to comment on the Draft Group Capital Calculation Regulatory Guidance and Analyst Reference Guide. As you are aware, Liberty Mutual has been a strong supporter of the NAIC’s Group Capital Calculation (“GCC”) and supports the fundamental goal of enhancing group wide supervision, including the GCC provisions that will allow for assessment of capital adequacy of an entire group.

To that end, Liberty Mutual endorses the current version of the proposed guidance to be added to the Financial Analysis Handbook. The draft guidance is fully consistent with the NAIC’s overall goal that the GCC be used as an additional analytical tool for regulators to conduct group-wide analysis. Liberty Mutual particularly appreciates the inclusion of language throughout the proposal that makes clear the GCC was not designed to be a trigger for regulatory action.¹

Liberty Mutual also supports the draft guidance’s emphasis that the mitigation of potential issues regarding an insurance group’s GCC should be taken largely at the insurance company legal entity level, which is where regulatory capital is primarily located in an insurance group and where state insurance regulators have the most authority. Liberty Mutual also believe that the technical components of the draft guidance are prudent and that the five Procedural Steps,

¹ See, e.g., Draft Group Capital Calculation Regulatory Guidance at 2 (“Analysts should be mindful that any stated threshold in the following procedures is for analysis purposes only and DOES NOT constitute a trigger for regulatory action”).
October 29, 2021
Page -2-

subparts of those Steps, and the various Benchmarks associated with each step are reasonable and logical. Further, the proposal’s provisions that clarify that these technical components should not be used as a checklist, but rather as a guide that properly aligns the GCC with existing insurance supervisory measures, is appropriate and consistent with the underlying rationale of the GCC as analytical tool.

In conclusion, we urge the NAIC to move promptly to adopt this version of the draft guidance so that states may begin implementing the GCC promptly and effectively. Should you have any questions, I’d be happy to discuss them with you.

Sincerely,

Mark J. Sagat
October 26, 2021

Via Electronic Delivery

Mr. John F. Rehagen, Division Director
Division of Insurance Company Regulation
Missouri Department of Insurance
301 West High Street
Jefferson City, Missouri 65105

Attention: Mr. Dan Daveline

RE: NAIC Regulatory Guidance for GCC and Analyst Reference Guidance for the GCC exposed the Group Capital Calculation (E) Working Group

Mr. Rehagan:

State Farm Mutual® Automobile Insurance Company and its affiliates ("State Farm"), appreciate the opportunity to submit these comments concerning the exposed draft of the NAIC Regulatory Guidance for GCC and Analyst Reference Guidance for the GCC via the Group Capital Calculation (E) Working Group (the “Working Group”). State Farm has been providing comments throughout the creation of the aggregation-based method of calculating capital for insurance groups under the National Association of Insurance Commissioners ("NAIC") and U.S. Federal Reserve Notice of Proposed Rulemaking under a similar process.

State Farm appreciates the edits to address most of our previous stated concerns with both the Regulatory Guidance for GCC (Regulatory Guidance) and Analyst Reference Guidance for the GCC (Analyst Reference) documents. Additionally, State Farm wants to express the openness and discussion on these topics with Mr. Daveline and all of his efforts on this project. However, there are few more areas of clarification or concerns within the documents that are discussed below and in that attached documents with comments.

The focus of State Farm’s comments and concerns are around the documents’ expression of group capital, group action and group risk. As expressed previously, the construct of “group” does not have legal entity status and as such does not hold, generate or distribute capital. Furthermore, the risk is faced by the legal entities that make up the group. As a result, the GCC is not calculating the “total available capital” for the group but is calculating the aggregated capital held by the legal entities that make up the group with capital still held by the individual...
legal entities. As noted previously the aggregation-based method of calculating capital for insurance groups or the GCC recognizes that the capital is legally owned by the individual entities that are being aggregated by utilizing the regulatory capital regime when one is available to establish the entity’s capital for the purposes of aggregating. The application of the GCC does not change underlying legal process that the entities operate under or change the legal obligations of the individual entity.

Finally, State Farm is still concerned that the Regulatory Guidance and Analyst Reference documents are not recognizing the “walls” in place in insurance regulations as well as the applicable non-insurance laws of the United States or the existing body of insurer regulatory financial surveillance by not fully recognizing the limitations of risk obligation transference among members of a group, particularly those that are insurers and not acknowledging that surplus held by an insurer in a group is not readily available by any other member in the group. In fact, the maintenance of the walls aspect of the current regulatory scheme would be aided by the GCC process by identifying the entities within the group that are identified as holding or generating risk which then the regulators could monitor transactions of the regulated insurance entities with the at risk entity to ensure that the risk is not somehow transferred or transferred in manner that inappropriately places risk on the regulated insurer.

Hopefully this provides the basis for the background of the comments provided in the draft Regulatory Guidance and Analyst Reference that are enclosed.

Thank you for your time and consideration in this project and to our comments. If there are any questions concerning the comments, please contact me.

Sincerely,

Chuck Feinen
State Farm Mutual Automobile Insurance Company

Enclosures
Review of the Group Capital Calculation

Consideration of the Insurance Holding Company System Structure

As the lead state begins to review the annual Group Capital Calculation filing for a particular group, it is important for the lead state to do so with consideration of the existing knowledge of both the organizational structure of the group, including changes in the structure from year to year, but more importantly the overall activities of each of the entities in the group which otherwise have the potential to transmit material risk to the insurers within the group. While the GCC will provide additional quantitative information on the entities in the group; the actual activities of the entities are also important in determining the scope of application of the GCC. The lead state is responsible for determining if any of the entities in the holding company structure should be excluded from the calculation, and therefore a smaller “scope of application” for the entities included in the GCC ratio. The filing includes a column for the group to propose what should be excluded as well as an additional column for the final determination made by the lead state. In general, the determination of scope of the application is suggested by the group but made in consultation and agreement with the lead state. This exercise should be undertaken in a manner that yields a clearly documented rationale for excluding entities or subgroups of the larger group. The Group Capital Calculation Instructions describes the basis for making this determination and the calculation itself is structured to facilitate this determination, with the inclusion in Schedule 1 of the calculation of financial data for all entities within the holding company. Similar to exclusion from the calculation itself is review of data for cases in which subgroups are completely excluded from the larger group, particularly with regard to Schedule 1; the rationale for the exclusion(s) should be provided in the GPS. The concept is that this Schedule 1 data should be utilized by the lead state in conjunction with its existing knowledge of the group and its activities (obtained from the Schedule Y, ORSA, Forms B/C, Form F, the non-insurance grid, etc.), and therefore likely material risks, to make this determination. To the extent the entities included in Schedule 1 differ from the analyst’s knowledge of the Group, further discussion and follow-up should be held with the group.

In the initial year(s) of a GCC filing, to help the analyst get comfortable with the Inventory and Schedule 1 process, consider the following:

- Gather appropriate background information for your group(s) (e.g., Group Profile Summary, ORSA, RBC Reports, Schedule Y). (Consider adding a review of the most recent financial examination(s) of the insurance entities within the group.)
- Determine that all Schedule Y entities are listed in schedule 1 or - in the schedule BA list in the other information tab or that an entity’s omission is understood / explained.
- Evaluate requests for exclusion of non-insurance/ non-financial entities w/o material risk to determine if you agree with exclusion.
- Confirm that all insurers and financial entities are de-stacked in the inventory tab.
- Determine if grouping has been properly applied.
- Evaluate level of risk assigned by filer to financial entities w/o regulatory capital requirements.
- Test check that the numbers reported in Schedule 1 and Inventory Tab look reasonable, especially for the insurers. A sample check should be sufficient.

The holding company structure and activities should also be utilized by the lead state in determining how to understand the GCC ratio. More specifically, information on structure can impact the flow of capital used by the group to make decisions on how to utilize resources among entities within the holding company structure. Therefore, understanding the following can assist in evaluating the flow of resources:

- Domestic insurance operations
- International insurance operations
- Banking or other financial services operations subject to regulatory capital requirements
• Financial and non-financial operations not subject to regulatory capital requirements*
  
  *The GCC instructions provide examples of financial versus non-financial entities in this category. All financial entities should be included in the scope of application of the GCC. However, there can be a broad array of entities that could be considered financial. The lead state should document the rationale for cases in which it concludes that an entity that may be financial in nature cannot be classified in the group’s GCC filing as “non-financial” and thus excluded from the scope of the group of the GCC.

  The GCC is intended to be used as an input into the GPS. The expectation is that the GCC summary section will help to document a high-level summary of the analyst’s take away of the GCC, as well as the Strategic branded risk. The manner in which the analyst determines what else should be documented beyond the GCC Summary and the Strategic branded risk should be based upon the following steps, since these steps contemplate the previously mentioned concept that the existing evaluation of the financial condition should be used in evaluating the depth of review of the GCC.

  In as much as the GCC is a new analytical tool for use by regulators and that it will take a number of years before there is both (1) sufficient data for any given group to provide the trend identification ultimately anticipated for the GCC, and (2) experience by regulators with its use. Analysts should be mindful that any stated threshold in the following procedures is for analysis purposes only and DOES NOT constitute a trigger for regulatory action. Rather, the stated threshold should be used as an opportunity for an analyst to understand issues and concerns that may be emerging and address them with the group, if needed. Nonetheless, the following procedure steps provide analysis with a framework to consider the GCC results in conjunction with other data and tools at their disposal, and to begin to gain and benefit from experience in utilizing the GCC as a new analytical tool.

  • Procedure Step 1 suggests that a review of the components of the GCC is appropriate when the GCC ratio is trending downward.

  • When Procedure Step 1 identifies the need to look further, Procedure Step 2 suggests from a high level determining the drivers of any decreases in the total calculated available capital pursuant to the GCC. While there are numerous benefits of the GCC over consolidated approaches, the ability to drill down on the drivers is one of the more significant and is consistent with the states approach to not just looking at capital, but to the drivers of capital issues.

  • When Procedure Step 1 identifies the need to look further, Procedure Step 3 suggests from a high level determining the driver of any increases in operating leverage, which is typically what drives insurance capital requirements up, be it asset risk/leverage or writings leverage. Similar to drivers of capital decreases, the GCC has detailed information on financial figures and ratios that can be used to isolate the issues.

  • When either Procedure Step 2 or Step 3 identify the need to understand better, Procedure Step 4 is similar in that it too utilizes detailed information on capital allocation patterns used by the group over time that are necessary for the analyst to understand if there are any future negative trends in the GCC.

  • When Procedure Steps 2, 3 and 4 identify the need to understand better, Procedure Steps 5, depending upon the analysis performed in previous Steps, is similar to legal entity analysis, where there is likely a benefit for the evaluation need to request determine what steps the group/company is already taking or plans to take in order to address the issues they feel are appropriate, if any. The analyst should also consider the Risk Based Capital position(s) of the insurance entity in the group to help in the evaluation of the issues identified. The guidance provided in these procedures is not intended to be exhaustive, but rather should give the analyst a starting point in better understanding the various issues.

  • If the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document their understanding of the material risks of the group observable from the GCC (as well as the required information to be included in all GPS from the GCC), this should be documented by the analyst in any workpapers deemed appropriate by the state and include the general
reason, therefore, In making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner and judgment based upon and existing understanding of the group and existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that decision.

**Procedure Step 1 - Understand the Adequacy of Group Capital**

1. Determine if the group capital position presents a risk to the group and its insurance subsidiaries based upon its recent trends and/or current measures in the GCC ratio.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Has there been a decrease in the GCC ratio over last two or more years? If “yes”, determine the cause(s) of the decline.</td>
<td>ST</td>
</tr>
<tr>
<td>b. Has there been a decrease in the GCC Total Calculated Available Capital from prior year? If “yes”, determine the cause(s) of the decline.</td>
<td>ST</td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d. Has there been a negative trend in the GCC ratio over the past five years suggesting an overall pattern of declining capital?</td>
<td>ST</td>
</tr>
</tbody>
</table>

If the answer to any of the above questions is “yes”, it is obvious that either the negative trend is caused by something such as the allowable debt, a change in a corporate tax rate, or some other non-indicator of negative trends, note as such but do not proceed to step 2. In addition, if it is obvious that the negative trend is clearly driven from one entity in the group, understand the cause and document as such but do not proceed to step 2. However, in all other cases if the answer to any of the above questions is “yes”, the analyst should proceed with procedure step 2, understanding decreases in total calculated available capital and/or procedure step 3, understanding increases in leverage to determine the cause(s) of the negative trends.
### Procedures Step 2 - Understand Decreases in Total Available Capital

2. Determine the source(s) of decreases in the GCC ratio or the GCC Total Available Capital

Recognizing that not all declines in capital ratios are necessarily "negative", i.e., they may be the result of sound capital management and ERM to more efficiently utilize capital, approved changes in the scope of application, or changes in underlying authority requirements, the intent of step 2 (and step 3) is to determine the actual source of the negative issues. In most cases, this equates to pinpointing the legal entity(ies) driving any negative trends. However, unless obvious from the information obtained in step 2, the analyst should proceed to step 5, using an understanding of items in Procedure Step 4, to understand more fully the actions the group, or the legal entity(ies) driving the negative trends already being taken or planned to be taken by the group to address the issues identified in step 2 that the group believes is needed. However, the analyst may already have a deep understanding of any such plans, and as a result, in some cases, it is possible that no further follow-up with the group will be necessary and that the lead state should simply update the GPS to be certain the main understanding of the issues is known to all of the regulators utilizing the GPS.

<table>
<thead>
<tr>
<th></th>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Review the ratio of available capital to calculated capital from each of the reported entities and compare to the same ratio from the prior year. Determine which entities may have led to the negative trends.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>If the change in the GCC is not driven from a legal entity, and instead the change in allowable debt, note as such.</td>
<td>ST</td>
</tr>
<tr>
<td>c.</td>
<td>Review the levels of profitability for each of the reported entities in the GCC in the current and prior years (as reported in the GCC) to determine if there are particular entities showing signs of decreasing profitability which may eventually lead to losses and future decreases in the GCC ratio or total available capital.</td>
<td>OP, PR/UW</td>
</tr>
<tr>
<td>d.</td>
<td>For each of the reported entities showing either 1) a meaningful decrease in the GCC due to a decrease in the total available capital, or 2) negative profitability trends, request information that identifies the issues by inquiring of the legal entity regulator first or the group itself (e.g., non-insurance company), if applicable.</td>
<td>OP, PR/UW, ST</td>
</tr>
<tr>
<td>e.</td>
<td>If due to pricing or underwriting issues, understand if the issues are the result of known pricing policies that are currently being modified or if the business is in runoff, recently identified products where metrics can quantify the issues whether new product lines, or geographic or other concentrations, volume/growth business strain, or other issues. When considering pricing that is being modified, include those products for which the price is adjusted through crediting rates.</td>
<td>PR/UW</td>
</tr>
<tr>
<td>f.</td>
<td>If due to reserve issues, understand the reserve development trends, whether reserve and pricing adjustments have been made as well as changes in business strategy apart from those products.</td>
<td>RV, ST</td>
</tr>
</tbody>
</table>
### Procedure Step 3—Understand Increases in Operating Leverage

3. Determine the source(s) of any decreases in the GCC ratio due to increases in leverage

Like step 2, the intent of step 3 is to determine the actual source of the negative issues. The difference between step 3 and step 2 is simply the types of issues. Step 2 is focused on issues that have resulted in negative capital

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Analysts</th>
</tr>
</thead>
<tbody>
<tr>
<td>g.</td>
<td>If due to market risk issues—i.e., capital losses—understand not only why the losses occurred, but the likely near-term impact given current and likely prospective economic conditions. Market issues include not only changes in equity prices, but also impact/exposure to interest rates and other rates such as foreign currency exchange rates or rates on various hedging products used by the group.</td>
<td>MK, CR</td>
</tr>
<tr>
<td>h.</td>
<td>If due to strategic issues such as planned growth, planned decline in writings or changes in the investment strategy, utilize the business plan from the Form F to better understand the anticipated changes and how the actual changes compare. Understanding the variance from the business plan is important in assessing the ongoing risk either in projected future profitability or in some cases the investments.</td>
<td>ST, PR/UW, OP</td>
</tr>
<tr>
<td>i.</td>
<td>If due to negative reputational issues, for example, have adversely impacted new business or retention of existing business, understand the issues more closely, whether potential ongoing changes in stock prices or financial strength ratings that may further impact market perception, or what the group is doing to address the potential future impact be it sales projections or access to the capital markets.</td>
<td>RP</td>
</tr>
<tr>
<td>j.</td>
<td>If due to credit losses, understand the current and future concentration in credit risks, be it investments, reinsurance, or other source of credit losses.</td>
<td>CR, MK</td>
</tr>
<tr>
<td>k.</td>
<td>If due to operational issues, such as extremely large catastrophe events, IT or cybersecurity events or relationships, understand the current and prospective impact.</td>
<td>OP, ST</td>
</tr>
<tr>
<td>l.</td>
<td>If due to legal losses, understand the underlying issues and degree of potential future legal losses.</td>
<td>LG</td>
</tr>
<tr>
<td>m.</td>
<td>If due to non-insurance reported entities in the group, understand the relationship of the non-insurance operations to the insurance entities and the potential impact to the insurance operations (i.e., intercompany agreements, services, capital needs, etc.).</td>
<td>ST, OP</td>
</tr>
<tr>
<td>n.</td>
<td>If due to a decrease connected to a regulated insurance entity, the analyst should review the Risk-based Capital (RBC) to determine if the decrease triggers regulatory action and if not, the analyst should note this information in the GPS.</td>
<td>—</td>
</tr>
</tbody>
</table>

**Commented [CP1]:** With the understanding that RBC is not definitive and there is more information to review and consider, the RBC is part of the “windows and walls” approach to the solvency regulation information concerning the regulated insurance entity should be included in GPS.
trends. Step 3; however, is focused on the issues that impact the risk being evaluated measured in the GCC. In most cases that risk is from the insurers and either from the asset side or from the liability side where in both cases there has been an increase in such risk that has not been offset by a corresponding or equal increase in capital. In general, this is referred to as operating leverage, where this risk can manifest itself either through increased insurance writings (e.g., the ratio of premiums to capital or liabilities to capital), or through increased assets that also carry risk. The expectation is that other regulated entities also have capital requirements that increase as these different types of risks increase, similar to how the NAIC RBC considers different types of products and assets that carry more risk. However, it is possible to have increased leverage outside of the insurance companies through for example increased exposure, which can manifest itself through increased liabilities or through increased assets. However, similar to other items noted in this document, such increases do not necessary represent negative trends, rather simply things the analyst may need to further understand the drivers of such. In most cases, this equates to pinpointing the legal entity(ies) driving any negative trends. Similar to step 2, using an understanding of items in Procedure Step 4, to understand more fully the actions the group, or the legal entity(ies) driving the negative trends already being taken or planned to be taken by the group to address the issues identified in step 2 that the group believes is needed.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>a.</td>
<td>Review the ratio of available capital to calculated capital from each of the reported entities and compare to the same ratio from the prior year. Determine which entities may have led to the negative trends based upon corresponding increases in leverage (e.g., writings/capital ratios or liability to capital ratios).</td>
<td>MK, CR, RV, ST, OP, RP</td>
</tr>
<tr>
<td>b.</td>
<td>Review the levels of operating leverage for each of the reported entities in the GCC as well as the same for the prior years as reported in the GCC to determine if there are particular entities showing signs of increasing operating leverage which may lead to future decreases in the GCC ratio or total available capital.</td>
<td>MK, CR, RV, ST, OP, RP</td>
</tr>
<tr>
<td>c.</td>
<td>For each of the reported entities showing a meaningful decrease in the GCC due to an increase in operating leverage, request information that identifies the issues by inquiring first from the legal entity regulator or the group itself (e.g., non-insurance company), if applicable.</td>
<td>MK, CR, RV, ST, OP, RP</td>
</tr>
<tr>
<td>d.</td>
<td>If operating leverage has increased, consider if growth may have resulted from underpriced products or a change in underwriting. Specifically inquire to determine if pricing was reduced to increase sales, or whether the growth is in new product lines or new geographic focus where the group may not have expertise. When considering pricing being modified, include those products that the price is adjusted through crediting rates.</td>
<td>PR/UW, OP, ST</td>
</tr>
<tr>
<td>e.</td>
<td>If operating leverage has increased, consider if reserving risk has also increased, through potential underpricing that ultimately manifests itself into reserve adjustments. To do so, obtain current profitability information on the products leading to the increased leverage.</td>
<td>RV</td>
</tr>
<tr>
<td>f.</td>
<td>If operating leverage has increased, obtain current information on the asset mix to be certain that there is a corresponding</td>
<td>CR, MK</td>
</tr>
</tbody>
</table>
decide in riskier assets to mitigate the otherwise likely increase in market and credit risk.

g. If due to a decrease connected to a regulated insurance entity, the analyst should review the Risk-Based Capital (RBC) to determine if the decrease triggers regulatory action and if not, the analyst should note this information in the GPS.

Unless obvious from the information obtained in step 3, the analyst should proceed to step 5, using understanding of items in Procedure 4, to understand more fully the actions being taken by the group, or the legal entity(ies) or planned to be taken by the group or planned to be taken by the group to address the issues that the group believes is needed, if any. However, in some cases, it is possible that no further follow up with the group will be necessary, and that the lead state should simply update the GPS to be certain issues are known to all of the regulators utilizing the GPS.

Procedure Step 4: Understand the Capital Allocation Patterns

4. Determine the capital allocation patterns to determine if some entities may put pressure on other legal entities.

Steps 2 and 3 are critical in understanding the issues faced by the group and in identifying the source of negative trends; and while additional follow up with the group is expected, before proceeding to Step 5, the lead state should understand the historical capital allocation patterns taken by the group or the likely future needed capital allocation patterns that may be needed by the group if negative trends continue. The GCC includes data on historical capital allocation patterns (e.g., contributed capital received/paid or dividends received/paid), which help to illustrate which entities have historically needed more capital and which entities have capital that they have provided other entities in the group in the past. While these patterns do not necessarily repeat themselves from one period to the next, there is often consistency in terms of entities that need capital or have excess capital, which may or may not be driven by losses, or by a change in strategy (e.g., increased writings at one company over another) by the group. These trends can also assist in discussions with the group about where capital may come from as a result of a future unexpected material event. Where similar information is also disclosed in Form F, the detail in the GCC may confirm what is already known by the analyst in this area and in some cases may provide greater detail.

<table>
<thead>
<tr>
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<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Review the underlying data from the GCC Analytics tab to determine the historical capital allocation patterns within the group and summarize the result of this analysis</td>
<td>ST</td>
<td>N/A</td>
</tr>
<tr>
<td>b. Using this data, as well as any recent information on net losses, or likely expected funding, determine if there may be an impact on the capital available to the insurance entities (either through the likelihood of higher dividends or through less capital being available for infusions and to fund future possible losses from other entities in the group and potentially become troubled themselves, regardless of the current capital in excess of RBC requirements)</td>
<td>OP, ST</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Procedure Step 5 - Consider the Need for Company Discussions for Reductions in Risk

5. Determine the group’s plans for addressing source(s) of any meaningful decreases in the GCC ratio or total calculated available capital. Please note, in some cases, the plan may be as simple as actions designed by the group to reverse a single negative trend.

Steps 5 is designed to assist in understanding the group’s plans for addressing any meaningful decreases in the GCC ratio or total available capital that are not otherwise already planned by the group (i.e., that are not the results of capital management so as to efficiently utilize capital while still maintaining sufficient levels for Enterprise Risk Management needs). The specific plans of the group may or may not fully address all the issues but to the extent the group believes they have addressed what is needed, ultimately what is most important is that such information and the regulators plan for evaluating and monitoring the situation is known to the other regulators. There is a multitude of possibilities, and this guidance is not intended to address all of those. This includes the multitude of possibilities by the group and its legal entities and the ultimate results. This also includes the multitude of possibilities to be taken by the legal entity regulators of the legal entities, including the fact that in some cases some regulators may choose to put their legal entity into some type of supervision, conservation, or some other form of receivership which, by necessity and intent, would presumably be done based upon existing legal entity authority since there is no authority provided under the GCC and not the group’s GCC. Similar to other areas, where similar information is also disclosed in Form F, further information may already be known in this area.
### V1.H. Group-Wide Supervision — Group Capital Calculation (Lead State) Procedures

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Obtain a copy of the most recent business plan and compare it to the prior year plan for variances. (See Additional Procedures below for additional follow-up analysis)</td>
<td>ST</td>
</tr>
<tr>
<td>b. Request information from the group or individual legal entities on how it intends to address the issues or negative trends (those that are not planned or due to approved changes to the GCC scope of application or the result of changes in underlying legal entity capital requirements) identified in Steps 1-3, if any. More specifically, determine how the group intends to decrease risk, and by what means, if any.</td>
<td>ST</td>
</tr>
<tr>
<td>c. Based on information received in S.b., determine the group’s capacity to reduce risks or raise additional capital.</td>
<td>ST</td>
</tr>
<tr>
<td>d. If the decrease in GCC does not warrant action, Where the remaining capital is adequate, document the findings in the GPS (or another document) and make available to the supervisory college and or domestic states with the presumption no further action is deemed necessary.</td>
<td>ST</td>
</tr>
<tr>
<td>e. Consider whether the collective information suggests that any of the U.S. legal entity regulators should deem the legal entity to be in a &quot;Hazardous Financial Condition&quot; and take appropriate action to address based upon the facts and circumstances and the provisions of the state’s law (similar to NAIC Model 385).</td>
<td>N/A</td>
</tr>
<tr>
<td>f. Where appropriate, consider holding a meeting of the supervisory college or of all the domestic states to fully understand the group’s plans. Where appropriate, request that the group present its plans to the supervisory college or all the domestic states, if any.</td>
<td>N/A</td>
</tr>
<tr>
<td>g. Where appropriate, determine if the plans proposed by the group are considered inadequate by any of the legal entity regulators, and more specifically if any are considering taking action over their applicable legal entity. If this is the case, hold a meeting of the supervisory college or of all the domestic states to provide this information.</td>
<td>N/A</td>
</tr>
<tr>
<td>h. Where appropriate, consider holding a broader meeting of all impacted jurisdictions in which entities of the group were selling insurance. Where appropriate, require the group to present its plans to all such regulators and for the regulators to announce their plans.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Purpose of the Group Capital Calculation (GCC) in Holding Company Analysis

The following information is intended to provide background and context concerning the issues/considerations for analysts when utilizing the NAIC Group Capital Calculation (GCC) for an insurance holding company group (hereafter referred to as “group”) completing the GCC where required. The GCC is a “tool” to quantitatively understand the group’s capital and the mathematically calculated risks within. The GCC framework is built on the RBC model; however, while the RBC has triggers with states’ laws to make formal actions as a capital requirement, the GCC is not designed with that purpose and is instead designed as an analytical tool.

Background Information

In 2008, the NAIC Solvency Modernization Initiative (SMI) began to consider whether there were any lessons learned from the financial crisis that would cause the solvency framework to be modified. The NAIC determined that changes should be made in the area of group supervision, starting with the new annual requirement for the Lead State of each group operating in the U.S. to complete a written holding company analysis. Since that time, other changes to state laws have been made to further enhance group supervision (e.g., Form F, ORSA, and Corporate Governance reporting). All of these new tools are inputs into the previously mentioned holding company analysis, which is now summarized into a consistent tool used by all states that is known as the Group Profile Summary (GPS).

Benefits of the GCC & Methods to Achieve Them

The Group Capital Calculation Instructions describes the background, intent, and calculation for the GCC in detail. As stated in the Group Capital Calculation Instructions, the GCC and related reporting provides more transparency about a group’s structure and related risks to insurance regulators and makes those risks more identifiable and more easily quantified. In this regard, this tool is intended to assist regulators in better understanding the risks that the non-insurance entities may pose to the group and ultimately regulated insurance entities. How capital is distributed across an entire group, and whether and to what degree insurance companies’ capital may be put at risk from the operations of non-insurance entities, potentially undermining the insurance company’s financial condition and/or placing upward pressure on the insurers in the group. An analyst is not expected to understand non-insurance industries represented within the group but is expected to understand through this calculation if a non-regulated entity could place pressure on or provide relief to a regulated entity.

The manner in which the GCC achieves some of these benefits or points varies. For example, with regard to understanding how capital is distributed across an entire group, this can be seen in two ways. One, is by viewing the tab titled “Input 4-Analytics” in the display of the “Ratio of Actual to Required Capital”. Two is by viewing the same tab and in the display of “Required Capital” in a separate column. The degree of subsidization can also be seen in the “Input 4-Analytics” tab, with the display of the columns as follows: 1) Capital Contributions Received/(Paid); 2) Net Income. While one year of information can show this exists, most will not be seen until after further years of the GCC are reported within the template. Once at least five years of data are displayed in this "Input 4-Analytics" tab, it will allow the analyst to better understand the financial condition of the group as a whole as well as the risks posed by non-insurance entities in the group. Of course, such conclusions can only be made once the analyst sees the data and understands from the group what is occurring that is leading to such figures.
Recognizing that legal entity supervision and related tools (e.g., RBC) is the primary means to address inadequate capital, the GCC may provide an additional early warning signal to regulators regarding risks or activities of non-insurers within the group that may pose material risk to the insurance operations. This early warning signal can be seen with the trending of the financial information in the “Input 4-Analytics” tab as well as through the application of sensitivity analysis in the Input 5 Tab and inclusion of other relevant information in the Input 6 Tab. However, the analyst should also understand that other “qualitative tools”, such as the Form F, are capable of also providing early warning signals if properly reported by the group. In addition, since most holding company systems may have a larger percentage of their operations in the insurance businesses, the insurance trends for the U.S. insurers in the group should already be known and made available to the lead-state by the legal entity regulator of the insurer(s). However, in the context of added policyholder protection, this may largely come into play with respect to the added quantitative data from non-insurers.

The GCC is an additional reporting requirement but with important confidentiality protections built into the legal authority to require such reporting. State insurance regulators already have broad authority to take action when an insurer is financially distressed, and the GCC is designed to provide regulators with further insights to allow them to make informed decisions on both the need for action, and the type of action to take as to a regulated insurance entity. That said, the GCC and its related provisions in the NAIC’s Model Holding Company Act and corresponding regulation are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group’s GCC. Regulators will use other existing tools and authorities to take action, primarily at the legal entity level.

While the new information from the GCC may offer new insights, it is equally important to understand that it will be up to the analyst to work with the insurance group to actually understand what is leading to the figures reported in the GCC, and from that perspective, especially in the early years of the GCC, it will require learning by both the analyst and the group to really be able to utilize the GCC in a manner as suggested in these introductory paragraphs.

Other Considerations When Considering Such Benefits

Unforeseen events and economic conditions (e.g., pandemic, recession, etc.) may also create stresses on a group, reinforcing the value of the quantitative data included in the GCC. Some stresses are similar to those experienced during the financial crisis and others are more unique. However, because the GCC is based upon a methodology that gets its inputs from individual legal entities, the capital calculated for each legal entity certainly can only capture the allowed capital resources of the legal entities in the group. While such an aggregation-based methodology is an appropriate group-level capital measure, until experience is gained with the GCC, it is not known as to how the GCC will behave in response to business cycles and various risk events, in part because it only recognizes limited diversification benefits among entities in the group except for the diversification embedded in existing entity specific regulatory capital requirements. And while the GCC is not meant to be used in a way that compares groups to each other, it is also true that it is unknown how it will behave across groups, peers and even sectors. This is true because of its limited diversification benefit, the differences between group types (mutual v. stock holding company), grouping of entities, and scope of entities included in the calculation. It is also true because application of jurisdictional accounting principles and use of scalars could have an impact on this as well via the foreign insurer profile of the group. The quantitative data collected in the GCC will evolve as state insurance regulators and, groups increase their understanding of the impact on available capital and calculated capital.

Commented [CF1]: Regulatory action should be on the legal entity level.

Commented [CF2]: How are these terms defined? Is “available capital” the same as total available calculated capital done under the GCC process? If so, what is “calculated capital”?
The following guidance on the GCC is intended to be utilized in a manner that allows the GCC to enhance group-wide financial analysis and to be used as an additional input into the GPS. The GCC provides the quantification of risk within the group and when combined with the information from the ORSA on the amount of capital needed to run the company’s current business model, puts the regulator in a much better position to understand the available capital and calculated capital within a group, as well as the financial condition of the group. Both are complimentary tools to each other. The ORSA provides management’s internal approach to capital management and an understanding of the economics of the group. The GCC provides a standard model that can better enable the analyst to understand where the entire group stands with respect to existing legal entity requirements as well as broad measures of risk for non-insurers. Analysts should be mindful of the differences between the ORSA and the GCC. For example, in the case of a group with predominantly U.S. operations, the GCC will largely be based on the standard model/RBC of the U.S. subsidiaries. However, the ORSA is not constrained by a standard model and will reflect management’s internal approach to capital management and may utilize or benefit from an economic capital model, other internal models, stress testing and other means. As a result, while the GCC is an additional input into the GPS, it may provide data and signals that don’t align with the risk measures within the ORSA.

Overall Theme of Remaining Guidance

The previous information describes the purpose for considering the GCC within the context of the states holding company analysis and corresponding GPS. In general, the remainder of this guidance provides more depth to the specific information included in the GPS; provides the analyst with a basic understanding of the GCC including why the entities included within the GCC may be a subset of those entities that are within the holding company structure; whether the trends within the GCC suggests questions should be raised with the group’s management to understand; whether the underlying data suggests trends exist that should likewise suggest questions should be raised with the group or with the respective legal entity’s supervisor; whether the information in the GCC filing is generally aligned with other information available to the analyst, and if not, why not, and whether that evidences other questions or concerns that should be addressed, or how they may already have been resolved. Notably, the purpose of the GCC is NOT to trigger regulatory action. Thus, even though the GCC is intended as a group-wide measure and provides insights as to capital adequacy and risks across the group, any regulatory action would have to result from other information made available to the regulator and based on legislative authority.

Utilization of the Group Capital Calculation in the Lead State’s Responsibilities

The lead state is responsible for completing the holding company analysis and documenting a summary of that analysis in the GPS. The depth and frequency of the holding company analysis will depend on the characteristics (i.e., sophistication, complexity, financial strength) of the insurance holding company (group) system (or parts thereof), and the existing or potential issues and problems found during review of the insurance holding company filings.

Similarly, in the analysis of the GCC, the depth of the review in the “five-step process” and specific inquiries will vary based on each group’s unique and situation. For example, in some groups, very little if any work (inquiries of the group) will be done after the first step due to generally positive trends of the ratio over time. While in other groups, the analyst may need to proceed through each of the five steps. Exactly how the analyst proceeds through the guidance will be dictated by a multitude of factors and requires judgement and as a result, the steps...
and sub procedures should not be used as checklist, but rather as a guide in how to utilize the GCC to increase the analysts understanding of the group.

GCC Construction That Also Impact its Utilization and Review

Some decision points may be addressed prior to the submission of a GCC template. These include: the scope of application (e.g., whether segments of the holding company system (group) should be excluded for financial conglomerates); whether a limited filing will be allowed (as permitted in Model Law #440 and Model Regulation #450); and whether subgroup reporting (as defined in the GCC instructions) of a foreign insurance group will be required. In general, the analytics provided by the GCC will be similar for all entities included in the template. (See the Primer on the Group Capital Calculation Formula) at the end of this section to better understand these points.

These factors are also a consideration in determining the depth of the analysis of the GCC and subsequent correspondence with the group. Refer to chapter VI.B. Roles and Responsibilities of Group-wide Supervisor/Lead State for details on responsibilities for completing the GPS.

The utilization of the GCC can be summarized as an additional input into the GPS. More specifically, once the analyst completes their review of the GCC, and trend of the ratio, a summary should be incorporated into the GPS to help support the assessment of strategic risk.

Documentation of Review of the GCC in the Group Profile Summary (GPS)

The purpose of these procedures is to document the GCC into the GPS. The following provides an example of a GCC Summary that represents the minimum expected input of the GCC into the GPS, with new information reported within the Strategic branded risk classification. The other purpose of this section is to determine if more follow-up with the group should be performed and, if so, to assess the information obtained from that additional review. The following is intended to assist in documenting the analysts’ understanding of the group’s GCC in the GPS.
Group Capital Calculation (GCC) Summary

Summarize your assessment of the GCC both quantitatively and qualitatively, including any such items as may not be applicable to a branded risk category. For example, it may be appropriate to indicate “The review of the group’s GCC indicated the scope of the application is consistent with the lead state’s determination” and if possible, to summarize succinctly, the general scope of the GCC. For example, “the GCC includes all U.S. and Bermuda operations, but excludes ABC non-insurance operations in South American countries”. It may also be appropriate to identify key drivers of risks for the group within the GCC that are discussed later in the branded risk categories, as those risks may be related to, and supplement existing risk assessments derived from holding company analysis or they may be new risks that warrant further review. “The group’s GCC of 201% in the current year was impacted by a decline in Total Calculated Available Capital of X which is related to group’s non-insurance operations in Bermuda and as well as the negative impact of market risks in the U.S. insurance legal entity ratio components, which based on further analysis has resulted from the recent financial market volatility”.

Branded Risk Assessment

Strategic: The group’s Group Capital Calculation is assessed as low and stable and is a positive consideration in the overall assessment of strategic risk. The GCC has generally been reasonable and consistent over the past five years as illustrated in the following table. Additionally, refer to the GCC Summary for further details.

<table>
<thead>
<tr>
<th>CY</th>
<th>PY</th>
<th>PY1</th>
<th>PY2</th>
<th>PY3</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCC Ratio</td>
<td>201%</td>
<td>207%</td>
<td>163%</td>
<td>202%</td>
</tr>
</tbody>
</table>

GCC Summary and Strategic Branded Risk Documentation:
The above information documented in a summary section of the GPS and into the strategic branded risk classification is expected to be the primary type of information that is always documented into the GPS. The GCC provides a capital measurement of the group and, consistent with the branded risk categories, should be reported in the strategic risk section. Similar to how RBC for an individual insurance company entity is helpful in allowing the analyst to better understand other potential issues given capital represents a relative measure of cushion for adverse risks, the GCC and inclusion herein helps regulators to understand the same, relative to a group. While the GCC is not a capital requirement, with specified ladders of intervention, each of the insurance legal entity figures are relative to individual company requirements, and therefore the GCC along with these procedures can provide a relative measure of risks against such minimum capital levels of the insurers.

Other Branded Risk Documentation:
To the extent the ratio is trending negatively, or total calculated available capital was decreasing, the analyst may choose to include more information in the strategic branded risk section of the GPS that summarizes any key drivers of such findings if they did not fall into one of the branded risk categories. Those drivers of the change would likely be documented in other specific branded risk categories, for example Pricing/Underwriting if driven by group-wide weak insurance underwriting, or reserving if the group-wide drivers were reserve deficiencies, etc. References to other branded risk categories may also be appropriate. However, this may not always occur or be possible for the analyst to pinpoint given the multitude of risks within any insurer’s regulatory capital requirement formulas. This guidance is simply meant to suggest that if the GCC does in fact appear to show
particular trends that are noteworthy on specific risks, further documentation into that (applicable) branded risk may be appropriate.

A determination for when documentation of risks from the GCC into other branded risk categories may be appropriate is driven by both the question of whether any of the thresholds in Procedures 1 were met, and the rest of the GCC information as described in Procedures 2-4. The GCC Summary is intended to be high-level, therefore other more detailed observations from reviewing the GCC should generally not be documented into the GPS unless they are specifically insightful, add to a high-level understanding of the group’s financial condition, or are specific to a branded risk category as stated.

Other Considerations:
In addition to the broad guidance provided herein on the documentation of the GCC into the GPS, the analyst should also understand the following more general points that could impact the GCC result for a particular group. Judgement is required when considering these points:

- If the group has a significant amount of business in legal entities that are domiciled in jurisdictions whose capital regime is based on market-based valuations, the GCC will inherently be more volatile (as compared to a pure U.S.-based group for which RBC and statutory valuations are the norm).
- Similarly, a group may have legal entities that are solely based in jurisdictions that utilize a standard model for capital requirements or have entities in jurisdictions where the use of internal models has been approved. All else being equal, the manner in which capital measures quantify requirements and behave over time will differ to some extent between the two. Also, a change from a standard method to one based on internal models for a key subsidiary will likely produce a noticeable change in the GCC that is not reflective of changes in the entity’s underlying business.
- The GCC provides a means for analysts to identify non-insurance operations outside of the insurance group and to determine the extent of risk they may pose to the insurers within the group. However, in doing so, analysts should understand that findings from review of Forms B, D and F might be equally valuable in these situations.
- When understanding capital requirements for non-insurer financial entities that are not subject to regulatory capital requirements, consideration should be given to the appropriateness of the GCC’s capital charge for a specific entity’s financial operations (e.g., an entity conducting large volume or size of complex transactions but with little net revenue or equity).
- When understanding capital requirements for non-insurer / non-financial entities, consideration should be given to the appropriateness of the level of risk assigned to specific entities.

Detailed Observation Documentation:
More detailed observations shall be documented separately from the GPS and in a form not dictated by this handbook. As in all holding company analysis, the level of documentation is determined by the lead state insurance department and is dependent on the characteristics and complexity of the group and its risks. These detailed observations generally need to only note those that are indicative of drivers of trends and/or actions being taken by the group to mitigate risks. In some cases, these points can be easily summarized into the GPS. In other cases they are too detailed and should be documented instead within a separate document not dictated in form by this handbook. The analysts are not expected, nor should they spend time documenting subtle changes within either the GCC or individual company movements that either do not create a trend at the group
level or identify a growing weakness in the group. However, judgment is required to make this determination. For example, a 10% (not point change) decrease in an RBC ratio of one of the smaller insurers within the group generally would not be documented. By contrast, a 10% decrease (not point change) in an RBC ratio in one of the larger insurers in the group that causes, either alone or jointly with other insurers, a 10% decrease in the GCC should be noted. However, it should be understood also that this 10% threshold is not intended to be used as a “bright-line.” In fact it is possible the 10% is not necessarily indicative of any negative trends at all. This could be the case when for example there was a change in the regulatory capital requirement. Therefore, again, judgement is required in making these determinations and this, as well as other thresholds used in this guidance are not meant to be bright lines. As the GCC is used more, both by the individual analyst, and by the various states, using judgement around these thresholds are expected to become easier as the judgement is informed with experience.

Specific Procedures for Completing Review and Understanding of the GCC

The following procedures should be used by the analyst in their review and documentation of results of the GCC. However, if the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document the material risks of the group observable from the GCC (as well as the required information to be included in the GPS from the GCC), this should be documented by the analyst in any workpapers deemed appropriate by the state and the general reasons supporting that conclusion. In making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner and judgement based upon existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that decision.

Procedures Step 1

The purpose of procedures step 1 is to assess the GCC level, and to identify the drivers of any changes in the GCC. In order to summarize and document that overall assessment in the GPS and its strategic risk category, which is the minimum expected input of the GCC into the GPS. However, the analyst should understand that in the early years of the GCC, limited amount of prior year(s) comparative data will be available, therefore requiring more judgement in determining if or where further analysis is warranted. Such judgement may need to be based upon various factors, including but not limited to other known information regarding the applicable group obtained from other sources (e.g., ORSA, Form F, Form B, etc.).

Procedure 1 is also intended to help the analyst determine if more follow-up review work should be performed. However, if the answer to any of the questions in 1 is “yes”, the analyst should proceed with step 2, understanding decreases in total available capital and/or step 3, understanding increases in leverage to determine the cause(s) of the negative trends. In the example provided above, the trends are positive with no decreases in the base ratio except in PY1; presumably the analyst may have performed some level of inquiry to the holding company to understand the driver of the drop.

Procedures Step 2a-2m

Unlike step 1, the intent of step 2 (and 3) is to determine the actual source of the negative issues and where they should be documented in the GPS. Procedure 2a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by looking at the ratio of actual-to-required capital for the legal entity insurers over the available years reported. The following sample of a table from the GCC calculation completed by the group from the data in Schedule 1 can be helpful in determining the source of the issues.
### VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

<table>
<thead>
<tr>
<th>Insurance Capital Table</th>
<th>Ratio of Actual to Required Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Template Groupings</td>
<td>2025</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer</td>
<td>XXXX</td>
</tr>
<tr>
<td>(P&amp;C)</td>
<td></td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer</td>
<td>XXXX</td>
</tr>
<tr>
<td>(Life)</td>
<td>[2]</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer</td>
<td>XXXX</td>
</tr>
<tr>
<td>(Health)</td>
<td>[3]</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer</td>
<td>XXXX</td>
</tr>
<tr>
<td>(Captive)</td>
<td>[4]</td>
</tr>
<tr>
<td>Non-RBC filing US.</td>
<td>XXXX</td>
</tr>
<tr>
<td>Insurer</td>
<td>[5]</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>[6]</td>
<td></td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>XXXX</td>
</tr>
<tr>
<td>[7]</td>
<td></td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>XXXX</td>
</tr>
<tr>
<td>[8]</td>
<td></td>
</tr>
<tr>
<td>Bermuda - Commercial</td>
<td>XXXX</td>
</tr>
<tr>
<td>Insurers</td>
<td>[9]</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>[10]</td>
<td></td>
</tr>
<tr>
<td>Japan - Non-Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>[11]</td>
<td></td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>[12]</td>
<td></td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>XXXX</td>
</tr>
<tr>
<td>[13]</td>
<td></td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>[14]</td>
<td></td>
</tr>
<tr>
<td>Australia - All</td>
<td>XXXX</td>
</tr>
<tr>
<td>[15]</td>
<td></td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>[16]</td>
<td></td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>[17]</td>
<td></td>
</tr>
</tbody>
</table>

Procedure 2b recognizes that the GCC does allow some debt to be included in capital up to a predetermined limit and can drive the overall GCC ratio. The following sample table taken from the GCC calculation using the data in Schedule 1 can be helpful in making this determination. Cases where debt is issued to address risk-driven reductions in the GCC ratio may not offset those reductions. This data metric may not be available in the case of a “limited filing”.

<table>
<thead>
<tr>
<th>Debt/Equity Table</th>
<th>Template Groupings</th>
<th>2025</th>
<th>2025</th>
<th>2025</th>
<th>2025</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>[8]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Procedure 2c recognizes that profitability is generally one of the biggest drivers of increases changes in positive capital and utilizing the following table from the GCC can assist in identifying if there are entities reporting net losses that may be driving the decreases in capital. The following table taken from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues.

<table>
<thead>
<tr>
<th>Income &amp; Leverage Table</th>
<th>Template Groupings</th>
<th>Net Income ($)</th>
<th>Return on Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2025</td>
<td>2025</td>
</tr>
<tr>
<td>US Ins</td>
<td>[1]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Non-US Ins</td>
<td>[2]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
</tbody>
</table>
If the source of the issues is the insurers, the following sample from a table from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues among the insurers.

<table>
<thead>
<tr>
<th>Core Insurance Table 1</th>
<th>Net Income ($)</th>
<th>Return on Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Template Groupings</td>
<td>2025</td>
<td>2024</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>[1] xxx</td>
<td>xxx</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>[2] xxx</td>
<td>xxx</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>[3] xxx</td>
<td>xxx</td>
</tr>
<tr>
<td>Insurer (Captive)</td>
<td>[5] xxx</td>
<td>xxx</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>[6] xxx</td>
<td>xxx</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>[7] xxx</td>
<td>xxx</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>[8] xxx</td>
<td>xxx</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>[9] xxx</td>
<td>xxx</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>[10] xxx</td>
<td>xxx</td>
</tr>
<tr>
<td>Japan - Non-Life</td>
<td>[12] xxx</td>
<td>xxx</td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>[14] xxx</td>
<td>xxx</td>
</tr>
<tr>
<td>Australia - All</td>
<td>[16] xxx</td>
<td>xxx</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>[17] xxx</td>
<td>xxx</td>
</tr>
</tbody>
</table>

Procedure 2d is focused on requesting more specific information from the legal entity regulator or the group to better identify the source of the issue(s). Procedures 2e-2l simply contemplates that if the source of the issues can be identified into one of the branded risk categories, it should be documented in the detailed workpapers and into the appropriate branded risk category of the GPS. However, it is recognized that the source of issues may be in multiple branded risk categories, in which case documentation of each of the sources into the detailed...
workpapers is still appropriate. However, documentation into one of the single branded risk categories of the
GPS is only appropriate if that risk category is a material driver of the negative trends. Procedure 2m is intended
to identify if the source of the issues is related to non-insurance operations. The GCC is intended to provide for
more consistent analysis of risks to on the insurer that may originate from non-insurance entities within the
holding company system.

Procedures Step 3a-3f
Procedure 3a is specifically focused on identifying the category of legal entities (and subsequently the individual
legal entities) that might be driving the issues by looking at indicators of leverage, e.g., leverage ratios, where
this risk may manifest itself either though increased writings or exposure, or through increased balances relative
to capital and surplus. The following sample of a table from the GCC calculation using the data in Schedule 1 can
be helpful in determining the source of the issues.

<table>
<thead>
<tr>
<th>Insurance Leverage Table</th>
<th>Net Premium Written ($)</th>
<th>Utilization ($) / Capital &amp; Surplus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Template Groupings</td>
<td>2025</td>
<td>2024</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>[1]</td>
<td>XXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>[2]</td>
<td>XXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>[3]</td>
<td>XXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>[4]</td>
<td>XXX</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>[5]</td>
<td>XXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>[6]</td>
<td>XXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>[7]</td>
<td>XXX</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>[8]</td>
<td>XXX</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>[9]</td>
<td>XXX</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>[10]</td>
<td>XXX</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>[12]</td>
<td>XXX</td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>[13]</td>
<td>XXX</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>[14]</td>
<td>XXX</td>
</tr>
<tr>
<td>Australia - All</td>
<td>[15]</td>
<td>XXX</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>[16]</td>
<td>XXX</td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>[17]</td>
<td>XXX</td>
</tr>
<tr>
<td>Hong Kong - Life</td>
<td>[18]</td>
<td>XXX</td>
</tr>
<tr>
<td>Hong Kong - Non-Life</td>
<td>[19]</td>
<td>XXX</td>
</tr>
<tr>
<td>Singapore - All</td>
<td>[20]</td>
<td>XXX</td>
</tr>
<tr>
<td>Chinese Taipei - All</td>
<td>[21]</td>
<td>XXX</td>
</tr>
</tbody>
</table>
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

<table>
<thead>
<tr>
<th>South Africa - Life</th>
<th>[22] XXXX XXXX XXXX</th>
<th>XXXX XXXX XXXX</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa - Composite</td>
<td>[23] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>South Africa - Non-Life</td>
<td>[24] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Mexico</td>
<td>[25] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>China</td>
<td>[26] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>South Korea</td>
<td>[27] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Malaysia</td>
<td>[28] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Chile</td>
<td>[29] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Brazil</td>
<td>[30] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>India</td>
<td>[31] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Other Regime</td>
<td>[32] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>TOTAL</td>
<td>[33] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
</tbody>
</table>

Procedure 3b is more forward looking by suggesting the analyst look at the same leverage ratios used in 3a to determine if the trends might continue and lead to further decreases in the GCC ratio. Procedure 3c simply requests the analyst use the leverage information to target questions to the group to better identify the drivers. Procedure 3d-3f are all questions designed to help the analyst consider whether the changes in leverage will lead to greater underwriting risk, reserving risk, or market and credit risk. Procedures 3d-3f provide general inquiries for additional information for the analyst. However, these inquiries may also appropriately provide a basis for the analyst to hold conversations with the group on the same topics to understand how the group views these topics and how the group is managing and monitoring these risks. For groups filing an ORSA, see also documentation within the ORSA report for additional information on the identified risks and the group’s monitoring of risks, as well as consistency of the discussion with management and management’s observations in the ORSA Summary report.

**Procedures Step 4a-4b.** Procedure 4a is intended to help the lead state understand the historical capital allocation patterns or the likely future needed capital allocation patterns by simply documenting in the detail analysis workpapers. This includes, for example, noting that there is consistency in the entities generating net income and distributing it further through the group, and in some cases may require distribution through other insurers, which in the US often requires approval if considered extraordinary. Procedure 4a is intended to utilize that knowledge, along with other planned actions of the group, to understand whether problems with repaying debt or other obligations in the group could occur. The intent is to be in a better position for discussions with the group on where the group may deem capital come from to support future expected activity or future unexpected material events. The following sample of tables from the GCC calculation using data in Schedule 1 can be helpful in determining the source of the issues.

<table>
<thead>
<tr>
<th>Insurance Capital Table Template Groupings</th>
<th>Capital Contributions $ Received/(Paid)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2025A</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C) [1]</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life) [2]</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health) [3]</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive) [4]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer [5]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canada - Life [6]</td>
<td>XXXX</td>
</tr>
</tbody>
</table>

Commented [CF5]: There are several capital transactions among affiliates that require prior notice filings with the regulators that do not require to be considered extraordinary before regulatory review. Support ending after approval.
<table>
<thead>
<tr>
<th>Insurance Capital Table Template Groupings</th>
<th>Intragroup Dividends Received/(Paid)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2025</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>[1] XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>[2] XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>[3] XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>[4] XXXX</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>[5] XXXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>[6] XXXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>[7] XXXX</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>[8] XXXX</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>[9] XXXX</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>[10] XXXX</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>[12] XXXX</td>
</tr>
<tr>
<td>Solvency II – Composite</td>
<td>[13] XXXX</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>[14] XXXX</td>
</tr>
<tr>
<td>Australia - All</td>
<td>[15] XXXX</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>[16] XXXX</td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>[17] XXXX</td>
</tr>
</tbody>
</table>

Procedures Step 5a-5h. Procedures 5a-5h are designed for those uncommon situations where the group believes they need to reduce risk because raising capital may be unlikely (see appendix for further discussion on that topic). In performing this procedure, the analyst should understand that Procedure 5e (Step 2 [Evaluating Decreases in Total Capital]) and Procedure 5f (Step 3 [Evaluating Increases in Operating Leverage]) have already been considered, and therefore concluded that either capital is decreasing, or operating leverage is increasing. As such, after considering information that may already be available to the regulator on the business plan, Procedure 5b is largely focused on better understanding directly from the group the drivers of the apparent negative trends. The analyst should understand that some of these trends may have already been known, through for example the ORSA review and discussions by the lead state of the ORSA. In fact, the key takeaways may already be documented in the GPS and therefore the remaining procedures in this section may be irrelevant and could be skipped if recently considered and understood. In addition, such trends from Procedure Steps 2 and 3 may suggest no additional understanding is necessary. It is for this reason - the first procedure is focused on the group’s existing business plan as it is - possible these trends may have been expected. Further, Procedure
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5a is based on the belief that reducing risk by the group may have been previously incorporated into the group’s latest business plan, which may have been obtained from the Annual Form F Filing.

Procedure 5b on the other hand contemplates that the manner to address any unexpected negative trends may not have been incorporated into the latest business plan and thus further contemplates that the analyst speaks with the group or identified regulated insurer causing the negative trend to understand how the group intends to address the issue. However, it should be recognized that some trends may appear to be “negative”, e.g., a decline in the reported GCC, may actually be the result of a conscience determination by the group to more efficiently deploy capital yet remaining at sufficient levels from an ERM perspective. This procedure is not meant to suggest action must be taken by a regulator, rather to understand whether a trend is in fact “negative” or not, and if so, what the group has already decided or plans on doing to address the issue. Some of what the group is currently doing may already be known by the lead state, either through the ORSA, the Form F, or a periodic meeting with the group that some states conduct annually. Rather, the procedure provides an opportunity for the analyst to ensure they understand the drivers and what if anything the group is already doing to address the underlying issues that the group thinks is appropriate. To be clear, increases in operating leverage are often planned, and often come with expected future actions by the group, such as capital injections or future transactions that may reduce risk. Meanwhile, decreases in capital sometimes are not expected, and may not result in immediate action, if any, but it is possible that it may lead the group to contemplate future actions to take. Therefore, these discussions would allow these potential actions to be better understood by the analyst and documented.

Procedure 5c contemplates assessing if the group, while recognizing that any action must be done by a legal entity within the group, has the ability and resources to either reduce its risks or to raise additional capital. See the section below for further Considerations of the Group’s Capacity to Raise Capital. This procedure is not intended to suggest the analyst has the capacity to make this determination on their own, but rather to question the reasonableness of the possibility. Further, the GCC and related provisions in the NAIC’s Model Holding Company Act and corresponding regulation are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group’s GCC; regulators will use other existing tools and authorities to take action, primarily at the legal entity level.

Procedure 5d contemplates that the group or legal entity may believe no action is necessary because it believes current capital is adequate to meet its business plan and is more likely to be the case when the company experienced a one-time reduction of capital is experienced as opposed to a growth in leverage that may continue. Procedure 5e is for the rare situation where the legal entity insurers have been strained or face impending pressure contemplated within NAIC Model 385—Model Regulation to Define Standards and Commissioner’s Authority for Companies Deemed to be in Hazardous Financial Condition that would suggest one or more of the insurers may be in a hazardous financial condition. Procedure 5f is designed to suggest the analyst bring the collective supervisors of the legal entity insurers together for a supervisory college to fully understand what is occurring and the identified legal entity’s group’s plans for addressing the underlying issues. Procedure 5g is an extension of Procedure 5f as it contemplates the regulators discussing whether the proposed actions from the legal entity group are adequate. This action could represent something either informally done before an insurer is in a regulatory action level, or formally once an insurer is in a regulatory action level. Procedure 5h is similar to the other actions contemplated within a supervisory college or, for example, to address a troubled insurance company under Accreditation requirements regarding communication with other states.
Additional Procedures – Business Plans

While there is a multitude of possibilities which are beyond the scope of this guidance to address, the following provides some of the related issues that may be helpful to the analyst to consider (See also section 6 regarding the analyst’s consideration of the structure of the group and capital infusion issues).

**Group’s Business Plan:**

Planning Process:
- Consider subcategories of changes including:
  - Overall potential changes in investment strategy
  - Overall potential changes in underwriting strategy or existing concentrations
  - Overall impact on financing matters (e.g., debt, requirements, etc.)
  - Overall impact on derivatives to mitigate economic conditions
  - Overall changes in governance or risk management procedures
  - Increased ceded reinsurance transactions (common approach to reducing risk/increasing surplus):
    - Details regarding the revised strategy
    - Specifics on types of coverage such as assumption reinsurance, loss portfolio transfers
    - Transfer of risk considerations

**Variances to Projections:**
- Consider the group’s history of explanations regarding variances in projected financial results and the insurer’s actual results. If analysts determine the goals of the business plan are not attainable and/or projections are unreasonable, a revised business plan may be requested.
- Identify any internal or external issues not considered in the plan that may affect future financial results. Examples of such issues include the following: 1) the existence of competitors to limit future sales levels; 2) recent state legislation restricting the company’s product designs; or 3) the loss of key marketing personnel.

**Evaluating a Business Plan:**
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Analysts should consider further detail where necessary in evaluating the proposed revised business plan, but also monitor, on a periodic basis, the insurer’s progress in achieving the initiatives included in the group’s plan. Assuming that the analyst has determined that a decline in the GCC is to be considered a “negative event”, i.e., it was not the result of capital management and planning to more efficiently utilize capital while staying within sound levelsould lead to ERM objectives, the goal of the plan would then be to address the improvement of the underlying causes that led to the issues and an improvement in subsequent GCC ratio results. Detail considerations for improving the plan may include the following (where considered inadequate):

- Trending comparative measures of targeted risk exposures including (where applicable):
  - Asset mix by detailed types
  - Credit risk by detailed types
  - Business writings/rotios by detailed product

- Impacts on financing items:
  - Projected cash flow movements for ongoing principal and interest payments on debt
  - Impact on debt interest coverage ratio, other debt covenants, rating agency ratings
  - Discussion of impact on parental guarantees and/or capital maintenance agreements
  - Expected source and form of liquidity should guarantees be called upon

- Impact of reasonable possible stress scenarios

- How the legal entities capital will be maintained at required levels

Consultation with Other Regulators

- Consult with members of the supervisory college (if applicable) or other domestic states for input in evaluating the revised business plan

**Considerations of Group’s Capacity to Raise Capital**

The following is designed simply as a reminder of considerations the lead state would contemplate when discussing the group system response to the issues identified in this section. More specifically, in most situations a group will first consider ways to reduce risk. In limited situations, it may consider trying to raise additional capital. While this is typically not an option for a group that is currently not performing as it anticipated, in some situations alternative sources of capital may be raised if the holders of the new capital are given rights that are attractive to the holder. In addition, in some cases the group may have the ability to issue other forms of capital (e.g., debt), which can be used to inject into the insurance subsidiaries. While these facts are not unique to the utilization of the group capital calculation, they are worth a reminder along with relevant other related details.
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**New Equity Considerations**

**Public Holding Company**
While no two groups are the same, issuing public stock may be limited for the reasons previously identified. In addition, regulators are reminded that a public holding company may be obligated to pay dividends in order to maintain expectations of their shareholders, making the reduction of risk a more viable action under the circumstances.

**Private Holding Company**
While no two groups are alike, a private company has some of the same characteristics as a public company in terms of owners’ expectations, but usually such expectations differ from a public company, and it may be more feasible for a private company given their access to specific individuals that may have a higher interest in higher capital rights.

**Mutual Insurance Company**
A mutual insurer is limited in terms of its access to capital because it cannot issue new stock but can issue surplus notes.

**Mutual Holding Company**
Because mutual holding companies have characteristics of both public companies and mutual companies, there are implications of how such a structure affects its operations.

**Non-profit Health Company**
Insurers that are non-profits are generally charitable organizations and it is not uncommon that some types of insurers, particularly those that provide health insurance, to have some history as a non-profit. It may be helpful to understand these types of dynamics when considering a group structure.

**Fraternal Associations**
Regulators often find similarities between a fraternal benefit society and a mutual insurer because both can be limited in terms of their ability to raise additional funds but can issue surplus notes. If allowed within state law and the charter, the fraternal could assess members or adjust members policy values.

**Reciprocal Exchanges**
Regulators often find similarities between reciprocal exchanges and fraternal benefit societies and mutual insurers because they can be limited in terms of their ability to raise additional funds. Although this is a general consideration for the regulator when evaluating the group system, there is generally much more that must be understood before coming to this conclusion because in some cases, the reciprocal may be able to assess policies that can serve a similar purpose as raising capital.

**New Debt Considerations**
Through discussions with the group, understand the potential impact of any new debt on the group system, including specifically the extent of future additional reliance on the insurance operations and whether those insurers have the capacity for such. Also consider an updated review of the following:
- Total debt service requirements.
- Revenue streams expected to be utilized to service the debt.
- Any new guarantees for the benefit of affiliates.
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- Any new pledge assets for the benefit of affiliates.
- Any new contingent liabilities on behalf of its affiliates.

**International Holding Company Considerations**

**International Holding Company Structure**

This section is applicable only to those international groups that are required to complete the GCC, which may be relatively few considering many international holding companies have a non-US groupwide supervisor and are exempt from the GCC. Those foreign groups that are required to complete the GCC will generally file a “subgroup” GCC that included entities that are part of the group’s U.S. operations. In those situations, the analysts should understand the structure to determine if it has any impact on this analysis. For example, a German-based holding company may have advisory boards established to communicate with U.S. regulators. Analysts should direct any regulatory concerns to the appropriate organization contact to ensure a prompt reply or resolution if the insurance regulator is not responding.

**Capital / Operational Commitment to U.S. Operations**

Some foreign holding companies may consider their U.S. enterprises non-core and consequently show weaker commitment to their ongoing business operations or financial support. In recent years, after sustaining continued losses from U.S. subsidiaries, several prominent foreign holding companies decided to cease their U.S. operations and liquidate their assets. Analysts should be aware of a holding company’s stated commitment to ensure the continued stability of U.S. operations. This commitment may include a written or verbal parental guarantee.
Primer on the Group Capital Calculation Formula

The National Association of Insurance Commissioners (NAIC) began development of the Group Capital Calculation (GCC) in late 2015 following extensive deliberation on potential measurement models and methodologies. The GCC uses a bottom-up aggregation approach, accounting for all available capital/financial resources, and the required regulatory capital based on the measurement of assets and liabilities of the various corporate entities, including insurers, financial and non-financial businesses.

The GCC Aggregation Methodology
As illustrated in the sample tables above, the proposed GCC is an aggregation or grouping of the available financial resources and calculated required capital of all legal entities in an insurance group that potentially pose material risk to the insurers in the group. The GCC allows some discretion in determining what entities under common control but outside of the defined Insurance Group may be excluded from the scope of application in the GCC. When reviewing a group’s choice of entities to be excluded from application of the GCC, the following points should be considered:

- The regulatory evaluation should be based on the criteria for material risk (e.g., structural separation; no history of cross subsidies, or other criteria as defined in the GCC instructions).
- Group requests for reducing the scope of application of the base GCC should be based on supporting information and rationale provided by the Group.
- Information on excluded entities should be made available upon request by the analyst.

The GCC includes the following types of entities and sets forth the general approach of calculated capital toward each:

U.S. Insurers – The available capital of U.S. domiciled insurers is determined by statutory accounting principles (SAP) as defined by state law and the NAIC Accounting Practices and Procedures Manual, which defines assets, liabilities, and in-tum net available capital/financial resources, sometimes referred to as policyholder surplus. The calculated capital for these insurers is subject to state law that requires these insurers to maintain minimum capital based on the applicable NAIC Risk-Based Capital formula at 200% x Authorized Control Level.

Non-U.S. Insurers – Similar to the available capital and calculated required capital of U.S. insurers, the available and calculated capital of non-U.S. insurers is determined by reference to the home jurisdiction’s basis of accounting and capital requirements converted to U.S. dollars. While most non-U.S. jurisdictions do not possess the same level of industry specific technical guidance, as included in the NAIC Accounting Practices and Procedures Manual, all jurisdictions have established accounting standards that insurers are required to follow to determine available capital/financial resources. In some cases, this represents local Generally Accepted Accounting Principles (GAAP), which may or may not be consistent with International Financial Reporting Standards (IFRS).

DRAFTING NOTE: While the GCC utilizes the available capital and home jurisdictions’ capital requirement, for jurisdictions where data is available, the use of appropriate scalars is currently being explored to produce more comparable measures for risk which can be aggregated into the group-wide measure. One such scaling methodology is included as part of sensitivity Analysis in the GCC template. That scalar methodology uses aggregated data from the U.S. and other jurisdictions at first intervention level to recognize that (for example),
state regulators often have much higher reserve requirements that are required to be carried as required capital in other jurisdictions. For jurisdictions where the data is not available, the full jurisdictional requirement at first intervention level is used.

U.S. Insurers Not Subject to RBC – Some types of U.S. insurers are not subject to an RBC formula (e.g., Financial Guaranty Insurers, Title Insurers). For these entities, the available capital/financial resources are determined by reference to state law and the NAIC Accounting Practices and Procedures Manual. However, since an RBC formula does not exist, calculated capital is determined by reference to the state minimum capital requirements set out in state law (or 300% of reserves for Title insurers). For U.S. captive insurers, available capital is determined based upon the states accounting requirements, but the calculated capital is required to be calculated using the applicable RBC formula even if RBC does not apply to that entity in their state of domicile.

Banking or Other Financial Service Operations Subject to Regulatory Capital Requirements – Non-insurers such as banks are subject to their own regulatory valuation methods (typically GAAP with tiering of available capital) and their own regulatory capital requirements (e.g., OCC, Federal Reserve, FDIC, or other requirements for banks). These regulatory values are used for the GCC.

Financial and non-financial operations not subject to regulatory capital requirements – in general, financial entities (as defined in the GCC instructions) are subject to a higher capital charge in the GCC than the non-financial entities. However, the GCC does require available capital/financial resources and calculated capital to be gathered for all such entities that pose a material risk to insurers. In both cases the GCC will utilize the valuation used by such legal entities (typically U.S. GAAP) and a calculated capital based upon a risk factor. There are two important exceptions:

- All entities within the defined insurance group (definition included in GCC Instructions) must be included
- All financial entities (definition included in GCC Instructions) must be included
- The level of risk (low / medium / high) and associated capital calculation assigned to a financial entity will be selected by the group and evaluated by the lead State reviewer
- Non-financial entities that are subsidiaries of U.S. insurers, foreign insurers, or banks where a capital charge for the non-financial entity is included in the regulated Parent’s capital formula will remain with the Parent and will not be inventoried. Regulators already have access to the financials of these entities if needed (if causing unrealized losses within the insurer).

Eliminations
The GCC uses an aggregation and elimination approach, where each of the above legal entities’ available capital/financial resources and calculated capital are combined, then eliminations are utilized to prevent any double counting of available capital/financial resources or calculated capital. The following example illustrates the use of eliminations for both available capital/financial resources and calculated capital. However, in practice the GCC only requires the foreign insurers and other financial entities owned by an insurance company to be “de-stacked” so if AA Holding Company was a U.S. insurer (e.g., AA Insurance Company) the capital required and calculated capital for DD Insurance Agency as a nonfinancial entity would remain in the values of AA Insurance Company and not be de-stacked.
In the above example, available capital/financial resources are referred to as available regulatory capital (ARC) and total authorized capital (TAC) and minimum calculated capital is referred to as minimal regulatory capital (MRC) and authorized control level (ACL2). The GCC will allow non-insurance / non-financial entities owned by RBC filers in the group to remain within the available capital and regulatory capital, so no eliminations are required for these entities. As shown, since AA Holding Company owns each of the other business entities in the organizational chart, $58 million (which is the amount of available capital/financial resources in the subsidiaries of AA) is eliminated from the TAC column since accounting methods include those as an asset on AA Insurance Company’s balance sheet. Also, the GCC includes capital calculations for AA Holding Company and DD Insurance Agency as part of the MRC in addition to the regulatory capital already included for the insurance subsidiaries. The MRC of the subsidiaries is eliminated from the parent’s (AA Holding Company) calculated capital. Therefore, in this example $4.81 million of calculated capital is eliminated from the MRC. Finally, the MRC of U.S. insurance subsidiary is multiplied by 2 in order to reflect Company Action Level (CAL) RBC as required in the GCC.

1 Terminology used in RBC for available capital/financial resources
2 Terminology used in RBC for calculated regulatory capital
Debt - It is important to note that the available capital used in deriving the GCC recognizes a portion of the group’s senior and hybrid debt as capital. This allowance recognizes that debt that is not already recognized as available capital/financial resources under all known accounting principles (SAP, U.S. GAAP or IFRS) may have some value to the group under the U.S. insurance regulatory requirements where such is dividend down to the insurance companies and where extraordinary dividends must be approved by the state. Qualifying debt along with limitations thereon is described in the GCC instructions as is the calculation for the additional available capital. In addition to looking at the group’s debt leverage overall consideration should be given to how the allowance for additional capital from debt interacts with changes in available capital and capital requirements from year to year. The impact of procyclical changes in the allowance for debt as capital should be assessed.

Other information included in the GCC
The GCC includes selected financial information (net income, premiums, liabilities, debt, etc.) that are captured in Schedule 1 and in the “Analytics” tabs of the GCC that are meant to be used to help isolate potential strengths and weaknesses of the group and more specifically where such exist among the entities in the group. Some important information related to other features in the GCC also should be considered and are discussed below. Schedule 1, a simplified version of the Inventory Tab, and most analytics are required in the case of a “limited filing”. However, data is not required for the capital instruments, sensitivity analysis and other information tabs in a limited filing.

Grouping - The GCC separately allows certain financial entities (e.g., asset managers) and non-financial entities included in the GCC to have their values and capital calculation combined (grouped) for more efficient reporting and analysis. Although the GCC instructions set parameters for such grouping, the general expectation is that regulators will work with each applicable GCC filer in determining where grouping is and is not appropriate outside of what is allowed within the GCC instructions. Grouping should be viewed in context of materiality. A single entity conducting a given activity may not be material, but when all entities conducting the same activity are combined, they can be material.

Excluded entities - The GCC provides two mechanisms for the exclusion of non-financial entities in Schedule 1 and in the Inventory Tab at the discretion of the lead state. State regulators should consider whether any of the information collected in the GCC template in support of, is collected for an entity or group of similar entities that would otherwise be excluded from the GCC ratio calculation. Regulators should separately monitor increases in the level of activity of an “excluded” entity or group of similar entities for purposes of materiality and potential subsequent inclusion in the GCC.

Sensitivity analysis - A tab devoted to individual sensitivity analysis is included in the GCC. These informational items provide the regulator with impact of discretion in excluding listed entities and alternative perspectives on risk charges for non-financial entities and foreign insurers. Monitoring of these items can help the regulator identify areas where the GCC may be improved, or capital calculations adjusted in the future. One item included in the sensitivity analysis is a “sensitivity test” that increases the overall calibration of the calculated capital in the GCC from its normal 200% x ACL RBC calibration to 300% x ACL RBC.

Accounting Adjustments - The impact of accounting adjustments and related detailed information is collected in the GCC template in the Inventory Tab and in the Other Information Tab respectively. Such adjustments can be material during the de-stacking process. For example, a consolidated holding company may include GAAP values for entities that would otherwise be valued under regulatory accounting rules (e.g., Statutory Accounting Principles - SAP) on a stand-alone basis. When the regulated entity is de-stacked the difference between the GAAP values and SAP values will be removed from the group's available capital. These "lost" values can result in a material reduction in the inventoried available capital compared to consolidated available capital. Understanding
the impact and the components of this adjustment can help the regulator when considering the impact of issuing new debt or when evaluating the allowance for debt as capital calculated in the GCC template.

**Intangible Assets** – Acquisitions, mergers and reorganization often can create significant intangible assets at a holding company level or possibly at an operating company (other than a regulated entity) level. The GCC template collects information on intangible assets held by inventoried entities in the Other Information Tab. The available capital associated with the value of entities whose assets are materially comprised of intangible assets should be evaluated in the context of fungible resources and in assessing the adequacy of the capital calculation assessed on such entities.

**Dividend pass-thru (gross view of dividends)** – Schedule 1D collects information on dividends paid and received within the group. It also includes a column that indicates whether dividends were declared but not yet paid, as well as cases where dividends received where retained or “passed thru” to another affiliate or paid out in dividends to shareholders. This information will assist the regulator in evaluating the movement of capital within the group to fund strategic insurance and non-insurance operations or activities (e.g., expansion of activities) or to fund entity specific capital shortfalls. It also provides a window to capital leaving the group (e.g., debt repayment, stock repurchase, or dividends to shareholders).

**Considerations When Exempting Insurers**

As stated elsewhere within this guidance, the GCC and its related provisions in the NAICs Model Holding Company Act and corresponding regulation are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group’s GCC. Rather, the GCC is intended to be a tool to better understand the risks of the group, mostly through the trending of the financial information in the “Input 4-Analytics” tab. However, specific to the provisions of the NAICs Model Holding Company Act and corresponding regulation, the Group Capital Calculation (E) Working Group did believe that the GCC might be more helpful for some groups and not as much for others when it developed criteria within the Act and the regulation for exemptions. On this point, the Working Group believed that in general the GCC would be more helpful for those groups that had 1) non-U.S. insurers within the group; 2) a bank within the group, or 3) a more material degree of non-insurers. Specific to the point regarding non-U.S. insurers or banks, the GCC is based upon the premise that the most relevant measure of capital is the actual legal entity requirements of capital from the applicable regulator. On this point, the required capital, as well as the trending of information on these particular legal entities might be the most valuable, particularly if the relative operations and assets of these entities compared to the U.S. RBC filers is material. Similarly, while the calculated capital on the non-insurance entities may not be as relevant as either required capital on regulated insurers or banks, if the relative operations and assets of non-insurers to US RBC filers is material, the GCC may provide greater value to such types of groups.

To these points, the NAICs Model Holding Company Act and corresponding regulation contain possible exemptions for groups that have less than $1 billion in premium and that do not possess these types of situations. The possible exemptions exist after the GCC has been filed once. The general consideration in developing the requirement in the model that the GCC must first be filed once for all groups, was that without seeing the completed GCC, it may be difficult for the lead-state to determine if the GCC has no value or is at least cost beneficial to require filing. However, it should also be understood that these three criteria of non-U.S. insurer, bank, or non-material non-insurers are not the only situations where the GCC would be valuable to the lead-state. As a reminder, all states are required to assess the sufficiency of capital within the holding company structure and that prior to the GCC, this was done by states using various methods (e.g., debt to equity ratios, interest coverage ratios, existing RBC ratios and relative size of insurance). The GCC is expected to enhance a state’s ability to make this assessment more easily, even if it is only used as a general gauge as its intended. Therefore, in deciding if a group should be exempted, the lead-state will need to consider a number of factors, including how easily it can make this assessment without the GCC, again, only as a general gauge. For small groups where the U.S. RBC operations and
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assets are much larger than the non-insurance operations, it is likely the GCC would provide a smaller degree of value and exempting from the GCC may be appropriate. However, the analyst should also consider the fact that the simpler the holding company structure, the more easily the GCC can be completed. Specifically, given all of the data included in the GCC is existing data and therefore readily available to the company, a smaller and simple structured group should be able to accumulate into the GCC template in a short period of time. Also worth considering is that if such operations are contained within a number of different U.S. insurers where it is difficult to determine the degree of double counting of capital, the GCC may provide more value. To be clear, these are not the only situations where the GCC might be helpful even with a relatively small group. This is because the value may come from figures the GCC requires that the state may have otherwise not been aware of. Specifically, the GCC may identify non-RBC filers who may be experiencing some level of financial difficulties. This possible identification of information the lead-state was not otherwise aware of is the primary reason the Working Group suggested the GCC be filed once before deciding on whether a group should be exempted. While the NAIC Accreditation program may not require a state to have such authority to have the GCC filed once before exempting, this background information provided herein is intended to encourage the state to consider such possibilities before deciding on exempting a group, particularly since it may be difficult to stop an exemption in a given year once it’s provided. In summary, as with everything else described in this documentation, the GCC requires judgement on behalf of the analyst and the lead-state which is based upon multiple factors including the existing knowledge of the group. This fact is no different when considering whether a group should be exempt.
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Review of the Group Capital Calculation

Consideration of the Insurance Holding Company System Structure

As the lead state begins to review the annual Group Capital Calculation filing for a particular group, it is important for the lead state to do so with consideration of the existing knowledge of both the organizational structure of the group, including changes in the structure from year to year, but more importantly the overall activities of each of the entities in the group which otherwise have the potential to transmit material risk to the insurers within the group. While the GCC will provide additional quantitative information on the entities in the group, the actual activities of the entities are also important in determining the scope of application of the GCC. The lead state is responsible for determining if any of the entities in the holding company structure should be excluded from the calculation, resulting in and therefore a smaller “scope of application” for the entities included in the GCC ratio. The filing includes a column for the group to propose what should be excluded as well as an additional column for the final determination made by the lead state. In general, the determination of scope of the application is suggested by the group but made in consultation and agreement with the lead state. This exercise should be undertaken in a manner that yields a clearly documented rationale for excluding entities or subgroups of the larger group. The Group Capital Calculation Instructions describes the basis for making this determination and the calculation itself is structured to facilitate this determination, with the inclusion in Schedule 1 of the calculation of financial data for all entities within the holding company. Similar to exclusion from the calculation itself is review of data for cases in which subgroups are completely excluded from the larger group, particularly with regard to Schedule 1; the rationale for the exclusion(s) should be provided in the GPS. The concept is that this Schedule 1 data should be utilized by the lead state in conjunction with its existing knowledge of the group and its activities (obtained from the Schedule Y, ORSA, Forms B/C, Form F, the non-insurance grid, etc.), and therefore likely material risks, to make this determination. To the extent the entities included in Schedule 1 differ from the analyst’s knowledge of the Group, further discussion and follow-up should be held with the group.

In the initial year(s) of a GCC filing, to help the analyst get comfortable with the Inventory and Schedule 1 process, consider the following:

- Gather appropriate background information for your group(s) (e.g., Group Profile Summary, ORSA, RBC Reports, Schedule Y)
- Determine that all Schedule Y entities are listed in schedule 1 or in the schedule BA list in the other information tab or that an entity’s omission is understood / explained
- Evaluate requests for exclusion of non-insurance/ non-financial entities with/without material risk to determine if you agree with exclusion.
- Confirm that all insurers and financial entities are de-stacked in the inventory tab.
- Determine if grouping has been properly applied.
- Evaluate the level of risk assigned by the filer to financial entities with/without regulatory capital requirements.
- Check that the numbers reported in Schedule 1 and Inventory Tab look reasonable, especially for the insurers. A sample check should be sufficient.

The holding company structure and activities should also be utilized by the lead state in determining how to understand the GCC ratio. More specifically, information on structure can help in understanding impact used by the group to make decisions on how to utilize resources among entities within the holding company structure. Therefore, understanding the following can assist in evaluating the flow of capital resources:

- Domestic insurance operations
- International insurance operations
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- Banking or other financial services operations subject to regulatory capital requirements
- Financial and non-financial operations not subject to regulatory capital requirements*

*The GCC instructions provide examples of financial versus non-financial entities in this category. All financial entities should be included in the scope of application of the GCC. However, there can be a broad array of entities that could be considered financial. The lead state should document the rationale for cases in which it concludes that an entity that may be financial in nature can nonetheless be classified in the group’s GCC filing as “non-financial” and thus excluded from the scope of the group in the GCC.

The GCC is intended to be used as an input into the GPS. The expectation is that the GCC summary section will help to document a high-level summary of the analyst’s take away of the GCC, as well as the Strategic branded risk. The manner in which the analyst determines what else should be documented beyond the GCC Summary and the Strategic branded risk should be based upon the following steps, since these steps contemplate the previously mentioned concept that the existing evaluation of the financial condition should be used in evaluating the depth of review of the GCC.

In as much as the GCC is a new analytical tool for use by regulators, and that it will take a number of years before there is both (1) sufficient data for any given group to provide the trend identification ultimately anticipated for the GCC; and (2) experience by regulators with its use. Analysts should be mindful that any stated threshold in the following procedures is for analysis purposes only and DOES NOT constitute a trigger for regulatory action. Rather, the stated threshold should be used as an opportunity for an analyst to understand issues and concerns that may be emerging and address them with the group, if needed. Nonetheless, the following procedure steps provide analysts with a framework to consider the GCC results in conjunction with other data and tools at their disposal, and to begin to gain and benefit from experience in utilizing the GCC as a new analytical tool.

- Procedure Step 1 suggests that a review of the components of the GCC is appropriate when the GCC ratio is trending downward.

- When Procedure Step 1 identifies the need to look further, Procedure Step 2 suggests from a high level determining, at a high level, the drivers of any decreases in the total available capital in the GCC. While there are numerous benefits of the GCC over consolidated approaches, the ability to drill down on the drivers is one of the more significant and is consistent with the states’ approach to not just looking at capital, but to the drivers of capital issues.

- When Procedure Step 1 identifies the need to look further, Procedure Step 3 suggests from a high level determining, at a high level, the drivers of any increases in operating leverage, which is typically what drives insurance capital requirements up, be it asset risk/leverage or writings leverage. Similar to drivers of capital decreases, the GCC has detailed information on financial figures and ratios that can be used to isolate the issues.

- When either Procedure Step 2 or Step 3 identify the need to understand the situation better, Procedure Step 4 is similar in that it too utilizes detailed information on capital allocation patterns used by the group over time that are necessary for the analyst to understand if there are any future negative trends in the GCC.

- When Procedure Steps 2, 3 and 4 together identify the need to understand the situation better, Procedure Steps 5, depending upon the analysis performed in previous Steps, is similar to legal entity analysis, where there is likely a need to determine what steps the group/company is already taking or plans to take in order to address any the issues that they perceive are appropriate.

- The guidance provided in these procedures is not intended to be exhaustive, but rather should give the analyst a starting point in better understanding the various issues.
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- If the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document their understanding of the material risks of the group observable from the GCC (as well as the required information to be included in all GPS from the GCC), the rationale for this determination should be documented by the analyst in any workpapers deemed appropriate by the state and include the general reason, therefore. In making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner and judgment based upon and existing understanding of the group and existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that decision.

Procedure Step 1-Understand the Adequacy of Group Capital

1. Determine if the group capital position presents a risk to the group and its insurance subsidiaries based upon its recent trends and/or current measures in the GCC ratio.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>ST</td>
</tr>
<tr>
<td>a. Has there been a decrease in the GCC ratio over last two or more years? If “yes”, determine the cause(s) of the decline.</td>
<td>ST a. &lt;-10% (this is not a point change)</td>
</tr>
<tr>
<td>b. Has there been a decrease in the GCC Total Available Capital from prior year? If “yes”, determine the cause(s) of the decline.</td>
<td>ST &lt;-10%</td>
</tr>
<tr>
<td>c.</td>
<td>ST N/A</td>
</tr>
<tr>
<td>d. Has there been a negative trend in the GCC ratio over the past five years suggesting an overall pattern of declining capital?</td>
<td>ST N/A</td>
</tr>
</tbody>
</table>

If the answer to any of the above questions is “yes”, but it is obvious that either the negative trend is caused by something such as a restriction on the allowable debt, or a change in a corporate tax rate, or some other factor external to the group’s operations not indicator of negative trends, note as such but do not proceed to step 2. In addition, if it is obvious that the negative trend is clearly driven from one entity in the group, understand the cause and document as such but do not proceed to step 2. However, in all other cases if the answer to any of the above questions is “yes”, the analyst should proceed with procedure step 2, understanding decreases in total available capital and/or procedure step 3, understanding increases in leverage to determine the cause(s) of the negative trends.
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Procedures Step 2-Understand Decreases in Total Available Capital

2. Determine the source(s) of decreases in the GCC ratio or the GCC Total Available Capital

Recognizing that not all declines in capital ratios are necessarily “negative”, i.e., they may be the result of sound capital management and ERM to more efficiently utilize capital, approved changes in the scope of application, or changes in underlying authority requirements, the intent of step 2 (and step 3) is to determine the actual source of the negative issues. In most cases, this equates to pinpointing the legal entity(ies) driving any negative trends. However, unless obvious from the information obtained in step 2, the analyst should proceed to steps 4 and 5, using an understanding of items in Procedure Step 4, to understand more fully the actions the group, or the legal entity(ies) driving the negative trends, are already being taking or planned to be taken by the group to address the issues identified in step 2, if that is not already clear from the information obtained in step 2 that the group believes is needed. However, the analyst may already have a deep understanding of any such plans, and as a result, in some cases, it is possible that no further follow-up with the group will be necessary and that the lead state should simply update the GPS to be certain the main understanding of the issues is known to all of the regulators utilizing the GPS.

<table>
<thead>
<tr>
<th>Branded Risk</th>
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<tbody>
<tr>
<td>a. Review the ratio of available capital to calculated capital from each of the reported entities and compare to the same ratio from the prior year. Determine which entities may have led to the negative trends.</td>
<td>&lt; -10%</td>
</tr>
<tr>
<td>b. If the change in the GCC is not driven from a legal entity, and instead the change in allowable debt, note as such.</td>
<td>ST</td>
</tr>
<tr>
<td>c. Review the levels of profitability for each of the reported entities in the GCC in the current and prior years (as reported in the GCC) to determine if there are particular entities showing loss signs of decreasing profitability which may eventually lead to losses and future decreases in the GCC ratio or total available capital.</td>
<td>OP, PR/UW</td>
</tr>
<tr>
<td>d. For each of the reported entities showing either 1) a meaningful decrease in the GCC due to a decrease in the total available capital, or 2) loss-negative profitability trends, request information that identifies the issues by inquiring of the legal entity regulator first or the group itself (e.g., non-insurance company), if applicable.</td>
<td>OP, PR/UW, ST</td>
</tr>
<tr>
<td>e. If due to pricing or underwriting issues, understand if the issues are the result of known pricing policies that are currently being modified, or if the business is in runoff, recently identified products where metrics can quantify the issues, whether new product lines, or geographic or other concentrations, volume/growth business strain, or other issues. When considering pricing that is being modified, include those products for which the price is adjusted through crediting rates.</td>
<td>PR/UW</td>
</tr>
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</table>
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<table>
<thead>
<tr>
<th>Procedure</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>f.</td>
<td>If due to reserve issues, understand the reserve development trends, whether reserve and pricing adjustments have been made as well as changes in business strategy apart from those products.</td>
</tr>
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<td>g.</td>
<td>If due to market risk issues—i.e., capital losses—understand not only why the losses occurred, but the likely near-term impact given current and likely prospective economic conditions. Market issues include not only changes in equity prices, but also impact/exposure to interest rates and other rates such as foreign currency exchange rates or rates on various hedging products used by the group.</td>
</tr>
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<tr>
<td>h.</td>
<td>If due to strategic issues such as planned growth, planned decline in writings or changes in the investment strategy, utilize the business plan from the Form F to better understand the anticipated changes and how the actual changes compare. Understanding the variance from the business plan is important in assessing the ongoing risk either in projected future profitability or in some cases the investments.</td>
</tr>
<tr>
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<tr>
<td>i.</td>
<td>If due to negative reputational issues, for example, have adversely impacted new business or retention of existing business, understand the issues more closely, whether potential ongoing changes in stock prices or financial strength ratings that may further impact market perception, or what the group is doing to address the potential future impact be it sales projections or access to the capital markets.</td>
</tr>
<tr>
<td></td>
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<tr>
<td>j.</td>
<td>If due to credit losses, understand the current and future concentration in credit risks, be it investments, reinsurance, or other source of credit losses.</td>
</tr>
<tr>
<td></td>
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<tr>
<td>k.</td>
<td>If due to operational issues, such as extremely large catastrophe events, IT or cybersecurity events or relationships, understand the current and prospective impact.</td>
</tr>
<tr>
<td></td>
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<tr>
<td>l.</td>
<td>If due to legal losses, understand the underlying issues and degree of potential future legal losses.</td>
</tr>
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<tr>
<td>m.</td>
<td>If due to non-insurance reported entities in the group, understand the relationship of the non-insurance operations to the insurance entities and the potential impact to the insurance operations (i.e., intercompany agreements, services, capital needs, etc.).</td>
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</table>

Procedure Step 3-Understand Increases in Operating Leverage

3. Determine the source(s) of any decreases in the GCC ratio due to increases in leverage

Like step 2, the intent of step 3 is to determine the actual source of the negative issues. The difference between step 3 and step 2 is simply the types of issues. Step 2 is focused on issues that have resulted in negative capital
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trends. Step 3, however, is focused on the issues that impact the risk being measured in the GCC. In most cases that risk is from the insurers and either from the asset side or from the liability side where in both cases there has been an increase in such risk that has not been offset by a corresponding or equal increase in capital. In general, this is referred to as operating leverage, where this risk can manifest itself either through increased insurance writings (e.g., the ratio of premiums to capital or liabilities to capital), or through increased assets that also carry risk. The expectation is that other regulated entities also have capital requirements that increase as these different types of risks increase, similar to how the NAIC RBC considers different types of products and assets that carry more risk. However, it is also possible to have increased leverage outside of the insurance companies and other regulated entities through for example increased exposure, which can manifest itself through increased liabilities or through increased assets. However, similar to other items noted in this document, such increases do not necessarily represent negative trends, rather simply things the analyst should need to further understand the drivers of such changes. In most cases, this equates to pinpointing the legal entity(ies) driving any negative trends. Similar to step 2, using an understanding of items in Procedure Step 4, to understand more fully the actions the group, or the legal entity(ies) driving the negative trends already being taken or planned to be taken by the group to address the issues identified in step 2 that the group believes is needed.

<table>
<thead>
<tr>
<th>Branded Risk</th>
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<tbody>
<tr>
<td>a. Review the ratio of available capital to calculated capital from each of the reported entities and compare to the same ratio from the prior year. Determine which entities may have led to the negative trends based upon corresponding increases in leverage (e.g., writings/capital ratios or liability to capital ratios).</td>
<td>MK, CR, RV, ST, OP, RP</td>
</tr>
<tr>
<td>b. Review the levels of operating leverage for each of the reported entities in the GCC as well as the same for the prior years as reported in the GCC to determine if there are particular entities showing signs of increasing operating leverage which may lead to future decreases in the GCC ratio or total available capital.</td>
<td>MK, CR, RV, ST, OP, RP</td>
</tr>
<tr>
<td>c. For each of the reported entities contributing to showing a meaningful decrease in the GCC due to an increase in operating leverage, request information that identifies the issues by inquiring first from the legal entity regulator or the group itself (e.g., non-insurance company), if applicable.</td>
<td>MK, CR, RV, ST, OP, RP</td>
</tr>
<tr>
<td>d. If operating leverage has increased, consider if growth may have resulted from underpriced products or a change in underwriting. Specifically inquire to determine if pricing was reduced to increase sales, or whether the growth is in new product lines or new geographic focus where the group may not have expertise. When considering pricing being modified, include those products that the price is adjusted through crediting rates.</td>
<td>PR/UW, OP, ST</td>
</tr>
<tr>
<td>e. If operating leverage has increased, consider if reserving risk has also increased, through potential underpricing that ultimately manifests itself into reserve adjustments. To do so, obtain current profitability information on the products leading to the increased leverage.</td>
<td>RV</td>
</tr>
<tr>
<td>f. If operating leverage has increased, obtain current information on the asset mix to be certain that there is a corresponding</td>
<td>CR, MK</td>
</tr>
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| decrease in riskier assets to mitigate the otherwise likely increase in market and credit risk. |

Unless obvious from the information obtained in step 3, the analyst should proceed to steps 4 and 5, using understanding of items in Procedure 4, to understand more fully the actions being taken by the group, or the legal entity(ies) driving the negative trend, are already being or planned to be taken by the group to address the issues identified in step 3, if that is not already clear from the information obtained in step 3 that the group believes is needed. However, in some cases, it is possible that no further follow up with the group will be necessary, and that the lead state should simply update the GPS to be certain issues are known to all of the regulators utilizing the GPS [BJR14].

Procedure Step 4 - Understand the Capital Allocation Patterns

4. Determine the capital allocation patterns to determine if some entities may put pressure on other legal entities.

Steps 2 and 3 are critical in understanding the issues faced by the group and in identifying the source of negative trends; and while additional follow up with the group is expected, before proceeding to Step 5, the lead state should understand the historical capital allocation patterns within the group and the likely future needed capital allocation patterns that may be needed by the group if negative trends continue. The GCC includes data on historical capital allocation patterns (e.g., contributed capital received/paid or dividends received/paid), which help to illustrate which entities have historically needed more capital and which entities have capital that they have provided other entities in the past [JKM15]. While these patterns do not necessarily repeat themselves from one period to the next, there is often consistency in terms of entities that need capital or have excess capital, which may or may not be driven by losses, or by a change in strategy (e.g., increased writings at one company over another) by the group. These trends can also assist in conversations with the group about where capital may come from as a result of a future unexpected material event. Where similar information is also disclosed in Form F, the detail in the GCC may confirm what is already known by the analyst in this area and in some cases may provide greater detail.

<table>
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<tr>
<th>Branded Risk</th>
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<tbody>
<tr>
<td>a. Review the underlying data from the GCC Analytics tab to determine the historical capital allocation patterns within the group and summarize the result of this analysis.</td>
<td>ST</td>
</tr>
<tr>
<td>b. Using this data, as well as any recent information on net losses, or likely expected funding, determine if there may be an impact on the capital available to the insurance entities (either through the likelihood of higher dividends or through less capital being available for infusions) and to fund future possible losses from other entities in the group and potentially become troubled themselves, regardless of the current capital in excess of RBC requirements [BJR16].</td>
<td>OP, ST</td>
</tr>
</tbody>
</table>
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Procedure Step 5-Consider the Need for Company Discussions for Reductions in Risk

5. Determine the group’s plans for addressing source(s) of any meaningful decreases in the GCC ratio or total available capital. Please note, in some cases, the plan may be as simple as actions designed by the group to reverse a single negative trend.

Steps 5 is designed to assist in understanding the group’s plans for addressing any meaningful decreases in the GCC ratio or total available capital that were not intended otherwise already planned by the group (i.e., that are not the results of capital management so as to efficiently utilize capital while still maintaining sufficient levels for Enterprise Risk Management needs). The specific plans of the group may or may not fully address all the issues but to the extent the group believes they have addressed what is needed, ultimately what is most important is that such information and the regulators plan for evaluating and monitoring the situation is known to the other regulators. There is a multitude of possibilities, and this guidance is not intended to address all of those. This includes the multitude of possibilities actions by the group and its legal entities and the ultimate results. This also includes the multitude of possibilities actions to be taken by the legal entity regulators of the individual legal entities, which may including the fact that in some cases some regulators may choosing to put their legal entity into some type of supervision, conservation, or some other form of receivership (which, by necessity and intent, would presumably be done based upon existing legal entity authority and not the group’s GCC). Similar to other areas, where similar information is also disclosed in Form F, further information may already be known in this area.
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<th>Branded Risk</th>
<th>Benchmark</th>
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<tbody>
<tr>
<td>a.</td>
<td>Obtain a copy of the group’s most recent business plan and compare it to the prior year plan for variances. (See Additional Procedures below for additional follow-up analysis)</td>
<td>ST</td>
</tr>
<tr>
<td>b.</td>
<td>Request information from the group on how it intends to address the issues or negative trends (those that are not planned or due to approved changes to the GCC scope of application or the result of changes in underlying legal entity capital requirements) identified in Steps 1-3. More specifically, determine whether the group intends to decrease risk or increase capital, and by what means.</td>
<td>ST</td>
</tr>
<tr>
<td>c.</td>
<td>Based on information received in 5.b., determine the group’s capacity to reduce risks or raise additional capital.</td>
<td>ST</td>
</tr>
<tr>
<td>d.</td>
<td>Where the remaining capital is adequate, document the findings in the GPS (or another document) and make available to the supervisory college and or domestic states with the presumption no further action is deemed necessary.</td>
<td>ST</td>
</tr>
<tr>
<td>e.</td>
<td>Consider whether the collective information suggests that any of the U.S. legal entity regulators should deem the legal entity to be in a “Hazardous Financial Condition” and take appropriate action to address based upon the facts and circumstances and the provisions of the state’s law (similar to NAIC Model 385).</td>
<td>N/A</td>
</tr>
<tr>
<td>f.</td>
<td>Where appropriate, consider holding a meeting of the supervisory college or all the domestic states to understand the group’s plans. Where appropriate, require the group to present its plans to the supervisory college or all the domestic states.</td>
<td>N/A</td>
</tr>
<tr>
<td>g.</td>
<td>Where appropriate, determine if the plans proposed by the group are considered inadequate by any of the legal entity regulators, and more specifically if any are considering taking action over their applicable legal entity. If this is the case, hold a meeting of the supervisory college or of all the domestic states to provide this information.</td>
<td>N/A</td>
</tr>
<tr>
<td>h.</td>
<td>Where appropriate, consider holding a broader meeting of all impacted jurisdictions in which the group is selling insurance. Where appropriate, require the group to present its plans to all such regulators and for the regulators to announce their plans.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

Purpose of the Group Capital Calculation (GCC) in Holding Company Analysis

The following information is intended to provide background and context concerning the issues/considerations for analysts when utilizing the NAIC Group Capital Calculation (GCC) for an insurance holding company group (hereafter referred to as “group”) completing the GCC where required. The GCC is a “tool” to quantitatively understand the group’s capital and the mathematically calculated risks within the group. The GCC framework is built on the RBC model; however, while the RBC, as a capital requirement, has triggers in with states’ laws to take formal actions as a capital requirement, the GCC is not designed for that purpose and is instead designed as an analytical tool.

Background Information

In 2008, the NAIC Solvency Modernization Initiative (SMI) began to consider whether there were any lessons learned from the financial crisis that would cause the solvency framework to be modified. The NAIC determined that changes should be made in the area of group supervision, starting with the new annual requirement for the Lead State of each group operating in the U.S. to complete a written holding company analysis. Since that time, other changes to state laws have been made to further enhance group supervision (e.g., Form F, ORSA, and Corporate Governance reporting). All of these new tools are inputs into the previously mentioned holding company analysis, which is now summarized into a consistent tool used by all states that is known as the Group Profile Summary (GPS).

Benefits of the GCC & Methods to Achieve Them

The Group Capital Calculation Instructions describes the background, intent, and calculation for the GCC in detail. As stated in the Group Capital Calculation Instructions, the GCC and related reporting provides more transparency about a group’s structure and related risks to insurance regulators and makes those risks more identifiable and more easily quantified. In this regard, this tool is intended to assist regulators in better understanding the risks that the non-insurance entities may pose to the group, how capital is distributed across an entire group, and whether and to what degree insurance companies’ capital may be put at risk from the operations of non-insurance entities, potentially undermining the insurance company’s financial condition and/or placing upward pressure on the insurers in the group. An analyst is not expected to understand non-insurance industries represented within the group but is expected to understand through this calculation if a non-regulated entity could place pressure on or provide relief to a regulated entity.

The manner in which the GCC achieves some of these intentions/benefits or points varies. For example, with regard to understanding how capital is distributed across an entire group, this can be seen in two ways. One is by viewing the Tab titled “Input 4-Analytics” for the display of the “Ratio of Actual to Required Capital”. The other two is by viewing the same Tab for and in the display of “Required Capital” in a separate column. The degree of capital movements can also be seen in the “Input 4-Analytics” tab, with the display of the columns as follows: 1) Capital Contributions Received/(Paid); 2) Net Income. While one year of information can provide insight on how this exists, a better understanding will be obtainablemost will not be seen until after further years of the GCC are reported within the template. Once at least five years of data are displayed in this “Input 4-Analytics” tab, it will allow the analyst to better understand the financial condition of the group as a whole as well as the risks posed by non-insurance entities in the group. Of course, such conclusions can only be made once the analyst sees the data and understands from the group what is occurring that is leading to such figures.
Recognizing that legal entity supervision and related tools (e.g., RBC) are the primary means to address inadequate capital, the GCC may provide an additional early warning signal to regulators regarding risks or activities of non-insurers within the group that may pose material risk to the insurance operations. This early warning signal can be seen with the trending of the financial information in the “Input 4-Analytics” tab as well as through the application of sensitivity analysis in the Input 5 Tab and inclusion of other relevant information in the Input 6 Tab. However, the analyst should also understand that other “qualitative tools,” such as the Form F, are capable of also providing early warning signals if properly reported by the group. In addition, since most holding company systems may have a larger percentage of their operations in the insurance businesses, the insurance trends for the U.S. insurers in the group should already be known and made available to the lead-state by the legal entity regulator(s) of the insurer(s). However, in the context of added policyholder protection, this may largely come into play with respect to the added quantitative data about non-insurers.

The GCC is an additional reporting requirement but with important confidentiality protections built into the legal authority to require such reporting. State insurance regulators already have broad authority to take action when an insurer is financially distressed, and the GCC is designed to provide regulators with further insights to allow them to make informed decisions on both the need for action, and the type of action to take. That said, the GCC and its related provisions in the NAIC’s Model Holding Company Act and corresponding regulation are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group’s GCC. Regulators will use other existing tools and authorities to take action, primarily at the legal entity level.

While the new information from the GCC may offer new insights, it is equally important to understand that it will be up to the analyst to work with the insurance group to actually understand what is leading to the figures reported in the GCC, and from that perspective, especially in the early years of the GCC, it will require learning by both the analyst and the group to really be able to utilize the GCC in a manner as suggested in these introductory paragraphs.

Other Considerations When Considering Such Benefits

Unforeseen events and economic conditions (e.g., pandemic, recession, etc.) may also create stresses on a group, reinforcing the value of the quantitative data included in the GCC. Some stresses are similar to those experienced during the financial crisis and others are more unique. However, because the GCC is based upon a methodology that gets its inputs from individual legal entities, the capital calculated for each legal entity certainly can only capture the allowed capital resources of the legal entities in the group. While such an aggregation-based methodology is an appropriate group-level capital measure, until experience is gained with the GCC, it is not known as to how the GCC will behave in response to business cycles and various risk events, in part because it only recognizes limited diversification benefits among entities in the group except for the diversification embedded in existing entity specific regulatory capital requirements. And while the GCC is not meant to be used in a way that compares groups to each other, it is also true that it is unknown how it will behave across groups, peers and even sectors. This is true because of its limited diversification benefit, the differences between group types (mutual v. stock holding company), grouping of entities, and scope of entities included in the calculation. It is also true because application of jurisdictional accounting principles and use of scalars could have an impact on this as well via the foreign insurer profile of the group. The quantitative data collected in the GCC will evolve as state insurance regulators and groups increase their understanding of the impact on available capital and calculated capital.
The following guidance on the GCC is intended to be utilized in a manner that allows the GCC to enhance group-wide financial analysis and to be used as an additional input into the GPS. The GCC provides the quantification of risk within the group and when combined with the information from the ORSA on the amount of capital needed to run the company's current business model, puts the regulator in a much better position to understand the available capital and calculated capital within a group, as well as the financial condition of the group. Both are complementary tools to each other. The ORSA provides management's internal approach to capital management and an understanding of the economics of the group. The GCC provides a standard model that can better enable the analyst to understand where the entire group stands with respect to existing legal entity requirements as well as broad measures of risk for non-insurers. Analysts should be mindful of the differences between the ORSA and the GCC. For example, in the case of a group with predominantly U.S. operations, the GCC will largely be based on the standard model/RBC of the U.S. subsidiaries. However, the ORSA is not constrained by a standard model and will reflect management’s internal approach to capital management and may utilize or benefit from an economic capital model, other internal models, stress testing and other means. As a result, while the GCC is an additional input into the GPS, it may provide data and signals that don’t align with the risk measures within the ORSA.

Overall Theme of Remaining Guidance

The previous information describes the purpose for considering the GCC within the context of the state’s holding company analysis and corresponding GPS. In general, the remainder of this guidance provides more depth to the specific information to be included in the GPS, and provides the analyst with a basic understanding of the GCC including: why the entities included within the GCC may be a subset of those entities that are within the holding company structure; whether the trends within the GCC suggests questions should be raised with the group’s management to understand; whether the underlying data suggests trends exist that should likewise suggests questions should be raised with the group or with the respective legal entity’s supervisor; whether the information in the GCC filing is generally aligned with other information available to the analyst, and if not, why not, and whether that evidences other questions or concerns that should be addressed, or how they may already have been resolved. Notably, the purpose of the GCC is NOT to trigger regulatory action. Thus, even though the GCC is intended as a group-wide measure and provides insights as to capital adequacy and risks across the group, any regulatory action would have to result from other information made available to the regulator and based on legislative authority.

Utilization of the Group Capital Calculation in the Lead State’s Responsibilities

The lead state is responsible for completing the holding company analysis and documenting a summary of that analysis in the GPS. The depth and frequency of the holding company analysis will depend on the characteristics (i.e., sophistication, complexity, financial strength) of the insurance holding company (group) system (or parts thereof), and the existing or potential issues and problems found during review of the insurance holding company filings.

Similarly, in the analysis of the GCC, the depth of the review in the “five-step process” and specific inquiries will vary based on each group’s unique situation. For example, in some groups, very little if any work (inquiries of the group) will be done after the first step due to generally positive trends of the ratio over time. While in other groups, the analyst may need to proceed through each of the five steps. Exactly how the analyst proceeds through the guidance will be dictated by a multitude of factors and requires judgment and as a result, the steps
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and sub-procedures should not be used as checklist, but rather as a guide in how to utilize the GCC to increase the analyst’s understanding of the group.

GCC Construction That Also Impact its Utilization and Review

Some decision points may be addressed prior to the submission of a GCC template. These include: the scope of application (e.g., whether segments of the holding company system (group) should be excluded for financial conglomerates); whether a limited filing will be allowed (as permitted in Model Law #440 and Model Regulation #450); and whether subgroup reporting (as defined in the GCC instructions) of a foreign insurance group will be required. In general, the analytics provided by the GCC will be similar for all entities included in the template. (See the Primer on the Group Capital Calculation Formula) at the end of this section to better understand these points.

These factors are also a consideration in determining the depth of the analysis of the GCC and subsequent correspondence with the group. Refer to chapter VI.B. Roles and Responsibilities of Group-wide Supervisor/Lead State for details on responsibilities for completing the GPS.

The utilization of the GCC can be summarized as an additional input into the GPS. More specifically, once the analyst completes their review of the GCC and trend of the ratio, a summary should be incorporated into the GPS to help support the assessment of strategic risk.

Documentation of Review of the GCC in the Group Profile Summary (GPS)

The purpose of these procedures is to explain how to document the GCC into the GPS. The following provides an example of a GCC Summary that represents the minimum expected input of the GCC into the GPS, with new information reported within the Strategic branded risk classification. The other purpose of this section is to determine if more follow-up with the group should be performed and, if so, to assess the information obtained from that additional review. The following is intended to assist in documenting the analyst’s understanding of the group’s GCC in the GPS.
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Group Capital Calculation (GCC) Summary

Summarize your assessment of the GCC both quantitatively and qualitatively, including any such items as may not be applicable to a branded risk category. For example, it may be appropriate to indicate “The review of the group’s GCC indicated the scope of the application is consistent with the lead state’s determination” and if possible, to summarize succinctly, the general scope of the GCC. For example, “the GCC includes all U.S. and Bermuda operations, but excludes ABC non-insurance operations in South American countries”. It may also be appropriate to identify key drivers of risks for the group within the GCC that are discussed later in the branded risk categories, as those risks may be related to, and supplement existing risk assessments derived from holding company analysis or are they may be new risks that warrant further review. “The group’s GCC of 201% in the current year was impacted by a decline in Total Available Capital of $X which is related to group’s non-insurance operations in Bermuda and as well as the negative impact of market risks in the U.S. insurance legal entity ratio components, which based on further analysis has resulted from the recent financial market volatility”.

Branded Risk Assessment

Strategic: The group’s Group Capital Calculation is assessed as low risk and stable and is a positive consideration in the overall assessment of strategic risk. The GCC has generally been reasonable and consistent over the past five years as illustrated in the following table. Additionally, refer to the GCC Summary for further details.

<table>
<thead>
<tr>
<th>Year</th>
<th>GCC Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY</td>
<td>201%</td>
</tr>
<tr>
<td>PY1</td>
<td>207%</td>
</tr>
<tr>
<td>PY2</td>
<td>163%</td>
</tr>
<tr>
<td>PY3</td>
<td>202%</td>
</tr>
<tr>
<td>PY4</td>
<td>197%</td>
</tr>
</tbody>
</table>

GCC Summary and Strategic Branded Risk Documentation:
The above information documented in a summary section of the GPS and into the strategic branded risk classification is expected to be the primary type of information that is always documented into the GPS. The GCC provides a capital measurement of the group and, consistent with the branded risk categories, should be reported in the strategic risk section. Similar to how RBC for an individual insurance company is helpful in allowing the analyst to better understand other potential issues, given capital represents a relative measure of cushion for adverse risks, the GCC (and its inclusion in the GPS) helps regulators to understand the same, relative to a group. While the GCC is not a capital requirement, with specified ladders of intervention, each of the insurance legal entity figures are relative to individual company requirements, and therefore the GCC can provide a relative measure of risks in terms of the against such minimum capital levels of the insurers.

Other Branded Risk Documentation:
To the extent the ratio is trending negatively, or available capital is decreasing, the analyst may choose to include more information in the strategic branded risk section of the GPS that summarizes any key drivers of such findings if they did not fall into one of the branded risk categories. Those drivers of the change might be documented in other specific branded risk categories, for example Pricing/Underwriting if driven by group-wide weak insurance underwriting, or reserving if the group-wide drivers were reserve deficiencies, etc. References to other branded risk categories may also be appropriate. However, this may not always occur or be possible for the analyst to pinpoint given the multitude of risks within any insurer’s regulatory capital requirement formulas. This guidance is simply meant to suggest that if the GCC does in fact appear to
show particular trends that are noteworthy on specific risks, further documentation into that (applicable) branded risk may be appropriate.

A determination for when documentation of risks from the GCC into other branded risk categories may be appropriate is driven by both the question of whether any of the thresholds in Procedures 1 were met, and by the rest of the GCC information as described in Procedures 2-4. The GCC Summary is intended to be high-level, therefore other more detailed observations from reviewing the GCC should generally not be documented into the GPS unless they are specifically insightful, add to a high-level understanding of the group’s financial condition, or are specific to a branded risk category as stated.

Other Considerations:
In addition to the broad guidance provided herein on the documentation of the GCC into the GPS, the analyst should also understand the following more general points that could impact the GCC result for a particular group. Judgement is required when considering these points:

- If the group has a significant amount of business in legal entities that are domiciled in jurisdictions whose capital regime is based on market-based valuations, the GCC will inherently be more volatile (as compared to a pure U.S.-based group for which RBC and statutory valuations are the norm).
- Similarly, a group may solely have legal entities that are solely based in jurisdictions that utilize a standard model for capital requirements or have entities in jurisdictions where the use of internal models has been approved. All else being equal, the manner in which capital measures quantify requirements and behave over time will differ to some extent between the two. Also, a change from a standard method to one based on internal models for a key subsidiary will likely produce a noticeable change in the GCC that is not reflective of changes in the entity’s underlying business.
- The GCC provides a means for analysts to identify non-insurance operations outside of the insurance group and to determine the extent of risk they may pose to the insurers within the group. However, in doing so, analysts should understand that findings from review of Forms B, D and F might be equally valuable in these situations.
- When understanding capital requirements for non-insurer financial entities that are not subject to regulatory capital requirements, consideration should be given to the appropriateness of the GCC’s capital charge for a specific entity’s financial operations (e.g., an entity conducting a large volume or size large dollar amount of complex transactions but with little net revenue or equity).
- When understanding capital requirements for non-insurer / non-financial entities, consideration should be given to the appropriateness of the level of risk assigned to specific entities.

Detailed Observation Documentation:
More detailed observations shall be documented separately from the GPS and in a form not dictated by this handbook. As in all holding company analysis, the level of documentation is determined by the lead state insurance department and is dependent on the characteristics and complexity of the group and its risks. These detailed observations generally need to only note those that are indicative of drivers of trends and/or actions being taken by the group to mitigate risks. In some cases, these points can be easily summarized into the GPS. In other cases they are too detailed and should be documented instead within a separate document not dictated in form by this handbook. The analysts are not expected, nor should they spend time documenting either subtle changes within either the GCC or individual company movements that either do not create a trend at the
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group level or identify a growing weakness in the group. However, judgment is required to make this determination. For example, a 10% (not point change) decrease in an RBC ratio of one of the smaller insurers within the group generally would not be documented. By contrast, a 10% decrease (not point change) in an RBC ratio in one of the larger insurers in the group that causes, either alone or jointly with other insurers, a 10% decrease in the GCC should be noted. However, it should be understood also that this 10% threshold is not intended to be a "bright-line." In fact it is possible the 10% is not necessarily indicative of any negative trends at all. This could be the case when for example there was a change in the regulatory capital requirement. Therefore, again, judgment is required in making these determinations and this, as well as other thresholds used in this guidance, are not meant to be bright lines. As the GCC is used more, both by the individual analyst, and by the various states, using judgment around these thresholds is expected to become easier as the judgement is informed by experience.

Specific Procedures for Completing Review and Understanding of the GCC

The following procedures should be used by the analyst in their review and documentation of results of the GCC. However, if the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document the material risks of the group observable from the GCC (as well as the required information to be included in the GPS from the GCC), this should be documented by the analyst in any workpapers deemed appropriate by the state along with the general reasons supporting that conclusion. In making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner and judgement based upon existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that decision. 

Procedures Step 1
The purpose of procedures 1 is to assess the GCC level, and to identify the drivers of any changes in the GCC, in order to summarize and to document that overall assessment in the GPS and its strategic risk category, which is the minimum expected input of the GCC into the GPS. However, the analyst should understand that in the early years of the GCC, a limited amount of prior year(s) comparative data will be available, therefore requiring more judgement in determining if or where further analysis is warranted. Such judgement may need to be based upon various factors, including but not limited to other known information regarding the applicable group obtained from other sources (e.g., ORSA, Form F, Form B, etc.).

Procedure 1 is also intended to help the analyst determine if more follow-up review work should be performed. However, if the answer to any of the questions in 1 is "yes", the analyst should proceed with step 2, understanding decreases in total available capital and/or step 3, understanding increases in leverage to determine the cause(s) of the negative trends. In the example provided above, the trends are positive with no decreases in the base ratio except in PY1; presumably the analyst may have performed some level of inquiry to the holding company to understand the driver of the drop.

Procedures Step 2a-2m
Unlike step 1, the intent of step 2 (and 3) is to determine the actual source of the negative issues and where they should be documented in the GPS. Procedure 2a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by looking at the ratio of actual-to-required capital for the legal entity insurers over the available years reported. The following sample of a table from the GCC calculation completed by the group from the data in Schedule 1 can be helpful in determining the source of the issues.
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### Insurance Capital Table Template Groupings

<table>
<thead>
<tr>
<th>Template Groupings</th>
<th>2025</th>
<th>2024</th>
<th>2023</th>
<th>2022</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada - Life</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Japan - Life</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Japan - Non-Life</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solvency II -- Composite</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia - All</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Procedure 2b recognizes that the GCC does allow some debt to be included in capital up to a predetermined limit and can drive the overall GCC ratio. The following sample table taken from the GCC calculation using the data in Schedule 1 can be helpful in making this determination. Cases where debt is issued to address risk-driven reductions in the GCC ratio may not offset those reductions. This data metric may not be available in the case of a “limited filing”.

### Debt/Equity Table Template Groupings

<table>
<thead>
<tr>
<th>Template Groupings</th>
<th>2025</th>
<th>2024</th>
<th>2023</th>
<th>2022</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Procedure 2c recognizes that profitability is generally one of the biggest drivers of changes in capital and utilizing the following table from the GCC can assist in identifying if there are entities reporting net losses that may be driving the decreases in capital. The following table taken from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues.

### Income & Leverage Table Template Groupings

<table>
<thead>
<tr>
<th>Template Groupings</th>
<th>Net Income ($)</th>
<th>Return on Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Ins</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Non-US Ins</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
</tbody>
</table>
If the source of the issues is the insurers, the following sample from a table from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues among the insurers.

<table>
<thead>
<tr>
<th>Core Insurance Table 1 Template Groupings</th>
<th>Net Income ($)</th>
<th>Return on Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2025</td>
<td>2024</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>[1]</td>
<td>XXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>[2]</td>
<td>XXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>[3]</td>
<td>XXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>[4]</td>
<td>XXX</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>[5]</td>
<td>XXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>[6]</td>
<td>XXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>[7]</td>
<td>XXX</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>[8]</td>
<td>XXX</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>[9]</td>
<td>XXX</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>[10]</td>
<td>XXX</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>[12]</td>
<td>XXX</td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>[13]</td>
<td>XXX</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>[14]</td>
<td>XXX</td>
</tr>
<tr>
<td>Australia - All</td>
<td>[15]</td>
<td>XXX</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>[16]</td>
<td>XXX</td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>[17]</td>
<td>XXX</td>
</tr>
</tbody>
</table>

Procedure 2d is focused on requesting more specific information from the legal entity regulator or the group to better identify the source of the issue(s). Procedures 2e-2l simply contemplates that if the source of the issues can be identified into one of the branded risk categories, it should be documented in the detailed workpapers and into the appropriate branded risk category of the GPS. However, it is recognized that the source of issues may be in multiple branded risk categories, in which case documentation of each of the sources into the detailed workpapers...
workpapers is still appropriate. However, documentation into one of the single branded risk categories of the GPS is only appropriate if that risk category is a material driver of the negative trends. Procedure 2m is intended to identify if the source of the issues is related to non-insurance operations. The GCC is intended to provide for more consistent analysis of risks to the insurer that may originate from non-insurance entities within the holding company system.

**Procedures Step 3a-3f**

Procedure 3a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by looking at indicators of leverage, e.g., leverage ratios, where this risk may manifest itself either through increased writings or exposure, or through increased balances relative to capital and surplus. The following sample of a table from the GCC calculation using the data in Schedule 1 can be helpful in determining the source of the issues.

<table>
<thead>
<tr>
<th>Insurance Leverage Table</th>
<th>Net Premium Written ($)</th>
<th>Liabilities ($) / Capital &amp; Surplus</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Japan - Non-Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Australia - All</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Hong Kong - Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Hong Kong - Non-Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Singapore - All</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Chinese Taipei - All</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
</tbody>
</table>
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Capital Contributions $ Received/(Paid)</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa - Life</td>
<td>2022</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>South Africa - Composite</td>
<td>2023</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>South Africa - Non-Life</td>
<td>2024</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Mexico</td>
<td>2025</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>China</td>
<td>2026</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>South Korea</td>
<td>2027</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Malaysia</td>
<td>2028</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Chile</td>
<td>2029</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Brazil</td>
<td>2030</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>India</td>
<td>2031</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Other Regime</td>
<td>2032</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2033</td>
<td>XXXX XXXX XXXX</td>
</tr>
</tbody>
</table>

Procedure 3b is more forward-looking by suggesting the analyst look at the same leverage ratios used in 3a to determine if the trends might continue and lead to further decreases in the GCC ratio. Procedure 3c simply requests the analyst use the leverage information to target questions to the group to better identify the drivers. Procedures 3d-3f are all questions designed to help the analyst consider whether the changes in leverage will lead to greater underwriting risk, reserving risk, or market and credit risk. Procedures 3d-3f provide general inquiries for additional information for the analyst. However, these inquiries may also appropriately provide a basis for the analyst to hold conversations with the group on the same topics to understand how the group views these topics and how the group is managing and monitoring these risks. For groups filing an ORSA, see also documentation within the ORSA report for additional information on the identified risks and the group’s monitoring of risks, as well as consistency of the discussion with management and management’s observations in the ORSA Summary report.

Procedures Step 4a-4b. Procedure 4a is intended to help the lead state understand the historical capital allocation patterns or the likely future needed capital allocation patterns by simply documenting those in the detail analysis workpapers. This includes, for example, noting that there is consistency in the entities generating net income and distributing it further through the group, and in some cases may require distribution through other insurers, which in the US often requires approval if considered extraordinary. Procedure 4b is intended to utilize that knowledge, along with other planned actions of the group, to understand whether problems with repaying debt or other obligations in the group could occur. The intent is to be in a better position for discussions with the group on where the group may expect capital to come from to support future expected activity or future unexpected material events. The following sample of tables from the GCC calculation using data in Schedule 1 can be helpful in determining the source of the issues.
Procedures Step 5a-5h. Procedures 5a-5h are designed for those uncommon situations where the group believes they need to reduce risk because raising capital may be unlikely [see appendix for further discussion on that topic]. In performing this procedure, the analyst should understand that Procedure step 2 (Evaluating Decreases in Total Capital) and Procedure step 3 (Evaluating Increases in Operating Leverage) will have already been performed to determine whether capital is decreasing, or operating leverage is increasing. As such, after considering information that may already be available to the regulator on the business plan, Procedure 5b is largely focused on better understanding directly from the group the group’s reaction to the apparent negative trends. The analyst should understand that some of these trends may have already been known, through for example the ORSA review and discussions of the ORSA by the lead state of the ORSA. In fact, the key takeaways may already be documented in the GPS and therefore the remaining procedures in this section may be irrelevant and could be skipped if recently considered and understood. In addition, such trends from Procedure Steps 2 and 3 may suggest no additional information is necessary. It is for this reason that the first procedure is focused on the group’s...
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

existing business plan as it is possible these trends may have been expected. Further, Procedure 5a is based on
the belief that reducing risk by the group may have been previously incorporated into the group’s latest business
plan, which may have been obtained from the Annual Form F Filing.

Procedure 5b on the other hand contemplates that the manner to address any unexpected negative trends may
not have been incorporated into the latest business plan and thus further contemplates that the analyst speaks
with the group to understand how the group intends to address the issue. However, it should be recognized that
some trends that may appear to be “negative”, e.g., a decline in the reported GCC, may actually be the result of
a conscious decision by the group to more efficiently deploy capital while yet remaining at sufficient levels from an ERM perspective. This procedure is not meant to suggest action must be taken by a regulator, but rather to help the analyst understand whether a trend is in fact “negative” or not, and if so, what the group has already decided or plans to do to address the issue. Some of what the group is currently doing may already be known by the lead state, either through the ORSA, the Form F, or a periodic meeting with the group that some states conduct annually. Rather, the procedure provides an opportunity for the analyst to ensure they understand the drivers and what if anything the group is already doing to address the underlying issues that the group thinks is appropriate. To be clear, increases in operating leverage are often planned, and often come with -expected future actions by the group, such as capital injections or future transactions that may reduce risk. Meanwhile, decreases in capital sometimes are not expected, and may not result in immediate action, if any, but it is possible that they may lead the group to contemplate future actions to take. Therefore, these discussions would allow these potential actions to be better understood by the analyst and documented.

Procedure 5c contemplates assessing if the group has the ability and resources to either reduce its risks or to
raise additional capital. See the section below for further Considerations of the Group’s Capacity to Raise Capital.
This procedure is not intended to suggest the analyst has the capacity to make this determination on their own,
but rather to question the reasonableness of the possibility. Further, the GCC and related provisions in the NAIC’s
Model Holding Company Act and corresponding regulation are not designed or otherwise intended for
regulators to take regulatory action based on the reported level of a group’s GCC; regulators will use other
existing tools and authorities to take action, primarily at the legal entity level.

Procedure 5d contemplates that the group may believe no action is necessary because it believes current capital
is adequate to meet its business plan, which is more likely to be the case when the company experienced a one-time reduction of capital as opposed to a growth in leverage that may continue. Procedure 5e is for the rare situation where the legal entity insurers have been strained or face impending pressure contemplated within NAIC Model 385–Model Regulation to Define Standards and Commissioner’s Authority for Companies Deemed to be in Hazardous Financial Condition that would suggest one or more of the insurers may be in a hazardous financial condition. Procedure 5f is designed to suggest the analyst bring the collective supervisors of the legal entity insurers together for a supervisory college to fully understand what is occurring and the group’s plans for addressing the underlying issues. Procedure 5g is an extension of Procedure 5f as it contemplates the regulators discussing whether the proposed actions from the group are adequate. This action could represent something either informally done before an insurer is in a regulatory action level, or formally once an insurer is in a regulatory action level. Procedure 5h is similar to the other actions contemplated within a supervisory college or, for example, to address a troubled insurance company under Accreditation requirements regarding communication with other states.
## Additional Procedures – Business Plans

While there is a multitude of possibilities which are beyond the scope of this guidance to address, the following provides some of the related issues that may be helpful to the analyst to consider. (See also section 6 regarding the analyst’s consideration of the structure of the group and capital infusion issues.).

**Group’s Business Plan:**

**Planning Process:**
- Understand the Group’s system’s overall planning process (e.g., who is involved, how frequently it occurs, etc.) and how the overall initiatives are determined
- Understand the group’s estimate of the impact of the proposed actions on financial results
- Review the plan’s assumptions for reasonableness. Consider the likelihood of variations in the assumptions and the resulting impact on the future financial results
  - Consider subcategories of changes including:
    - Overall potential changes in investment strategy
    - Overall potential changes in underwriting strategy or risk concentrations
    - Overall impact on financing matters (e.g., debt, requirements, etc.)
    - Overall impact on derivatives to mitigate economic conditions
    - Overall changes in governance or risk management procedures
    - Increased ceded reinsurance transactions (common approach to reducing risk/increasing surplus):
      - Details regarding the revised strategy
      - Specifics on types of coverage such as assumption reinsurance, loss portfolio transfers
      - Transfer of risk considerations

**Variances to Projections:**
- Consider the group’s history of explanations regarding variances in projected financial results and the insurer’s actual results. If analysts determine the goals of the business plan are not attainable and/or projections are unreasonable, a revised business plan may be requested.
- Identify any internal or external issues not considered in the plan that may affect future financial results. Examples of such issues include the following: 1) the existence of competitors to limit future sales levels; 2) recent state legislation restricting the company’s product designs; or 3) the loss of key marketing personnel.

**Evaluating a Business Plan:**
Analysts should consider further detail where necessary in evaluating the proposed revised business plan but also monitor, on a periodic basis, the insurer’s progress in achieving the initiatives included in the group’s plan. Assuming that the analyst has determined that a decline in the GCC is to be considered a negative event, i.e., it was not the result of capital management and planning to more efficiently utilize capital while staying within sound levels to achieve ERM objectives, the goal of the plan would then be to address the improvement of the underlying causes that led to the issues and an improvement in subsequent GCC ratio results. Detail considerations for improving the plan may include the following (where considered inadequate):

- Trending comparative measures of targeted risk exposures including (where applicable):
  - Asset mix by detailed types
  - Credit risk by detailed types
  - Business writings/ratios by detailed product
- Impacts on financing items:
  - Projected cash flow movements for ongoing principal and interest payments on debt
  - Impact on debt interest coverage ratio, other debt covenants, rating agency ratings
  - Discussion of impact on parental guarantees and/or capital maintenance agreements
  - Expected source and form of liquidity should guarantees be called upon
- Impact of reasonable possible stress scenarios
- How the individual legal entities’ capital will be maintained at required levels

Consultation with Other Regulators
- Consult with members of the supervisory college (if applicable) or other domestic states for input in evaluating the revised business plan

Considerations of Group’s Capacity to Raise Capital

The following is designed simply as a reminder of considerations the lead state would contemplate when discussing the group system response to the issues identified in this section. More specifically, in most situations a group will first consider ways to reduce risk. In limited situations, it may consider trying to raise additional capital. While this is typically not an option for a group that is currently not performing as anticipated, in some situations alternative sources of capital may be raised if the holders of the newly issued equity securities capital are given rights that are attractive to the holder. In addition, in some cases the group may have the ability to issue other forms of capital (e.g., debt), which can be used to inject into the insurance subsidiaries. While these facts are not unique to the utilization of the group capital calculation, they are worth a reminder along with relevant other related details.
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

New Equity Considerations

Public Holding Company
While no two groups are the same, issuing public stock may be limited for the reasons previously identified. In addition, regulators are reminded that a public holding company may be obligated to pay dividends in order to maintain expectations of their shareholders, making the reduction of risk a more viable action under the circumstances.

Private Holding Company
While no two groups are alike, a private company has some of the same characteristics as a public company in terms of owners’ expectations, but usually such expectations differ from those for a public company, and it may be more feasible for a private company given its access to specific individuals that may have a higher interest in additional capital rights.

Mutual Insurance Company
A mutual insurer is limited in terms of its access to capital because it cannot issue new stock, but however, it can issue surplus notes.

Mutual Holding Company
Because mutual holding companies have characteristics of both public companies and mutual companies, there are implications of how such a structure affects its operations.

Non-profit Health Company
Insurers that are non-profits are generally charitable organizations and it is not uncommon for that some types of insurers, particularly those that provide health insurance, to have some history as a non-profit. It may be helpful to understand these types of dynamics when considering a group structure.

Fraternal Associations
Regulators often find similarities between a fraternal benefit society and a mutual insurer because both can be limited in terms of their ability to raise additional funds but can issue surplus notes. If allowed within state law and the charter, the fraternal could assess members or adjust members policy values.

Reciprocal Exchanges
Regulators often find similarities between reciprocal exchanges and fraternal benefit societies and mutual insurers because they can be limited in terms of their ability to raise additional funds. Although this is a general consideration for the regulator when evaluating the group system, there is generally much more that must be understood before coming to this conclusion because in some cases, the reciprocal may be able to assess policies that can serve a similar purpose as raising capital.

New Debt Considerations
Through discussions with the group, understand the potential impact of any new debt on the group system, including specifically the extent of future additional reliance on the insurance operations and whether those insurers have the capacity for such. Also consider an updated review of the following:

- Total debt service requirements.
- Revenue streams expected to be utilized to service the debt.
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

- Any new guarantees for the benefit of affiliates.
- Any new pledge of assets for the benefit of affiliates.
- Any new contingent liabilities on behalf of its affiliates.

International Holding Company Considerations

International Holding Company Structure
This section is applicable only to those international groups that are required to complete the GCC, which may be relatively few considering many international holding companies have a non-US groupwide supervisor and are exempt from the GCC. Those foreign groups that are required to complete the GCC will generally file a “subgroup” GCC that included entities that are part of the group’s U.S. operations. In those situations, the analysts should understand the structure to determine if it has any impact on this analysis. For example, a German-based holding company may have advisory boards established to communicate with U.S. regulators. Analysts should direct any regulatory concerns to the appropriate organizational contact to ensure a prompt reply or resolution if the insurance regulator is not responding.

Capital / Operational Commitment to U.S. Operations
Some foreign holding companies may consider their U.S. enterprises non-core and consequently show weaker commitment to their ongoing business operations or financial support. In recent years, after sustaining continued losses from U.S. subsidiaries, several prominent foreign holding companies decided to cease their U.S. operations and liquidate their assets. Analysts should be aware of a holding company’s stated commitment to ensure the continued stability of U.S. operations. This commitment may include a written or verbal parental guarantee.
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Primer on the Group Capital Calculation Formula
The National Association of Insurance Commissioners (NAIC) began development of the Group Capital Calculation (GCC) in late 2015 following extensive deliberation on potential measurement models and methodologies. The GCC uses a bottom-up aggregation approach, accounting for all available capital/financial resources, and the required regulatory capital based on the measurement of assets and liabilities of the various corporate entities, including insurers, other financial entities, and non-financial businesses.

The GCC Aggregation Methodology
As illustrated in the sample tables above, the proposed GCC is an aggregation or grouping of the available financial resources and calculated required capital of all legal entities in an insurance group that could potentially pose material risk to the insurers in the group. The GCC allows some discretion in determining what entities under common control but outside of the defined Insurance Group may be excluded from the scope of application in the GCC. When reviewing a group’s choice of entities to be excluded from application of the GCC, the following points should be considered:

- The regulatory evaluation should be based on the criteria for material risk (e.g., structural separation, no history of cross subsidies, or other criteria as defined in the GCC instructions).
- Group requests for reducing the scope of application of the base GCC should be based on supporting information and a rationale provided by the Group.
- Information on excluded entities should be made available upon request from the analyst.

The GCC includes the following types of entities (listed with sets forth the general approach of calculated capital toward each):

U.S. Insurers – The available capital of U.S. domiciled insurers is determined by statutory accounting principles (SAP) as defined by state law and the NAIC Accounting Practices and Procedures Manual, which defines assets, liabilities, and net available capital/financial resources, sometimes referred to as policyholder surplus. The calculated capital for these insurers is subject to state law that requires these insurers to maintain minimum capital based on the applicable NAIC Risk-Based Capital formula at 200% x Authorized Control Level.

Non-U.S. insurers – Similar to the available capital and calculated required capital of U.S. insurers, the available and calculated capital of non-U.S. insurers is determined by reference to the home jurisdiction’s basis of accounting and capital requirements converted to U.S. dollars. While most non-U.S. jurisdictions do not possess the same level of industry specific technical guidance as included in the NAIC Accounting Practices and Procedures Manual, all jurisdictions have established accounting standards that insurers are required to follow to determine available capital/financial resources. In some cases, this represents local Generally Accepted Accounting Principles (GAAP), which may or may not be consistent with International Financial Reporting Standards (IFRS).

DRAFTING NOTE: While the GCC utilizes the available capital and home jurisdictions’ capital requirement, for jurisdictions where data is available, the use of appropriate scalars is currently being explored to produce more comparable measures for risk which can be aggregated into the group-wide measure. One such scaling methodology is included as part of a sensitivity analysis in the GCC template. That scalar methodology uses aggregated data from the U.S. and other jurisdictions at the first intervention level to recognize that (for
example), state regulators often have much higher reserve requirements, incorporating amounts that are required to be carried as required capital in other jurisdictions. For jurisdictions where the data is not available, the full jurisdictional requirement at the first intervention level is used.

U.S. Insurers Not Subject to RBC – Some types of U.S. insurers are not subject to an RBC formula (e.g., Financial Guaranty Insurers, Title Insurers). For these entities, the available capital/financial resources are determined by reference to state law and the NAIC Accounting Practices and Procedures Manual. However, since an RBC formula does not exist, calculated capital is determined by reference to the state minimum capital requirements set out in state law (or 300% of reserves for Title insurers). For U.S. captive insurers, available capital is determined based upon the states accounting requirements, but the calculated capital is required to be calculated using the applicable RBC formula even if RBC does not apply to that entity in its state of domicile.

Banking or Other Financial Service Operations Subject to Regulatory Capital Requirements – Non-insurers such as banks are subject to their own regulatory valuation methods (typically GAAP with tiering of available capital) and their own regulatory capital requirements (e.g., OCC, Federal Reserve, FDIC, or other requirements for banks). These regulatory values are used for the GCC.

Financial and non-financial operations not subject to regulatory capital requirements – In general, financial entities (as defined in the GCC Instructions) are subject to a higher capital charge in the GCC than the non-financial entities. However, the GCC does require available capital/financial resources and calculated capital to be gathered for all such entities that pose a material risk to insurers. In both cases the GCC will utilize the valuation used by such legal entities (typically U.S. GAAP) and a calculated capital based upon a risk factor. There are two important exceptions:

- All entities within the defined insurance group (definition included in GCC Instructions) must be included
- All financial entities (definition included in GCC Instructions) must be included
- The level of risk (low / medium / high) and associated capital calculation assigned to a financial entity will be selected by the group and evaluated by the lead-state reviewer
- Non-financial entities that are subsidiaries of U.S. insurers, foreign insurers, or banks where a capital charge for the non-financial entity is included in the regulated Parent’s capital formula will remain with the Parent and will not be inventoried. Regulators already have access to the financials of these entities if needed (if causing unrealized losses within the insurer).

Eliminations
The GCC uses an aggregation and elimination approach, where each of the above legal entities’ available capital/financial resources and calculated capital are combined, then eliminations are utilized to prevent any double counting of available capital/financial resources or calculated capital. The following example illustrates the use of eliminations for both available capital/financial resources and calculated capital. However, in practice the GCC only requires the foreign insurers and other financial entities owned by an insurance company to be “de-stacked” so if AA Holding Company was a U.S. insurer (e.g., AA Insurance Company) the capital required and calculated capital for DD Insurance Agency as a nonfinancial entity would remain in the values of AA Insurance Company and not be de-stacked.
**VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) – Analyst Reference Guide**

**EE Insurance Group (EEIG)**

<table>
<thead>
<tr>
<th>Entity</th>
<th>TAC</th>
<th>Less: Subs TAC</th>
<th>Adjusted TAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Holding Co.</td>
<td>50.0M</td>
<td>(38.0M)</td>
<td>12.0M</td>
</tr>
<tr>
<td>BB Life Ins. Co.</td>
<td>30.0M</td>
<td>0</td>
<td>30.0M</td>
</tr>
<tr>
<td>CC Insurance Co.</td>
<td>6.0M</td>
<td>0</td>
<td>6.0M</td>
</tr>
<tr>
<td>DD Ins. Agency</td>
<td>2.0M</td>
<td>0</td>
<td>2.0M</td>
</tr>
<tr>
<td><strong>ARC (EEIG Group Total)</strong></td>
<td><strong>50.0M</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. For Non-RBC filers this is regulatory available capital or stockholder equity
2. There is no regulatory capital for these entities when owned by a non-regulated entity.
3. Calculated Capital is added @ 10.5% x stand-alone ARC

<table>
<thead>
<tr>
<th>Entity</th>
<th>Total Available Capital</th>
<th>Minimum Regulatory Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Holding Company</td>
<td>50.0 million</td>
<td>0</td>
</tr>
<tr>
<td>BB Life Insurance Co.</td>
<td>30.0 million</td>
<td>3.0 million</td>
</tr>
<tr>
<td>CC Insurance Co.</td>
<td>6.0 million</td>
<td>1.6 million</td>
</tr>
<tr>
<td>DD Insurance Agency</td>
<td>2.0 million</td>
<td>0</td>
</tr>
</tbody>
</table>

**Calculation of ARC**

**Calculation of MRC**

<table>
<thead>
<tr>
<th>Entity</th>
<th>ACL or Calculated Capital¹</th>
<th>Less: Subs Calculated Capital</th>
<th>Adjusted Calculated Capital</th>
<th>Multiply by 2.0²</th>
<th>MRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Holding Co.</td>
<td>6.07M</td>
<td>(4.81M)</td>
<td>1.26M</td>
<td>NA</td>
<td>1.26M</td>
</tr>
<tr>
<td>BB Life Ins. Co.</td>
<td>3.0M</td>
<td>0</td>
<td>3.0M</td>
<td>6.0M</td>
<td>6.0M</td>
</tr>
<tr>
<td>CC Insurance Co.</td>
<td>1.6M</td>
<td>0</td>
<td>1.60M</td>
<td>NA</td>
<td>1.6M</td>
</tr>
<tr>
<td>DD Ins. Agency</td>
<td>0.21M</td>
<td>0</td>
<td>0.21M</td>
<td>NA</td>
<td>0.21M</td>
</tr>
<tr>
<td><strong>MRC Total</strong></td>
<td><strong>9.07M</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Estimated post covariance factor of 10.5% @ CAL x ARC per GCC added for AA Holding Co. and DD Ins. Agency
2. Amount of Calculated Capital for Subs as follows: (3.0M + 1.6M + 0.21M)

In the above example, available capital/financial resources are referred to as available regulatory capital (ARC) and total authorized capital (TAC) and minimum calculated capital is referred to as minimal regulatory capital (MRC) and authorized control level (ACL). The GCC will allow non-insurance / non-financial entities owned by RBC filers in the group to remain within the available capital and calculated regulatory capital of the parent, so no eliminations are required for these entities. As shown, since AA Holding Company owns each of the other business entities in the organizational chart, $38 million (which is the amount of available capital/financial resources in the subsidiaries of AA) is eliminated from the TAC column since accounting methods include those as an asset on AA Insurance Company’s balance sheet. Also, the GCC includes capital calculations for AA Holding Company and DD Insurance Agency as part of the MRC in addition to the regulatory capital already included for the insurance subsidiaries. The MRC of the subsidiaries is eliminated from the parent’s (AA Holding Company) calculated capital. Therefore, in this example $4.81 million of calculated capital is eliminated from the MRC. Finally, the MRC of U.S. insurance subsidiary is multiplied by 2 in order to reflect Company Action Level (CAL) RBC as required in the GCC.

1. Terminology used in RBC for available capital/financial resources
2. Terminology used in RBC for calculated regulatory capital
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) – Analyst Reference Guide

Debt-It is important to note that the available capital used in deriving the GCC recognizes a portion of the group’s senior and hybrid debt as capital. This allowance recognizes that debt that is not already recognized as available capital/financial resources under all known accounting principles (SAP, U.S. GAAP or IFRS) may have some value to the group under the U.S. insurance regulatory requirements where debt proceeds are contributed such as dividend down to the insurance companies and where extraordinary dividends must be approved by the state. Qualifying debt along with limitations thereon are described in the GCC instructions as is the calculation for the additional available capital. In addition to looking at the group’s debt leverage, overall consideration should be given to how the allowance for additional capital from debt interacts with changes in available capital and capital requirements from year to year. The impact of procyclical changes in the allowance for debt as capital should be assessed.

Other Information Included in the GCC
The GCC includes selected financial information (net income, premiums, liabilities, debt, etc.) that are captured in Schedule 1 and in the “Analytics” tabs of the GCC, which is meant to be used to help isolate potential strengths and weaknesses of the group and more specifically where such exist among the entities in the group. Some important information related to other features in the GCC also should be considered and are discussed below. Schedule 1, a simplified version of the Inventory Tab, and most analytics are required in the case of a “limited filing”. However, data is not required for the capital instruments, sensitivity analysis and other information tabs in a limited filing.

Grouping - The GCC separately allows certain financial entities (e.g., asset managers) and non-financial entities included in the GCC to have their values and capital calculation combined (grouped) for more efficient reporting and analysis. Although the GCC instructions set parameters for such grouping, the general expectation is that regulators will work with each applicable GCC filer in determining where grouping is and is not appropriate outside of what is allowed within the GCC Instructions. Grouping should be viewed in the context of materiality. A single entity conducting a given activity may not be material, but when all entities conducting the same activity are combined, they may be material.

Excluded entities – The GCC provides two mechanisms for the exclusion of non-financial entities in Schedule 1 and in the Inventory Tab at the discretion of the lead state. State regulators should consider whether any of the information collected in the GCC template in support of, should be collected for an entity or group of similar entities that would otherwise be excluded from the GCC ratio calculation. Regulators should separately monitor increases in the level of activity of an “excluded” entity or group of similar entities for purposes of materiality and potential subsequent inclusion in the GCC.

Sensitivity analysis – A tab devoted to sensitivity analysis is included in the GCC. These informational items provide the regulator with impact of discretion in excluding listed entities and alternative perspectives on risk charges for non-financial entities and foreign insurers. Monitoring of these items can help the regulator identify areas where the GCC may be improved, or capital calculations adjusted in the future. One item included in the sensitivity analysis is a “sensitivity test” that increases the overall calibration of the calculated capital in the GCC from its normal 200% x ACL RBC calibration to 300% x ACL RBC.

Accounting Adjustments - The impact of accounting adjustments and related detailed information is collected in the GCC template in the Inventory Tab and in the Other Information Tab respectively. Such adjustments can be material during the de-stacking process. For example, a consolidated holding company may include GAAP values for entities that would otherwise be valued under regulatory accounting rules (e.g., Statutory Accounting Principles - SAP) on a stand-alone basis. When the regulated entity is de-stacked the difference between the GAAP
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) – Analyst Reference Guide

values and SAP values will be removed from the group’s available capital. These “lost” values can result in a material reduction in the inventoried available capital compared to consolidated available capital. Understanding the impact and the components of this adjustment can help the regulator when considering the impact of issuing new debt or when evaluating the allowance for debt as capital calculated in the GCC template.

Intangible Assets – Acquisitions, mergers and reorganization often can create significant intangible assets at a holding company level or possibly at an operating company (other than a regulated entity) level. The GCC template collects information on intangible assets held by inventoried entities in the Other Information Tab. The available capital associated with the value of entities whose assets are materially comprised of intangible assets should be evaluated in the context of fungible resources and in assessing the adequacy of the capital calculation assessed on such entities.

Dividend pass-through (gross view of dividends) – Schedule 1D collects information on dividends paid and received within the group. It also includes a column that indicates whether dividends were declared but not yet paid, as well as cases where dividends received were retained or “passed through” to another affiliate or paid out in dividends to shareholders. This information will assist the regulator in evaluating the movement of capital within the group to fund strategic insurance and non-insurance operations or activities (e.g., expansion of activities) or to fund entity specific capital shortfalls. It also provides a window to capital leaving the group (e.g., debt repayment, stock repurchase, or dividends to shareholders).

Considerations When Exempting Groups

As stated elsewhere within this guidance, the GCC and its related provisions in the NAICs Model Holding Company Act and corresponding regulation are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group’s GCC. Rather, the GCC is intended to be a tool to better understand the risks of the group, mostly through the trending of the financial information in the “Input 4-Analytics” tab. However, specific to the provisions of the NAICs Model Holding Company Act and corresponding regulation, the Group Capital Calculation (E) Working Group did believe that the GCC might be more helpful for some groups and not as much for others when it developed criteria within the Act and the regulation for exemptions. On this point, the Working Group believed that in general the GCC would be more helpful for those groups that had 1) non-U.S. insurers within the group; 2) a bank within the group, or 3) a more material degree of non-insurers. Specific to the point regarding non-U.S. insurers or banks, the GCC is based upon the premise that the most relevant measure of capital is the actual legal entity requirements of capital from the applicable regulator. On this point, the required capital, as well as the trending of information on these particular legal entities might be the most valuable, particularly if the relative operations and assets of these entities compared to the U.S. RBC filers is material. Similarly, while the calculated capital on the non-insurance entities may not be as relevant as either required capital on regulated insurers or banks, if the relative operations and assets of non-insurers relative to those of US RBC filers are material, the GCC may provide greater value to such types of groups.

To these points, the NAICs Model Holding Company Act and corresponding regulation contain possible exemptions for groups that have less than $1 billion in premium and that do not possess any of the three characteristics just described. These possible exemptions exist after the GCC has been filed once, because the general consideration in developing the requirement in the model that the GCC must first be filed once for all groups, was that without seeing the completed GCC at least once for a group, it may be difficult for the lead-state to determine if the GCC has no value or is at least cost beneficial to require filing. However, it should also be understood that these three criteria of non-U.S. insurer, bank, or non-material non-insurers are not the only situations where the GCC would be valuable to the lead-state. As a reminder, all states are required to assess the sufficiency of capital within the holding company structure, and that prior to the GCC, this was done by states using various methods (e.g., debt to equity ratios, interest coverage ratios, existing RBC ratios and relative size of insurance). The GCC is expected to enhance a state’s ability to make this assessment more easily, even if it is only
used as a general gauge as its intended. Therefore, in deciding if a group should be exempted, the lead-state will need to consider a number of factors, including how easily it can make this assessment without the GCC, again, only as a general gauge. For small groups where the U.S. RBC operations and assets are much larger than the non-insurance operations, it is likely the GCC would provide a smaller degree of value and exempting such groups from the GCC may be appropriate. However, the analyst should also consider the fact that the simpler the holding company structure, the more easily the GCC can be completed. Specifically, given all of the data included in the GCC is existing data and therefore readily available to the company, a smaller and simpler structured group should be able to accumulate into the GCC template in a short period of time. Also worth considering is that if such operations are contained within a number of different U.S. insurers where it is difficult to determine the degree of double counting of capital, the GCC may provide more value. To be clear, these are not the only situations where the GCC might be helpful even with a relatively small group. This is because the value may come from figures the GCC requires that the state may have otherwise not been aware of. Specifically, the GCC may identify non-RBC filers who may be experiencing some level of financial difficulties. This possible identification of information the lead-state was not otherwise aware of is the primary reason the Working Group suggested the GCC be filed once before deciding on whether a group should be exempted. While the NAIC Accreditation program may not require a state to have such authority to have the GCC filed once before exempting, this background information provided herein is intended to encourage the state to consider such possibilities before deciding on exempting a group, particularly since it may be difficult to stop an exemption in a given year once it’s provided. In summary, as with everything else described in this documentation, the GCC requires judgement on behalf of the analyst and the lead-state which is based upon multiple factors including the lead-state’s existing knowledge of the group. This fact is no different. The same applies when considering whether a group should be exempt.
The Group Capital Calculation (E) Working Group of the Financial Condition (E) Committee conducted an e-vote that concluded Sept. 13, 2021. The following Working Group members participated: John Rehagen, Chair (MO); Kathy Belfi, Vice Chair (CT); Susan Bernard (CA); Philip Barlow (DC); Ray Spudeck (FL); Carrie Mears (IA); Kevin Fry (IL); Roy Eft (IN); Judy Weaver (MI); Kathleen Orth (MN); Jackie Obusek (NC); Justin Schrader (NE); David Wolf (NJ); Bob Kasinow (NY); Dale Bruggeman (OH); Greg Lathrop (OR); Melissa Greiner (PA); Jamie Walker (TX); and Amy Malm (WI).


As a result of receiving comments (Attachment Two-B1) on proposed changes to the *Financial Analysis Handbook* to address the group capital calculation (GCC), NAIC staff were directed to make modifications to the proposed guidance to address those comments provided they were consistent with the original intent of the guidance. After providing the Working Group members with revised guidance as directed, a majority of the members voted in favor of re-exposing the guidance for a 45-day public comment period ending Oct. 29.

Having no further business, the Group Capital Calculation (E) Working Group adjourned

*Attachment Two-B1-9-13-21 E-Vote Minutes.docx*
Review of the Group Capital Calculation

Consideration of the Insurance Holding Company System Structure

As the lead state begins to review the annual Group Capital Calculation filing for a particular group, it’s important for the lead state to do so with consideration of the existing knowledge of the organizational structure of the group, including changes in the structure from year to year, but more importantly the overall activities of each of the entities in the group which otherwise have the potential to transmit material risk to the insurers within the group. While the GCC will provide additional quantitative information on the entities in the group; the actual activities of the entities are also important in determining the scope of application of the GCC. Specific to that point, the lead state is responsible for determining if any of the entities in the holding company structure should be excluded from the calculation. The filing includes a column for the group to propose what should be excluded as well as an additional column for the final determination made by the lead state. In general, the determination of scope of the application is suggested by the group but made in consultation and agreement with the lead state. This exercise should be undertaken in a manner that yields a clearly documented rationale for excluding entities or subgroups of the larger group. The Group Capital Calculation Instructions describes the basis for making this determination and the calculation itself is structured to facilitate this determination, with the inclusion in Schedule 1 of the calculation financial data of all entities within the holding company. Similar to exclusion from the calculation itself is data for cases in which subgroups of the larger group are completely excluded from the group, particularly with regard to Schedule 1: the rationale for the exclusion(s) should be provided in the GPS. The concept is that this Schedule 1 data should be utilized by the lead state in conjunction with their existing knowledge of the group and its activities (obtained from the Schedule Y, ORSA, Forms B/C, Form F, the non-insurance grid, etc.), and therefore likely material risks, to make this determination. To the extent the entities included in Schedule 1 differ from the analyst’s knowledge of the Group, further discussion and follow-up should be done with the group.

In the initial year(s) of a GCC filing, to help the analyst get comfortable with the Inventory and Schedule 1 process, consider the following:

- Gather appropriate background information for your group(s) (e.g. Group Profile Summary, ORSA, RBC Reports, Schedule Y)
- Determine that all Schedule Y entities are listed in schedule 1 or in the Schedule BA list in the other information tab or that an entity’s omission is understood/explained
- Evaluate requests for exclusion of non-insurance/non-financial entities w/o material risk to determine if you agree with exclusion.
- Confirm that all insurers and financial entities are de-stacked in the inventory tab.
- Determine if grouping has been properly applied.
- Evaluate level of risk assigned by filler to financial entities w/o regulatory capital requirements.
- Test check that the numbers reported in Schedule 1 and Inventory Tab look reasonable, especially for the insurers. A simple check should be sufficient.
- Review the impact of the stress scenario (Stress Inputs and Stress Summary Tabs) and narrative (if provided in Other Information Tab)

The holding company structure and activities should also be utilized by the lead state in determining how to understand the GCC ratio. More specifically, information on structure can impact the flow of capital and resources among entities within the holding company structure. Therefore, understanding the following can assist in evaluating the flow of resources:

- Domestic insurance operations
- International insurance operations
• Banking or other financial services operations subject to regulatory capital requirements
• Financial and non-financial operations not subject to regulatory capital requirements*

*The GCC instructions provide examples of financial versus non-financial entities in this category. All financial entities should be included in the scope of application of the GCC. However, there can be a broad array of entities that could be considered financial. The lead-state should document the rationale for cases in which it concludes that a “financial” entity should be excluded.

The GCC is intended to be used as an input into the GPS. The expectation is that the GCC summary section is used to document a high-level summary of the analyst’s take away of the GCC, as well as the Strategic branded risk, since that is the area where capital measurement is reported. The manner in which the analyst determines what else should be documented beyond the GCC Summary and the Strategic branded risk should be based upon the following steps, since these steps contemplate the previously mentioned concept that the existing evaluation of the financial condition should be used in evaluating the depth of review of the GCC. From a high level, the following summarized the different steps that can be taken:

• Procedure Step 1 suggests that a review of the components of the GCC (identified in Procedures 2-5) is appropriate when either the GCC ratio is below a predefined suggested threshold of 150% (equivalent to an RBC of 300%) since that is the same threshold used in the sensitivity analysis in the GCC Template, or the GCC ratio is trending materially downward.

• When Procedure Step 1 identifies the need to look further, Procedure Step 2 suggests from a high level determining the driver of any decreases in the total available capital in the GCC. While there are numerous benefits of the GCC over consolidated approaches, the ability to drill down on the drivers is one of the more significant and is consistent with the states approach to not just looking at capital, but to the drivers of capital issues.

• When Procedure Step 1 identifies the need to look further, Procedure Step 3 suggests from a high level determining the driver of any increases in operating leverage, which is typically what drives insurance capital requirements up, be it asset risk/leverage or writings leverage. Similar to drivers of capital decreases, the GCC has detailed information on financial figures and ratios that can be used to isolate the issues.

• When Procedure Steps 2 and 3 identify the need to understand better, Procedure Step 4 is similar in that it too utilizes detailed information on capital allocation patterns that are necessary to understand if there are negative trends in the GCC since these can become important if there are any issues that might require further distribution of capital across the entities.

• When Procedure Steps 2, 3 and 4 identify the need to understand better, Procedure Steps 5: Depending upon the analysis performed in previous Steps, similar to legal entity analysis, there is likely a need to determine what steps the company is taking or plans to take to address the issues seen in the analysis of the GCC. The guidance provided in these procedures is not intended to be exhaustive, but rather should give the analyst a starting point in better evaluating the various issues.

If the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document the material risks of the group observable from the GCC (as well as the required information to be included in all GPS from the GCC), this should be documented by the analyst in any workpapers deemed appropriate by the state and include the general reason therefore. In making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner and judgement based upon existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that judgement decision.
Procedure Step 1-Evaluate the Adequacy of Group Capital

1. Determine if the group capital position presents a risk to the group and its insurance subsidiaries based upon its recent trends and/or current measures in the GCC ratio.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Is the GCC &lt;150%? If &quot;yes&quot;, determine the most significant risk factors causing the result.</td>
<td>ST</td>
</tr>
<tr>
<td>b. Has there been a decrease in the GCC ratio over last two or more years? If &quot;yes&quot;, determine the cause(s) of the decline.</td>
<td>ST</td>
</tr>
<tr>
<td>c. Has there been a decrease in the GCC Total Available Capital from prior year? If &quot;yes&quot;, determine the cause(s) of the decline.</td>
<td>ST</td>
</tr>
<tr>
<td>d. If the GCC &lt;150%, has there been a change from prior year? If so, determine the cause(s) of the change. If the GCC was &lt;150% in the prior years also, consider more carefully the causes.</td>
<td>ST</td>
</tr>
<tr>
<td>e. Has there been a negative trend in the GCC ratio over the past five years suggesting an overall pattern of declining capital?</td>
<td>ST</td>
</tr>
</tbody>
</table>

If the answer to any of the above questions is "yes", the analyst should proceed with procedure step 2, evaluating decreases in total available capital and/or procedure step 2, evaluating increases in leverage to determine the cause(s) of the negative trends.
Procedures Step 2—Understand Decreases in Total Available Capital
2. Determine the source(s) of decreases in the GCC ratio or the GCC Total Available Capital

Unlike step 1, the intent of the step 2 (and 3) is to determine the actual source of the negative issues. However, unless obvious from the information obtained in step 2, the analyst should proceed to step 5 using understanding of items in Procedure Step 4, to understand more fully the actions being taken by the group to address the issues identified in step 2. However, in some cases, it’s possible that no further follow-up with the group will be necessary and that the lead state should simply update the GPS to be certain the main understanding of the issues are known to all of the regulators utilizing the GPS.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Review the GCC ratio from each of the reported entities and compare to the same ratio from the prior year. Determine which entities may have led to the negative trends.</td>
<td>&lt;10%</td>
</tr>
<tr>
<td>b. If the change in the GCC is not driven from a legal entity, and instead the change in allowable debt, note as such.</td>
<td>ST N/A</td>
</tr>
<tr>
<td>c. Review the levels of profitability for each of the reported entities in the GCC in the current and prior years (as reported in the GCC) to determine if there are particular entities showing signs of decreasing profitability which may lead to future decreases in the GCC ratio or total available capital.</td>
<td>OP, PR/UW &lt;10%</td>
</tr>
<tr>
<td>d. For each of the reported entities showing either, 1) a meaningful decrease in the GCC due to a decrease in the total available capital, or 2) negative profitability trends; request information that identifies the issues by inquiring from the legal entity regulator first or the group itself (e.g., non-insurance company), if applicable.</td>
<td>OP, PR/UW, ST N/A</td>
</tr>
<tr>
<td>e. If due to pricing or underwriting issues, understand if the issues are the result of known pricing policies that are currently being modified or if the business is in runoff, recently identified products where metrics can quantify the issues whether new product lines, or geographic or other concentrations, volume/growth business strain, or other issues. When considering pricing that is being modified, include those products that the price is adjusted through crediting rates.</td>
<td>PR/UW N/A</td>
</tr>
<tr>
<td>f. If due to reserve issues, understand the reserve development trends, whether reserve and pricing adjustments have been made as well as changes in business strategy apart from those products.</td>
<td>RV, ST N/A</td>
</tr>
<tr>
<td>g. If due to market risk issues—i.e., capital losses—understand not only why the losses occurred, but the likely near-term future impact given current and likely prospective economic conditions. Market issues include not only changes in equity prices, but also impact/exposure to interest rates and other rates such as foreign</td>
<td>MK, CR N/A</td>
</tr>
</tbody>
</table>
### VLH, Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

<table>
<thead>
<tr>
<th>Currency exchange rates or rates on various hedging products used by the group.</th>
<th>ST, PR/UW, OP</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>h. If due to strategic issues such as planned growth, planned decline in writings or changes in the investment strategy, utilize the business plan from the Form F to better understand the anticipated changes and how the actual changes compare. Understanding the variance from the business plan is important in assessing the ongoing risk either in projected future profitability or in some cases the investments.</td>
<td>ST, PR/UW, OP</td>
<td>N/A</td>
</tr>
<tr>
<td>i. If due to negative reputational issues, understand the issues more closely, whether potential ongoing changes in stock prices or financial strength ratings that may further impact market perception, or what the group is doing to address the potential future impact be it sales projections or access to the capital markets.</td>
<td>RP</td>
<td>N/A</td>
</tr>
<tr>
<td>j. If due to credit losses, understand the current and future concentration in credit risks, be it investments, reinsurance or other source of credit losses.</td>
<td>CR, MK</td>
<td>N/A</td>
</tr>
<tr>
<td>k. If due to operational issues, such as extremely large catastrophe events, IT or cybersecurity events or relationships, understand the current and prospective impact.</td>
<td>OP, ST</td>
<td>N/A</td>
</tr>
<tr>
<td>l. If due to legal losses, understand the underlying issues and degree of potential future legal losses.</td>
<td>LG</td>
<td>N/A</td>
</tr>
<tr>
<td>m. If due to non-insurance reported entities in the group, understand the relationship of the non-insurance operations to the insurance entities and the potential impact to the insurance operations (i.e. intercompany agreements, services, capital needs, etc.).</td>
<td>ST, OP</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Procedure Step 3 - Understand Increases in Operating Leverage

3. Determine the source(s) of any decreases in the GCC ratio due to increases in leverage

Like step 2, the intent of the step 3 is to determine the actual source of the negative issues. The difference between step 3 and step 2 is simply the types of issues. Step 2 is focused on issues that have resulted in negative capital trends. Step 3; however, is focused on the issues that impact the risk being measured in the GCC. In most cases that risk is either from the asset side or from the liability side where in both cases there has been an increase in such risk that has not been offset by a corresponding or equal increase in capital. In general, this is referred to as operating leverage, where this risk can manifest itself either through increased writings or exposure (e.g., the ratio of premiums to capital or liabilities to capital), or through increased assets that also carry risk. The expectation is that other regulated entities also have capital requirements that increase as the different types of risks increase, similar to how the NAIC RBC considers different types of products and assets that carry more risk.
a. Review the GCC ratio from each of the reported entities and compare it to the same ratio from the prior year. Determine which entities may have led to the negative trends based upon corresponding increases in leverage.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>MK, CR, RV, ST, OP, RP</td>
<td>&lt;10%</td>
</tr>
</tbody>
</table>

b. Review the levels of operating leverage for each of the reported entities in the GCC as well as the same for the prior years as reported in the GCC to determine if there are particular entities showing signs of increasing operating leverage which may lead to future decreases in the GCC ratio or total available capital.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>MK, CR, RV, ST, OP, RP</td>
<td>&lt;10%</td>
</tr>
</tbody>
</table>

c. For each of the reported entities showing a meaningful decrease in the GCC due to an increase in operating leverage, request information that identifies the issues by inquiring first from the legal entity regulator or the group itself (e.g., non-insurance company), if applicable.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>MK, CR, RV, ST, OP, RP</td>
<td>N/A</td>
</tr>
</tbody>
</table>

d. If operating leverage has increased, consider if growth may have resulted from underpriced products or a change in underwriting. Specifically inquire to determine if pricing was reduced to increase sales, or whether the growth is in new product lines or new geographic focus where the group may not have expertise. When considering pricing being modified, include those products that the price is adjusted through crediting rates.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>PR/UW, OP, ST</td>
<td>N/A</td>
</tr>
</tbody>
</table>

e. If operating leverage has increased, consider if the reserve risk has also increased, through potential underpricing that ultimately manifests itself into reserve adjustments. To do so, obtain current profitability information on the products leading to the increased leverage.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>RV</td>
<td>N/A</td>
</tr>
</tbody>
</table>
f. If operating leverage has increased, obtain current information on the asset mix to be certain that there is a corresponding decrease in riskier assets to mitigate the otherwise likely increase in market and credit risk.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR, MK</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Unless obvious from the information obtained in step 3, the analyst should proceed to step 5 using understanding of items in Procedure Step 4, to understand more fully the actions being taken by the group to address the issues identified in step 3. However, in some cases, it’s possible that no further follow up with the group will be necessary, and that the lead state should simply update the GPS to be certain the main understanding of the issues are known to all of the regulators utilizing the GPS.

**Procedure Step 4-Understand the Capital Allocation Patterns**

4. Determine the capital allocation patterns to determine if some entities may put pressure on other legal entities.

Steps 2 and 3 are critical in understanding the issues faced by the group and in identifying the source of negative trends; and while additional follow up with the group is expected, before proceeding to Step 5, the lead state should understand the historical capital allocation patterns or the likely future needed capital allocation patterns.
The GCC includes data on historical capital allocation patterns (e.g., contributed capital received/paid or dividends received/paid), which help to illustrate which entities need capital and which entities have capital that can be provided. While these patterns do not necessarily repeat themselves from one period to the next, there is often consistency in terms of entities that need capital or have excess capital, which may or may not be driven by losses, but rather a change in strategy (e.g., increased writings at one company over another). These trends can also assist in discussions with the group on where capital may come from as a result of a future unexpected material event. Where similar information is also disclosed in Form F, the detail in the GCC may confirm what is already known in this area and in some cases may provide greater detail.

<table>
<thead>
<tr>
<th>Procedure Step 5-Consider the Need for Company Discussions for Reductions in Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Review the data from the GCC to determine the historical capital allocation patterns within the group and summarize the result of this analysis.</td>
</tr>
<tr>
<td>Branded Risk</td>
</tr>
<tr>
<td>ST</td>
</tr>
<tr>
<td>b. Using this data, as well as any recent information on net losses, or likely expected funding, determine if it’s possible any of the insurance companies will be required to fund future possible losses from other entities in the group and potentially become troubled themselves, regardless of the current capital in excess of RBC requirements.</td>
</tr>
<tr>
<td>OP, ST</td>
</tr>
</tbody>
</table>

Steps 5 is designed to assist a review of the insurance company’s plans for addressing any meaningful decreases in the GCC ratio or total available capital. The specific plans of the group may or may not fully address all the issues but ultimately what is most important is that such information and the regulators plan for evaluating and monitoring the situation is known to the other regulators. There is a multitude of possibilities and this guidance is not intended to address all of those, including the fact that in some cases some regulators may choose to put their legal entity into some type of supervision, conservation or some other form of receivership. Similar to other areas, where similar information is also disclosed in Form F, further information may already be known in this area.
### VI.H. Group-Wide Supervision  – Group Capital Calculation (Lead State) Procedures

<table>
<thead>
<tr>
<th>Step</th>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>ST</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Obtain a copy of the group’s most recent business plan and compare it to the prior year plan for variances. (see Additional Procedures below for additional follow-up analysis)</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>ST</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Request information from the group on how it intends to address the issues or trends identified in Steps 1-3. More specifically, determine how the group intends to decrease risk, and by what means.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>ST</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Based on information received in 5.b., determine the group’s capacity to reduce risks or raise additional capital.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>ST</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Where the remaining capital is adequate, document the findings into the GPS (or another document) and make available to the supervisory college and or domestic states with the presumption no further action is deemed necessary.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Consider whether the collective information suggests that any of the U.S. legal entity regulators should deem the legal entity to be in a “Hazardous Financial Condition” and takes appropriate action to address based upon the facts and circumstances and the provisions of the state’s law (similar to NAIC Model 385).</td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Where appropriate, consider holding a meeting of the supervisory college or of all the domestic states to fully understand the group’s plans. Where appropriate, require the group to present its plans to the supervisory college or all the domestic states.</td>
<td></td>
</tr>
<tr>
<td>g.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Where appropriate, determine if the plans proposed by the group are inadequate to any of the legal entity regulators, and more specifically if any are considering taking action over their applicable legal entity. If this is the case, hold a meeting of the supervisory college or of all the domestic states to provide this information.</td>
<td></td>
</tr>
<tr>
<td>h.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Where appropriate, consider holding a broader meeting of all impacted jurisdictions in which the group is selling insurance. Where appropriate, require the group to present its plans to all such regulators and for the regulators to announce their plans.</td>
<td></td>
</tr>
</tbody>
</table>
Purpose of the Group Capital Calculation (GCC) in Holding Company Analysis

The following information is intended to provide background and context of the issues/considerations for analysts when utilizing the NAIC Group Capital Calculation (GCC) for an insurance holding company (hereafter referred to as “group”) completing the GCC where required. The GCC is a “tool” to quantitatively understand the group’s capital and the mathematically calculated risks within. The GCC framework is built on the RBC model; however, while the RBC has triggers with states’ laws to make formal actions as a capital requirement, the GCC is not designed as a regulatory tool in that manner.

Background Information

Beginning in 2008, the NAIC Solvency Modernization Initiative (SMI) began to consider whether there were any lessons learned from the financial crisis that would cause the solvency framework to be modified. The NAIC determined that changes should be made in the area of group supervision, starting with the new annual requirement for the Lead State of each group operating within the U.S. to complete a written holding company analysis. Since that time, other changes to state laws have been made to further enhance group supervision (e.g. Form F, ORSA, and Corporate Governance reporting). All of these new tools are inputs into the previously mentioned holding company analysis, which is now summarized into a consistent tool used by all states in what is known as the Group Profile Summary (GPS).

Benefits of the GCC & Methods for Achieving

The Group Capital Calculation Instructions describes the background, intent, and calculation for the GCC in detail. As stated in the Group Capital Calculation Instructions, the GCC and related reporting provides more transparency of an insurance group’s structure and related risks to insurance regulators and makes those risks more identifiable and more easily quantified. In this regard, this tool is intended to assist regulators in holistically understanding the financial condition of non-insurance entities, how capital is distributed across an entire group, and whether and to what degree insurance companies’ capital may be put at risk from the operations of non-insurance entities, potentially undermining the insurance company’s financial condition and/or placing upward pressure on premiums to the detriment of insurance policyholders. An analyst is not asked to understand any non-insurance industries represented within the group, but to understand through this calculation if a non-regulated entity could place pressure on or provide relief to a regulated entity.

The manner in which the GCC achieves some of these benefits varies. For example, with regard to understanding how capital is distributed across an entire group can be seen in two ways, both by viewing the Tab titled “Input 4-Analytics” as follows: 1) the display of the “Ratio of Actual to Required Capital”, 2) display of “Required Capital” in a separate column. The degree of subsidization can also be seen in the “Input 4-Analytics” tab, with the display of the columns as follows: 1) Capital Contributions Received/(Paid); 2) Net Income. While certainly one year of information can show this exists, most of this benefit will not be seen until after further years of the GCC are reported within the template. Once five years of data are displayed in this “Input 4-Analytics” tab, it will allow the analyst to better understand the financial condition of the group as a whole as well as the non-insurance entities. Of course, such conclusions can only be made once the analyst can both see such data as well as understand from the group what is occurring that is leading to such figures.

This calculation provides an additional early warning signal to regulators so they can begin working with a company to resolve any concerns in a manner that will ensure that policyholders will be protected. This early
VI.H. Group-Wide Supervision — Group Capital Calculation (Lead State)

warning signal can be seen with the trending of the financial information in the "Input 4-Analytics" tab as well as through the application of sensitivity analysis in the Input 5 Tab and inclusion of other relevant information in the Input 6 Tab. However, the analyst should also understand that other "qualitative tools" such as the Form F, are capable of also providing early warning signals if properly reported by the group. In addition, since most holding company systems may have a larger percentage of their operations in the insurance businesses, the insurance trends for the U.S. insurers in the group should already be known and made available to the lead-state by the legal entity regulator. However, in the context of added policyholder protection, this largely comes into play with respect to the added quantitative data on non-insurers.

The GCC is an additional reporting requirement but with important confidentiality protections built into the legal authority to require such reporting. State insurance regulators already have broad authority to take action when an insurer is financially distressed, and the GCC is designed to provide regulators with further insights to allow them to make informed decisions on both the need for action, and the type of action to take. While the new information from the GCC may offer new insights, its equally important to understand that it will be up to the analyst to work with the insurance group to actually understand what is leading to the figures reported in the GCC, and from that perspective, especially in the early years of the GCC, it will require learning by both the analyst and the group to really be able to utilize the GCC in a manner as suggested in these introductory paragraphs.

Other Considerations When Considering Such Benefits

Recent events and economic conditions [i.e., pandemic, recession, etc.] can create stresses on a group, reinforcing the value of the quantitative data included in the GCC. Some stresses are similar to those experienced during the financial crisis and others are more unique. However, because the GCC is based upon a methodology that gets its inputs from individual legal entities, the capital calculated for each legal entity certainly can only capture the allowed capital resources of the legal entities in the group. While such an aggregation-based methodology is an appropriate group-level capital measure, until experience is gained with the GCC, it is not known as to how the GCC will behave in response to business cycles and various risk events, given in part because it only recognizes limited diversification benefits among entities in the group except for the diversification embedded in existing entity specific regulatory capital requirements. And while the GCC is not meant to be used in a way that compares groups to each other, it’s also true that it is unknown how it will behave across groups, peers and even sectors. This is true both because of its limited diversification benefit, the differences between group types (mutual v. stock holding company), grouping of entities, and scope of entities included in the calculation. But also because application of jurisdictional accounting principles and use of scalars could have an impact on this as well via the foreign insurer profile of the group. The quantitative data collected in the GCC will evolve as state insurance regulators and insurance groups increase their understanding of the impact on available capital and calculated capital.

The following guidance on the GCC is intended to be utilized in a manner that allows the GCC to enhance group-wide financial analysis and to be used as an additional input into the GPS. The GCC provides the quantification of risk within the group and when combined with the information from the ORSA on the amount of capital needed to run the company’s current business model, puts the regulator in a much better position to understand the available capital and calculated capital within a group, as well as the financial condition of the group. Both are complimentary tools to each other, with the ORSA providing management’s internal approach to capital management, and beneficial in understanding the economics of the group, the GCC provides a standard model
that can better enable the analyst to understand where the entire group stands with respect to existing legal entity requirements as well as broad measures of risk for non-insurers.

**Utilization of the Group Capital Calculation in the Lead State’s Responsibilities**

The lead state is responsible for completing the holding company analysis and documenting a summary of that analysis in the GPS. The depth and frequency of the holding company analysis will depend on the characteristics (i.e., sophistication, complexity, financial strength) of the insurance holding company (group) system (or parts thereof), and the existing or potential issues and problems found during review of the insurance holding company filings.

The analysis of the GCC will be used in a similar fashion under this guidance since it provides the depth of the review in the “five-step process” that will vary by group and situations. For example, in some groups, very little if any work (inquiries of the group) will be done after the first step due to a generally strong GCC figure and generally positive trends of the ratio over time; while in other groups, the analyst may need to proceed through each of the five steps. Exactly how the analyst proceeds through the guidance will be dictated by a multitude of factors and requires judgement.

**GCC Construction That Also Impact its Utilization and Review**

Some decision points may be addressed prior to the submission of a GCC template. These include: the scope of application (e.g. whether segments of the holding company system should be excluded for financial conglomerates); whether a limited filing will be allowed (as permitted in Model Law #440 and Model Regulation #450); and whether subgroup reporting (as defined in the GCC instructions) of a foreign insurance group will be required. In general, the analytics provided by the GCC will be similar for all entities included in the template. See the end of this section (Primer on the Group Capital Calculation Formula) to better understand these points. These facts are also a consideration in determining the depth of the analysis of the GCC and subsequent correspondence with the group. Refer to chapter VI.B Roles and Responsibilities of Group-wide Supervisor/Lead State for details on responsibilities for completing the GPS.

The utilization of the GCC can be summarized as an additional input into the GPS. More specifically, once the analyst completes their review of the GCC, the overall ratio, the trend of the ratio, a summary should be incorporated into the GPS to help support the assessment of strategic risk.

**Documentation of Review of the GCC in the Group Profile Summary (GPS)**

The purpose of procedures is to document the GCC into the GPS. The following provides an example of a GCC Summary that represents the minimum expected input of the GCC into the GPS, with additional information also reported within the Strategic branded risk classification. The other purpose of this section is to determine if more follow-up should be performed and, if so, to assess the results of that additional review. The following is intended to assist in understanding summary documentation of the GCC to be included in the GPS.
Group Capital Calculation (GCC) Summary

Summarize your assessment of the GCC both quantitatively and qualitatively, including any such items as may not be applicable to a branded risk category. For example, it may be appropriate to indicate "The review of the group’s GCC indicated the scope of the application is consistent with the lead state’s determination" and if possible to summarize succinctly, the general scope of the GCC. For example, "the GCC includes all U.S. and Bermuda operations, but excludes ABC non-insurance operations in South American countries". It may also be appropriate to identify key drivers of risks for the group within the GCC that are discussed later in the branded risk categories, as those risks may be related to and supplement existing risk assessments derived from holding company analysis or they may be new risks that warrant further review. “The group’s GCC of 201% in the current year was impacted by a decline in Total Available Capital of $X which is related to group’s non-insurance operations in Bermuda and as well as the negative impact of market risks in the U.S. insurance legal entity ratio components, which based on further analysis has resulted from the recent financial market volatility”.

Branded Risk Assessment

Strategic: The group’s Group Capital Calculation is assessed as low and stable, and is a positive consideration in the overall assessment of strategic risk. The GCC has generally been reasonable and consistent over the past five years as illustrated in the following table. Additionally, refer to the GCC Summary for further details.

<table>
<thead>
<tr>
<th>GCC Ratio</th>
<th>CY</th>
<th>PY</th>
<th>PY1</th>
<th>PY2</th>
<th>PY3</th>
</tr>
</thead>
<tbody>
<tr>
<td>201%</td>
<td>207%</td>
<td>163%</td>
<td>202%</td>
<td>197%</td>
<td></td>
</tr>
</tbody>
</table>

GCC Summary and Strategic Branded Risk Documentation:

The above information documented in a summary section of the GPS and into the Strategic branded risk is expected to be the primary type of information that is always documented into the GPS since the GCC does provide a capital measurement of the group and, consistent with the branded risk categories, should be reported in the strategic risk section. Similar to how RBC for individual insurance company is helpful in allowing the analyst to better evaluate other potential issues given capital represents a relative measure of cushion for adverse risks, the GCC and inclusion herein helps regulators to understand the same relative to a group. While the GCC is not a capital requirement, with specified ladders of intervention, each of the insurance legal entity figures are relative to individual company requirements, and therefore the GCC can provide a relative measure of risks against such minimum capital levels of the insurers.

Other Branded Risk Documentation:

To the extent the ratio was trending negatively, or available capital was decreasing, the analyst may choose to include more information in the strategic section of the GPS that summarizes any key drivers of such if they did not fall into one of the branded risk categories. Those drivers of the change would likely be documented in other specific branded risk categories, for example Pricing/Underwriting if driven by group-wide weak insurance underwriting, or Reserving if the group-wide drivers were reserve deficiencies, etc. References to other branded risk categories may also be appropriate. However, practically speaking, this may not always occur or be possible for the analyst to pinpoint given the multitude of risks within any insurers regulatory capital requirement formulas. This guidance is simply meant to suggest that if the GCC does in fact appear to show particular trends...
that are noteworthy on specific risks such as the underwriting branded risk, further documentation into that (applicable) branded risk may be appropriate.

A determination for when documentation of risks from the GCC into other branded risk categories may be appropriate is driven by both the question of whether any of the thresholds in Procedures 1a-1e were met, and the information obtained from the rest of the GCC information as described in Procedures 2-4. The GCC Summary is intended to be high-level, therefore other more detailed observations from reviewing the GCC should generally not be documented into the GPS unless they are specifically insightful, add to a high-level understanding of the group’s financial condition, as shown in the example above, or are specific to a branded risk category as stated.

Other Considerations:
In addition to the broad guidance provided herein on the documentation of the GCC into the GPS, the analyst should also understand the following more general points that could impact the GCC result for a particular group: 

- If the group has a significant amount of business in legal entities that are domiciled in jurisdictions whose capital regime is based on market-based valuations, the GCC will inherently be more volatile (as compared to a pure U.S.-based group for which RBC and statutory valuations are the norm).
- Similarly, a group may have legal entities that are solely based in jurisdictions that utilize a standard model for capital requirements or have entities in jurisdictions where the use of internal models has been approved. All else being equal, the manner in which capital measures quantity requirements and behave over time will differ to some extent between the two. Also, a change from a standard method to one based on internal models for a key subsidiary will likely produce a noticeable change in the GCC that is not reflective of changes in the entity’s underlying business.
- The GCC provides a means for analysts to identify non-insurance operations outside of the insurance group and to determine the extent of risk they may pose to the insurers within the group. However, in doing so, analysts should understand that findings from review of Forms B, D and F might be equally valuable in these situations.
- When understanding capital requirements for non-insurer financial entities that are not subject to regulatory capital requirements, consideration should be given to the appropriateness of the GCC’s capital charge for a specific entity’s financial operations (e.g., an entity conducting large volume or size of complex transactions but with little net revenue or equity).
- When evaluating capital requirements for non-insurer / non-financial entities, consideration should be given to the appropriateness of the level of risk assigned to specific entities.

Detailed Observation Documentation:
More detailed observations shall be documented separately from the GPS and in a form not dictated by this handbook. As in all holding company analysis, the level of documentation is determined by the state insurance department and is dependent on the characteristics and complexity of the group and its risks. These detailed observations generally need to only note observations that are indicative of drivers of trends and/or actions being taken by the group to mitigate risks. In some cases, these points can be easily summarized into the GPS, in other cases they are too detailed and should be documented instead within the separate document not dictated in form by this handbook. The analysts are not expected, nor should they spend time documenting

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subtle changes within either the GCC or individual company movements that either do not create a trend at the group level or identify a growing weakness in the group. However, judgment is required to make this determination. For example, a 10% decrease in an RBC ratio of one of the smaller insurers within the group generally would not be documented, although a 10% decrease in an RBC ratio in one of the larger insurers in the group that causes, or jointly with other insurers, causes a 10% decrease in the GCC should be noted. However, it should be understood also that this 10% threshold is not intended to be used as a “bright-line”, and in fact it’s possible the 10% is not necessarily indicative of any negative trends at all. This could be the case when, for example, there was a change in the regulatory capital requirement. Therefore, again, judgement is required in making these determinations and this, as well as other thresholds used in this guidance, are not meant to be bright-lines. As the GCC is used more, both by the individual analyst, as well as all of the states, using judgement around these thresholds are expected to become easier.

**Specific Procedures for Completing Review and Understanding of the GCC**

It should be understood that if the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document the material risks of the group observable from the GCC (as well as the required information to be included in all GPS from the GCC), this should be documented by the analyst in any workpapers deemed appropriate by the state and the general reasons therefore. In making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner and judgement based upon existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that judgement decision.

**Procedures Step 1a-1e**

The purpose of procedures 1a-1e is to assess the GCC level, and to identify the drivers of any changes in the GCC, in order to summarize and to document that overall assessment in the GPS and its strategic risk category, which is the minimum expected input of the GCC into the GPS. However, the analyst should understand that in the early years of the GCC, limited amount of prior year(s) comparative data will be available, therefore requiring more judgement in determining if or where further analysis is warranted. Such judgement may need to be based upon various factors, including but not limited to other known information regarding the applicable group obtained from other sources (e.g. ORSA, Form F, Form B, etc).

Procedure 1 is also intended to help the analyst determine if more follow-up review work should be performed. However, if the answer to any of the questions in 1a-1e is “yes”, the analyst should proceed with step 2, understanding decreases in total available capital and/or step 3, understanding increases in leverage to determine the cause(s) of the negative trends. In the example provided above, the ratio is above 150%, which suggests further review may not be necessary. In addition, the trends are positive with no decreases in the base ratio and the only year below the 150% benchmark being in PY1 where presumably the analyst may have performed some level of inquiry to the holding company to understand the driver of the drop. Even then, the drop was below the Handbook’s predefined threshold of 10% and may not have been necessary.

**Procedures step 2a-2m**

Unlike step 1, the intent of the step 2 (and 3) is to determine the actual source of the negative issues and where to document them in the GPS. Procedure 2a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by looking at the ratio of actual-to-required capital for the legal entity insurers over the available years reported. The following sample of a table from the GCC calculation completed by the group from the data in Schedule 1 can be helpful in determining the source of the issues.
Procedure 2b recognizes that the GCC does allow some debt to be included in capital up to a predetermined limit and can drive the overall GCC ratio. The following sample table taken from the GCC calculation using the data in Schedule 1 can be helpful in making this determination. Cases where debt is issued to address risk driven reductions in the GCC ratio, may not offset those reductions. This data metric may not be available in the case of a "limited filing".

<table>
<thead>
<tr>
<th>Insurance Capital Table Template Groupings</th>
<th>Ratio of Actual to Required Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Japan - Non-Life</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Australia - All</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>XXXX XXXX XXXX</td>
</tr>
</tbody>
</table>

Procedure 2c recognizes that profitability is generally one of the biggest drivers of changes in capital and utilizing the following table from the GCC can assist in identifying if there are entities reporting net losses that may be driving the decreases in capital. The following table taken from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues.

<table>
<thead>
<tr>
<th>Debt/Equity Table Template Groupings</th>
<th>Debt/Equity ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>XXXX XXXX XXXX 0 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income &amp; Leverage Table Template Groupings</th>
<th>Net Income ($)</th>
<th>Return on Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Ins</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
</tbody>
</table>
VI. Group-Wide Supervision – Group Capital Calculation (Lead State)

<table>
<thead>
<tr>
<th>Core Insurance Template Groupings</th>
<th>Net Income ($)</th>
<th>Return on Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>[1]</td>
<td>XXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>[2]</td>
<td>XXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>[3]</td>
<td>XXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>[4]</td>
<td>XXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>[6]</td>
<td>XXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>[7]</td>
<td>XXX</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>[8]</td>
<td>XXX</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>[9]</td>
<td>XXX</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>[10]</td>
<td>XXX</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>[12]</td>
<td>XXX</td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>[13]</td>
<td>XXX</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>[14]</td>
<td>XXX</td>
</tr>
<tr>
<td>Australia - All</td>
<td>[15]</td>
<td>XXX</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>[16]</td>
<td>XXX</td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>[17]</td>
<td>XXX</td>
</tr>
</tbody>
</table>

If the source of the issues is the insurers, the following sample from a table from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues among the insurers.

Procedure 2d is focused on requesting more specific information from the legal entity regulator or the group to better identify the source of the issue(s). Procedures 2e-2i simply contemplates that if the source of the issues can be identified into one of the branded risk categories, to document as such in the detailed workpapers and into that the appropriate category of the GPS. However, it’s recognized that the source of issues may be in
multiple branded risk categories, in which case, documentation of each of the sources into the detailed workpapers is still appropriate. However, documentation into one of the single branded risk classifications of the GPS is only appropriate if that risk category is a material driver of the negative trends. Procedure 2m is intended to identify if the source of the issues is related to non-insurance operations. The GCC is intended to provide for more consistent analysis of risks to the insurer that may originate from non-insurance entities within the holding company system.

Procedures Step 3a-3f

Procedure 3a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by looking at the leverage ratios. The following sample of a table from the GCC calculation using the data in Schedule 1 can be helpful in determining the source of the issues.

<table>
<thead>
<tr>
<th>Insurance Leverage Table Template Groupings</th>
<th>Net Premium Written ($)</th>
<th>Liabilities ($)/Capital &amp; Surplus</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>[1] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>[2] XXXX XXXX XXXX</td>
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</tr>
<tr>
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<tr>
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<tr>
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<tr>
<td>Canadian - P&amp;C</td>
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<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>[8] XXXX XXXX XXXX</td>
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<td>Bermuda - Commercial Insurers</td>
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<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>[10] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>[12] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>[13] XXXX XXXX XXXX</td>
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</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>[14] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
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<td>[15] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
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<td>XXXX XXXX XXXX</td>
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<tr>
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<td>Hong Kong - Non-Life</td>
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<td>[21] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
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<tr>
<td>South Africa - Life</td>
<td>[22] XXXX XXXX XXXX</td>
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VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

<table>
<thead>
<tr>
<th>Country</th>
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<th>2024</th>
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<th>2027</th>
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<tr>
<td>South Africa - Non-Life</td>
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<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
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</tr>
</tbody>
</table>

Procedure 3b is more forward looking by suggesting the analyst look at the same leverage ratios used in 3a to determine if the trends might continue and lead to further decreases in the GCC ratio. Procedure 3c simply requests the analyst use the leverage information to target questions to the group to better identify the drivers. Procedure 3d-3f are all questions designed to help the analyst consider whether the changes in leverage will lead to greater underwriting risk, reserving risk, or market and credit risk. Procedures 3d-3f provide general inquiries for additional information for the analyst, however, these inquiries may also appropriately provide a basis for the analyst to enter conversations with the group on the same topics to understand how the group views these topics and how the group is managing and monitoring these risks. For groups filing an ORSA, see also documentation within the ORSA report for additional information on the identified risks and the group’s monitoring of risks, as well as consistency of the discussion with management and managements observations in the ORSA Summary report.

 Procedures Step 4a-4b. Procedure 4a is intended to help the lead state understand the historical capital allocation patterns or the likely future needed capital allocation patterns by simply documenting in the detail analysis workpapers. This includes, for example, noting that there is consistency in the entities generating net income and distributing it further through the group, and in some cases may require distribution through other insurers, which in the US often requires approval if considered extraordinary. Procedure 4a is intended to utilize that knowledge, along with other planned actions of the group, to understand whether problems with repaying debt or other obligations in the group could occur. The intent is to be in a better position for discussions with the group on where capital may come, to support future expected activity or future unexpected material events. The following sample of tables from the GCC calculation using data in Schedule 1 can be helpful in determining the source of the issues.

<table>
<thead>
<tr>
<th>Insurance Capital Table</th>
<th>2024</th>
<th>2025</th>
<th>2026</th>
<th>2027</th>
<th>2028</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
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<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
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<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
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<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
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<td>Canadian - P&amp;C</td>
<td>XXXX</td>
<td>XXXX</td>
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### VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

<table>
<thead>
<tr>
<th>Template Groupings</th>
<th>2024</th>
<th>2023</th>
<th>2022</th>
<th>2021</th>
<th>2020</th>
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<tbody>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>[8]</td>
<td>XXX</td>
<td>XXX</td>
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<tr>
<td>Solvency II - Composite</td>
<td>[10]</td>
<td>XXX</td>
<td>XXX</td>
<td>XXX</td>
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</tr>
<tr>
<td>Solvency II - Life</td>
<td>[12]</td>
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<td>XXX</td>
<td>XXX</td>
<td></td>
</tr>
<tr>
<td>Japan - Life</td>
<td>[13]</td>
<td>XXX</td>
<td>XXX</td>
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</tr>
<tr>
<td>Bermuda - Other</td>
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<tr>
<td>Switzerland - Life</td>
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<tr>
<td>Switzerland - Non-Life</td>
<td>[16]</td>
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</table>

### Insurance Capital Table

<table>
<thead>
<tr>
<th>Template Groupings</th>
<th>Intragroup Dividends $ Received/(Paid)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>2024</td>
</tr>
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<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>[1]</td>
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<td>RBC Filing U.S. Insurer (Life)</td>
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<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>[3]</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>[5]</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>[6]</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>[7]</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>[8]</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>[9]</td>
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<tr>
<td>Japan - Non-Life</td>
<td>[10]</td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>[12]</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>[13]</td>
</tr>
<tr>
<td>Australia - All</td>
<td>[14]</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>[15]</td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>[16]</td>
</tr>
</tbody>
</table>

Procedures Step 5a-5h. Procedures 5a-5h are designed for those rare situations where the group has a need to reduce risk given the alternative of raising capital may be unlikely (see appendix for further discussion on this topic). In performing this procedure, the analyst should understand that procedure Step 2 (Evaluating Decreases in Total Capital) and Procedure Step 3 (Evaluating Increases in Operating Leverage) have already been considered, and therefore concluded that either capital is decreasing or operating leverage is increasing. As such, after considering information that may already be available to the regulator on the business plan, Procedure 5b is largely focused on better understanding directly from the group the drivers of the apparent negative trends. The analyst should understand that some of these trends may have already been known, through for example the ORSA, and discussions by the lead state regarding such takeaways from such ORSA discussions. In fact, if already known, the key takeaways may already be documented in the GPS and therefore the remaining procedures in this section may be irrelevant and could be skipped if recently already considered and evaluated. In addition, to be sure, such trends from Procedure Step 2 and 3 may not suggest anything more needs to be done, in fact that is why the first procedure is focused on an existing business plan since its possible these trends may have been expected. In fact, Procedure 5a is based upon the belief that reducing risk by the group may have
already been incorporated into the group’s latest business plan, which may have already been obtained from the Annual Form F Filing.

Procedure 5b contemplates that the manner to address any negative trends may not have already been incorporated into the latest business plan and simply contemplates the analyst speaks with the group to understand how the group intends to address the issue. The existence of this procedure is not meant to suggest action must be taken by any regulator, rather to understand what the group is already doing to address the issue. To be sure, some of what the group is already doing may already be known by the lead state, either through the ORSA, the Form F, or a periodic meeting with the group that some states conduct annually with all groups. Rather, the procedure provides an opportunity for the analyst to make sure they understand the drivers and what if anything the group is doing to address. To be clear, increases in operating leverage are often planned, and often come with them expected future actions by the group, such as capital injections or future transactions that may reduce risk. Therefore, these discussions would allow these actions to be completely documented and understood. Meanwhile, decreases in capital sometimes are not expected, and may not result in immediate action, if any, but it’s possible that it may lead the group to take future actions, or contemplate future possible actions. Therefore, these discussions would allow these potential actions to be completely documented and understood.

Procedure 5c contemplates assessing if the group has the ability and resources to either reduce its risks or to raise additional capital. See the section below for further Considerations of the Group’s Capacity to Raise Capital. This procedure is not intended to suggest the analyst has the capacity to make this determination on their own, but rather to question the reasonableness of the possibility. Procedure 5d contemplates that the group may believe no action is necessary because it believes current capital is adequate to meet its business plan and is more likely to be the case when the company experienced a one-time reduction of capital as opposed to a growth in leverage that may continue. Procedure 5e is for the rare situation where the legal entity insurers have been strained enough or face impending pressure contemplated within NAIC Model 385—Model Regulation to Define Standards and Commissioner’s Authority for Companies Deemed to be in Hazardous Financial Condition that would suggest one or more of the insurers may be in a hazardous financial condition. Procedure 5f is designed to suggest the analyst bring the collective supervisors of the legal entity insurers together for a supervisory college to fully understand what is occurring and the group’s plans for addressing the issues it is facing. Procedure 5g is an extension of Procedure 5f as it contemplates the regulators discussing whether they believe the proposed actions from the group are adequate. This action could represent something either informally done before an insurer is in a regulatory action level, or formally once an insurer is in a regulatory action level. Procedure 5h is similar to the other actions contemplated within a supervisory college or, for example, to address a troubled insurance company under Accreditation requirements regarding communication with other states.

Additional Procedures – Business Plans

While there is a multitude of possibilities and this guidance is not intended to address all of those, the following provides some summary of related issues that may be helpful to the analyst (See also section 6 to consider the structure of the group and capital infusion issues).

<table>
<thead>
<tr>
<th>Group’s Business Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning Process:</td>
</tr>
</tbody>
</table>

**VI. Group-wide Supervision – Group Capital Calculation (Lead State)**

**Financial Analysis Handbook**

2022 Annual / 2023 Quarterly
**VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)**

- Group system’s overall planning process (e.g., who is involved, how frequently it occurs, etc.) and how the overall initiatives are determined
- Understand the group’s estimate of the impact of the proposed actions on financial results
- Review the plan’s assumptions for reasonableness. Consider the likelihood of variations in the assumptions and the resulting impact on the future financial results
  - Consider subcategories of changes including:
    - Overall potential changes in investment strategy
    - Overall potential changes in underwriting strategy or existing concentrations
    - Overall impact on financing matters (e.g. debt, requirements, etc.)
    - Overall impact on derivatives to mitigate economic conditions
    - Overall changes in governance or risk management procedures
    - Increased ceded reinsurance transactions (common approach to reducing risk/increasing surplus):
      - Details regarding the revised strategy
      - Specifics on types of coverage such as assumption reinsurance, loss portfolio transfers
      - Transfer of risk considerations

**Variance to Projections:**

- Consider the group’s history of explanations regarding variances in projected financial results and the insurer’s actual results. If analysts determine the goals of the business plan are not attainable and/or projections are unreasonable, a revised business plan may be requested;
- Identify any internal or external problems not considered in the plan that may affect future financial results. Examples of such problems include the following: 1) the existence of competitors to limit future sales levels; 2) recent state legislation restricting the company’s product designs; or 3) the loss of key marketing personnel.

**Evaluating a Business Plan:**

Analysts should consider further detail when necessary in evaluating the proposed revised business plan but also monitor, on a periodic basis, the insurer’s progress in achieving the initiatives included in the group’s plan. The goal of any plan is the improvement of the underlying causes that led to the issues and an improvement in subsequent GCC base ratio results. Detail considerations for improving the plan may include the following (where considered inadequate):

- Trending comparative measures of targeted risk exposures including (where applicable):
  - Asset mix by detailed types
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

- Credit risk by detailed types
- Business writings/risks by detailed product

- Impacts on financing items:
  - Projected cash flow movements for ongoing principal and interest payments on debt
  - Impact on debt interest coverage ratio, other debt covenants, rating agency ratings
  - Discussion of impact on parental guarantees and/or capital maintenance agreements
  - Expected source and form of liquidity should guarantees be called upon

- Impact of reasonable possible stress scenarios
- How the legal entities capital will be maintained at required levels

Consultation with Other Regulators

- Consult with members of the supervisory college (if applicable) or other domestic states for input in evaluating the revised business plan

Considerations of Group’s Capacity to Raise Capital

The following is designed simply as a reminder of considerations the lead-state would contemplate when discussing the group system response to the issues identified in this section. More specifically, in most situations a group will first consider ways to reduce risk but in limited situations they may consider trying to raise additional capital. While this is typically not an option for a group that is currently not performing as it anticipated, in some situations alternative sources of capital can be raised if the holders of the new capital are given rights that are attractive to the holder. In addition, in some cases the group may have the ability to issue other forms of capital (e.g., debt), which can be used to inject into the insurance subsidiaries. While these facts are not unique to the utilization of the group capital calculation, they are worth a reminder along with relevant other related details.

New Equity Considerations

Public Holding Company

While no two groups are the same, issuing public stock may be limited for the reasons previously identified. In addition, regulators are reminded that a public holding company may be obligated to pay dividends in order to maintain expectations of their shareholders, making the reduction of risk a more viable action under the circumstances.

Private Holding Company

While no two groups are alike, a private company has some of the same characteristics as a public company in terms of owners’ expectations, but usually such expectations differ from a public company and it may be more
feasible for a private company given their access to specific individuals that may have a higher interest in higher capital rights.

**Mutual Insurance Company**
A mutual insurer is limited in terms of its access to capital because it cannot issue new stock, but can issue surplus notes.

**Mutual Holding Company**
Because mutual holding companies have characteristics of both public companies and mutual companies, there are implications of how such a structure affects its operations.

**Non-profit Health Company**
Insurers that are non-profits are generally charitable organizations and it is not uncommon that some types of insurers, particularly those that provide health insurance, to have some history as a non-profit. It may be helpful to understand these types of dynamics when considering a group structure.

**Fraternal Associations**
Regulators often find similarities between a fraternal benefit society and a mutual insurer because both can be limited in terms of their ability to raise additional funds, but can issue surplus notes. If allowed within state law and the charter, the fraternal could assess members or adjust member policy values.

**Reciprocal Exchanges**
Regulators often find similarities between reciprocal exchanges and fraternal benefit societies and mutual insurers because they can be limited in terms of their ability to raise additional funds. Although this is a general consideration for the regulator when evaluating the group system, there is generally much more that must be understood before coming to this conclusion because in some cases, the reciprocal may be able to assess policies that can serve a similar purpose as raising capital.

**New Debt Considerations**
Through discussions with the group, understand the potential impact of any new debt on the group system, including specifically the extent of future additional reliance on the insurance operations and whether those insurers have the capacity for such. Consider also an updated review on the following:
- Total debt service requirements.
- Revenue streams expected to be utilized to service the debt.
- Any new guarantees for the benefit of affiliates.
- Any new pledge assets for the benefit of affiliates.
- Any new contingent liabilities on behalf of its affiliates

**International Holding Company Considerations**

**International Holding Company Structure**
This section is applicable only to those international groups that are required to complete the GCC, which may be relatively small considering many international holding companies have a non-US groupwide supervisor and
are exempt from the GCC. Those foreign groups that are required to complete the GCC will generally file a “subgroup” GCC that included entities that are part of the group's U.S. operations. In those situations, the analysts should understand the structure to determine if it has any impact on this analysis. For example, a German-based holding company may have advisory boards established to communicate with U.S. regulators. Analysts should direct any regulatory concerns to the appropriate organization contact to ensure a prompt reply or resolution if the insurance regulator is not responding.

**Capital / Operational Commitment to U.S. Operations**

Some foreign holding companies may consider their U.S. enterprises non-core and consequently show weaker commitment to their ongoing business operations or financial support. In recent years, after sustaining continued losses from U.S. subsidiaries, several prominent foreign holding companies decided to cease their U.S. operations and liquidate their assets. Analysts should be aware of a holding company's stated commitment to ensure the continued stability of U.S. operations. This commitment may include a written or verbal parental guarantee.
Primer on the Group Capital Calculation Formula

The National Association of Insurance Commissioners (NAIC) began development of the Group Capital Calculation (GCC) in late 2015 following extensive deliberation on potential measurement models and methodologies. The GCC uses a bottom-up aggregation approach, accounting for all available capital/financial resources, and the required regulatory capital based on the measurement of assets and liabilities of the various corporate entities, including insurers, financial and non-financial businesses.

The GCC Aggregation Methodology
As illustrated in the sample tables above, the proposed GCC is an aggregation or grouping of the available financial resources and calculated required capital of all legal entities in an insurance group that potentially pose material risk to the insurers in the group. The GCC allows some discretion in determining what entities under common control but outside of the defined Insurance Group may be excluded from the scope of application in the GCC. When reviewing a group’s choice of entities to be excluded from application of the GCC, the following points should be considered:

- The regulatory evaluation should be based on the criteria for material risk (e.g. structural separation; no history of cross subsidies, or other criteria as defined in the GCC instructions);
- Group requests for reducing the scope of application of the base GCC should be based on supporting information and rationale provided by the Group;
- Information on excluded entities should be made available upon request by the analyst.

The GCC includes the following types of entities and sets forth the general approach of calculated capital toward each.

U.S. Insurers – The available capital of U.S. domiciled insurers is determined by statutory accounting principles (SAP) as defined by state law and the NAIC Accounting Practices and Procedures Manual, which defines assets, liabilities, and in-turn the available capital/financial resources, sometimes referred to as policyholder surplus. The calculated capital for these insurers is subject to state laws that require these insurers to maintain minimum capital based on the applicable NAIC Risk-Based Capital formula at 200% x Authorized Control Level (Trend Test level).

Non-U.S. insurers – Similar to the available capital and calculated required capital of U.S. insurers, the available and calculated capital of non-U.S. insurers is determined by reference to the home jurisdiction’s basis of accounting and capital requirements converted to U.S. dollars. While most non-U.S. jurisdictions do not possess the same level of industry-specific technical guidance, as included in the NAIC Accounting Practices and Procedures Manual, all jurisdictions have established accounting standards that insurers are required to follow to determine available capital/financial resources. In some cases, this represents local Generally Accepted Accounting Principles (GAAP), which may or may not be consistent with International Financial Reporting Standards (IFRS).

DRAFTING NOTE: While the GCC utilizes the available capital and home jurisdictions’ capital requirement, for jurisdictions where data is available, appropriate scalars are currently being explored to produce comparable measures for risk which can be aggregated into the group-wide measure. One such scaling methodology is included as part of sensitivity Analysis in the GCC template. That scalar methodology uses aggregated data from
the U.S. and other jurisdictions at first intervention level to recognize that (for example), state regulators often have much higher reserve requirements that are required to be carried as required capital in other jurisdictions. For jurisdictions where the data is not available, the full jurisdictional requirement at first intervention level we used.

**U.S. Insurers Not Subject to RBC** – Some types of U.S. insurers are not subject to an RBC formula (e.g., Financial Guaranty Insurers, Title Insurers). For these entities, the available capital/financial resources is determined by reference to state law and the NAIC Accounting Practices and Procedures Manual. However, since an RBC formula does not exist, calculated capital is determined by reference to the state minimum capital requirements set out in state law (or 300% of reserves for Title insurers). For U.S. captive insurers, available capital is determined based upon the states accounting requirements, but the calculated capital is required to be calculated using the applicable RBC formula even if RBC does not apply to that entity in their state of domicile.

**Banking or Other Financial Service Operations Subject to Regulatory Capital Requirements** – Non-insurers such as banks are subject to their own regulatory valuation methods (typically GAAP with tiering of available capital) and their own regulatory capital requirements (e.g., OCC, Federal Reserve, FDIC or other requirements for banks). These regulatory values are used for the GCC.

**Financial and non-financial operations not subject to regulatory capital requirements** – In general, financial entities (as defined in the GCC Instructions) are subject to a higher capital charge in the GCC than the non-financial entities. However, the GCC does require available capital/financial resources and calculated capital to be gathered for all such entities that pose a material risk to insurers. In both cases the GCC will utilize the valuation used by such legal entities (typically U.S. GAAP) and a calculated capital based upon a risk factor. There are two important exceptions:

- All entities within the defined insurance group (definition included in GCC Instructions) must be included
- All financial entities (definition included in GCC Instructions) must be included
- The level of risk (low / medium / high) and associated capital calculation assigned to a financial entity will be selected by the group and evaluated by the lead-State reviewer
- Non-financial entities that are subsidiaries of U.S. insurers, foreign insurers or banks where a capital charge for the non-financial entity is included in the regulated Parent’s capital formula will remain with the Parent and will not be inventoried. Regulators already have access to the financials of these entities if needed (if causing unrealized losses within the insurer).

**Eliminations**

The GCC uses an aggregation and elimination approach, where each of the above legal entities’ available capital/financial resources and calculated capital are combined, then eliminations are utilized to prevent any double counting of available capital/financial resources or calculated capital. The following example illustrates the use of eliminations for both available capital/financial resources and calculated capital. However, in practice the GCC only requires the foreign insurers and other financial entities owned by an insurance company to be “de-stacked” so if AA Holding Company was a U.S. insurer (e.g. AA Insurance Company) the capital required and calculated capital for DD Insurance Agency as a nonfinancial entity would remain in the values of AA Insurance Company and not be de-stacked.
### EEIG Financial Information

<table>
<thead>
<tr>
<th>Entity</th>
<th>TAC, Less Subs TAC</th>
<th>Adjusted TAC</th>
<th>Minimum Regulatory Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Holding Co.</td>
<td>30.0M</td>
<td>13.0M</td>
<td>0</td>
</tr>
<tr>
<td>BB Life Insurance Co.</td>
<td>38.0M</td>
<td>0</td>
<td>5.0 Million</td>
</tr>
<tr>
<td>CC Insurance Co.</td>
<td>6.0M</td>
<td>6.0M</td>
<td>1.6 Million</td>
</tr>
<tr>
<td>DD Insurance Agency</td>
<td>2.0M</td>
<td>2.0M</td>
<td>0</td>
</tr>
<tr>
<td>EEIG (Group Total)</td>
<td>58.0M</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Amount of TAC for Subs as follows: (30.0M + 6.0M + 2.0M) = 38.0M

Calculation of ARC

<table>
<thead>
<tr>
<th>Entity</th>
<th>TAC, Less Subs TAC</th>
<th>Adjusted TAC</th>
<th>MRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Holding Co.</td>
<td>30.0M</td>
<td>13.0M</td>
<td>0.0M</td>
</tr>
<tr>
<td>BB Life Insurance Co.</td>
<td>38.0M</td>
<td>0</td>
<td>2.03M</td>
</tr>
<tr>
<td>CC Insurance Co.</td>
<td>6.0M</td>
<td>6.0M</td>
<td>0.0M</td>
</tr>
<tr>
<td>DD Insurance Agency</td>
<td>2.0M</td>
<td>2.0M</td>
<td>0.0M</td>
</tr>
<tr>
<td>EEIG (Group Total)</td>
<td>58.0M</td>
<td></td>
<td>0.0M</td>
</tr>
</tbody>
</table>

1. For Non-RBC filers this is regulatory available capital or stockholder equity
2. There is no regulatory capital for the entities when owned by a non-regulated entity
3. Calculated Capital is added @ 10.5% x stand-alone ARC

Calculation of MRC

<table>
<thead>
<tr>
<th>Entity</th>
<th>MRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Holding Co.</td>
<td>0.0M</td>
</tr>
<tr>
<td>BB Life Insurance Co.</td>
<td>2.03M</td>
</tr>
<tr>
<td>CC Insurance Co.</td>
<td>0.0M</td>
</tr>
<tr>
<td>DD Insurance Agency</td>
<td>0.0M</td>
</tr>
<tr>
<td>EEIG (Group Total)</td>
<td>0.0M</td>
</tr>
</tbody>
</table>

In the above example, available capital/financial resources are referred to as available regulatory capital (ARC) and total authorized capital (TAC) and minimum calculated capital is referred to as minimal regulatory capital (MRC) and authorized control level (ACL2). The GCC will allow non-insurance / non-financial entities owned by RBC filers in the group to remain within the available capital and regulatory capital so no eliminations are required for these entities. As shown, since AA Holding Company owns each of the other business entities in the organizational chart, $38 million (which is the amount of available capital/financial resources in the subsidiaries of AA) is eliminated from the TAC column since accounting methods include those as an asset on AA Insurance Company’s balance sheet. Also, the GCC includes capital calculations for AA Holding Company and DD Insurance Agency as part of the MRC in addition to the regulatory capital already included for the insurance subsidiaries. The MRC of the subsidiaries is eliminated from the parent’s (AA-Holding Company) calculated capital. Therefore, in this example $4.81 million of calculated capital is eliminated from the MRC. Finally, the MRC of U.S. insurance subsidiaries is multiplied by 2 in order to reflect Company Action Level (CAL) RBC as required in the GCC.

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1. Terminology used in RBC for available capital/financial resources
2. Terminology used in RBC for calculated regulatory capital
Debt - It is important to note that the available capital used in deriving the GCC recognizes a portion of the group's senior and hybrid debt as capital. This allowance recognizes that debt that is not already recognized as available capital/financial resources under all known accounting principles (SAP, U.S. GAAP or IFRS) may have some value to the group under the U.S. insurance regulatory requirements where such is dividend down to the insurance companies and where extraordinary dividends must be approved by the state. Qualifying debt along with limitations thereon is described in the GCC instructions as is the calculation for the additional available capital. In addition to looking at the group's debt leverage overall consideration should be given to how the allowance for additional capital from debt interacts with changes in available capital and capital requirements from year to year. The impact of pro-cyclical changes in the allowance for debt as capital should be assessed.

Other Information Included in the GCC
The GCC includes selected financial information (net income, premiums, liabilities, debt, etc.) that are captured in Schedule 1 and in the “Analytics” tabs of the GCC that are meant to be used to help isolate potential strengths and weaknesses of the group and more specifically where such exist among the entities in the group. Some important information related to other features in the GCC also should be considered and are discussed below. Schedule 1, a simplified version of the Inventory Tab, and most analytics are required in the case of a “limited filing”. However, data is not required for the capital instruments, sensitivity analysis and other information tabs in a limited filing.

Grouping - The GCC separately allows certain financial entities (e.g. asset managers) and non-financial entities included in the GCC to have their values and capital calculation combined (grouped) for more efficient reporting and analysis. Although the GCC instructions set parameters for such grouping, the general expectation is that regulators will work with each applicable GCC filer in determining where grouping is and is not appropriate outside of what is allowed within the GCC instructions. Grouping should be viewed in context of materiality. A single entity conducting a given activity may not be material, but when all entities conducting the same activity are combined, they can be material.

Excluded entities - The GCC provides two mechanisms for the exclusion of non-financial entities in Schedule 1 and in the Inventory Tab at the discretion of the lead state. State regulators should consider whether any of the information collected in the GCC template in support of, is collected for an entity or group of similar entities that would otherwise be excluded from the GCC ratio calculation. Regulators should separately monitor increases in the level of activity of an “excluded” entity or group of similar entities for purposes of materiality and potential subsequent inclusion in the GCC.

Sensitivity analysis - A tab devoted to individual sensitivity analysis is included in the GCC. These informational items provide the regulator with impact of discretion in excluding listed entities and alternative perspectives on risk charges for non-financial entities and foreign insurers. Monitoring of these items can help the regulator identify areas where the GCC may be improved or capital calculations adjusted in the future. A sensitivity analysis increases the overall calibration of the capital requirements in the GCC from its normal 200% x ACL RBC calibration to 300% x ACL. This should be used as an initial benchmark to conduct further analytical review. No other cushion should be applied.

Accounting Adjustments - The impact of accounting adjustments and related detailed information is collected in the GCC template in the Inventory Tab and in the Other Information Tab respectively. Such adjustments can be material during the de-stacking process. For example, a consolidated holding company may include GAAP values for entities that would otherwise be valued under regulatory accounting rules (e.g., Statutory Accounting Principles - SAP) on a stand-alone basis. When the regulated entity is de-stacked the difference between the GAAP values and SAP values will be removed from the group’s available capital. These “lost” values can result in a
material reduction in the inventoried available capital compared to consolidated available capital. Understanding the impact and the components of this adjustment can help the regulator when considering the impact of issuing new debt or when evaluating the allowance for debt as capital calculated in the GCC template.

**Intangible Assets** — Acquisitions, mergers and reorganization often can create significant intangible assets at a holding company level or possibly at an operating company (other than a regulated entity) level. The GCC template collects information on intangible assets held by inventoried entities in the Other Information Tab. The available capital associated with the value of entities whose assets are materially comprised of intangible assets should be evaluated in the context of fungible resources and in assessing the adequacy of the capital calculation assessed on such entities.

**Dividend pass-thru (gross view of dividends)** — Schedule 1D collects information on dividends paid and received within the group. It also includes a column that indicates whether dividends were declared but not yet paid, as well as cases where dividends received where retained or "passed thru" to another affiliate or paid out in dividends to shareholders. This information will assist the regulator in evaluating the movement of capital within the group to fund strategic insurance and non-insurance operations or activities (e.g. expansion of activities) or to fund entity specific capital shortfalls. It also provides a window to capital leaving the group (e.g. debt repayment, stock repurchase, or dividends to shareholders).
July 30, 2021

Via Electronic Delivery

Mr. John F. Rehagen, Division Director
Division of Insurance Company Regulation
Missouri Department of Insurance
301 West High Street
Jefferson City, Missouri 65105

Attention: Mr. Dan Daveline

RE: NAIC Regulatory Guidance for GCC and Analyst Reference Guidance for the GCC exposed the Group Capital Calculation (E) Working Group

Mr. Rehagan:

State Farm Mutual® Automobile Insurance Company and its affiliates ("State Farm"), appreciate the opportunity to submit these comments concerning the exposed draft of the NAIC Regulatory Guidance for GCC and Analyst Reference Guidance for the GCC via the Group Capital Calculation (E) Working Group (the “Working Group”). State Farm has been providing comments throughout the creation of the aggregation-based method of calculating capital for insurance groups under the National Association of Insurance Commissioners (“NAIC”) and U.S. Federal Reserve Notice of Proposed Rulemaking under a similar process.

State Farm is concerned with both the Regulatory Guidance for GCC (Regulatory Guidance) and Analyst Reference Guidance for the GCC (Analyst Reference) as both documents wrongly assume or infer that the GCC somehow creates group capital, establishes an amount or ratio that must be maintained by a group and that issues identified in an entity in a group is automatically risk attributable to another individual regulated insurer in the same group.

The aggregation-based method of calculating capital for insurance groups or the GCC recognizes that the capital is legally owned by the individual entities that are being aggregated by utilizing the regulatory capital regime when one is available to establish the entity’s capital for the purposes of aggregating. The application of the GCC does not change underlying legal process that the entities operate under or change the legal obligations of the individual entity. There are several statements made in the both documents that need further clarification to understand the
extent of the statement. For example, the Regulatory Guidance entitles Procedure Step 1 as “Evaluate the Adequacy of Group Capital” and asks for a determination to be made of whether “…the group capital position presents a risk to the group and its insurance subsidiaries based upon its recent trends and/or current measures in the GCC ratio”. This assumes that capital is fungible among the group and risk is freely transferable among the entities of a group which is contrary to established law. However, these issues are somewhat recognized in the Analyst Reference on page 4 in the last sentence of the GCC Summary and Strategic Branded Risk Documentation section provides “[w]hile the GCC is not a capital requirement, with specified ladders of intervention…” which is legally accurate and State Farm’s understanding. However, to further the wrong assumption that capital and risk is freely transferable under Procedure Step 5 of the Regulatory Guidance the following statement is made:

Depending upon the analysis performed in Steps 1-4, similar to legal entity analysis, there is likely a need to determine what steps the company is taking or plans to take to address the issues seen in the analysis of the GCC.

While it is not clear which entity is being referenced by the use of “company” but the “issues” presumably derive from the GCC ratio changing and the reasons for that change identified via Procedure Steps 1-4. The company is then to provide steps or plans to bring the GCC ratio back to some previously established position. All of which infers there is a GCC ratio being required or a level of group capital both legally not established and runs contrary to the regulatory scheme underlying and prior to the application of the GCC contrary to law and statements made in several documents concerning the GCC.

We should not lose sight of how the GCC sits on top of years of regulatory financial surveillance tools already developed and at the disposal of the domestic state regulator and/or lead state regulator. These tools are both qualitative and quantitative and already provide insight to both the individual insurers financial health as well as risks that may impact that individual insurer deriving from being a member of the group as well as other laws in the United States. An individual insurer is regulated through many different requirements, including but not limited to, the filing of annual and quarterly financial statements; audited by a certified independent accountant; risk based capital requirements with specific regulator intervention points; holding company requirements regulating the individual insurer’s ability to enter into affiliate transactions; regulation around the type of admitted assets that can be used to meet the individual insurers surplus needs as required; state based rating laws that require the insurer to set premium rates for the obligation of its policy that are not excessive, unfairly discriminatory, or inadequate; and no less than every five years an extensive financial examination of the insurer is conducted by its domestic state regulator. In addition to the individual insurance entity regulatory scheme and in addition to the GCC, and somewhat similar, there are other group level regulatory requirements, such as Form F and the Own Risk Surveillance Assessment (ORSA) that provide regulatory tools to evaluate aggregated risk at a group level.

Finally, State Farm is concerned that the Regulatory Guidance and Analyst Reference is not recognizing the “walls” in place in insurance regulations as well as the applicable non-insurance
laws of the United States or the existing body of insurer regulatory financial surveillance by not fully recognizing the limitations of risk obligation transference among members of a group, particularly those that are insurers and not acknowledging that surplus held by an insurer in a group is not readily available by any other member in the group. In fact, the maintenance of the walls aspect of the current regulatory scheme would be aided by the GCC process by identifying the entities within the group that are identified as holding or generating risk which then the regulators could monitor transactions of the regulated insurance entities with the at risk entity to ensure that the risk is not somehow transferred or transferred in manner that inappropriately places risk on the regulated insurer.

This provides the basis for the background of the comments provided in the draft Regulatory Guidance and Analyst Reference that are enclosed.

Thank you for your time and consideration in this project and to our comments. If there are any questions concerning the comments, please contact me.

Sincerely,

Chuck Feinen
State Farm Mutual Automobile Insurance Company
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

Review of the Group Capital Calculation

Consideration of the Insurance Holding Company System Structure

As the lead state begins to review the annual Group Capital Calculation filing for a particular group, it’s important for the lead state to do so with consideration of the existing knowledge of the organizational structure of the group, including changes in the structure from year to year, but more importantly the overall activities of each of the entities in the group which otherwise have the potential to transmit material risk to the insurers within the group. While the GCC will provide additional quantitative information on the entities in the group; the actual activities of the entities are also important in determining the scope of application of the GCC. Specific to that point, the lead state is responsible for determining if any of the entities in the holding company structure should be excluded from the calculation. The filing includes a column for the group to propose what should be excluded as well as an additional column for the final determination made by the lead state. In general, the determination of scope of the application is suggested by the group but made in consultation and agreement with the lead state. This exercise should be undertaken in a manner that yields a clearly documented rationale for excluding entities or subgroups of the larger group. The Group Capital Calculation Instructions describes the basis for making this determination and the calculation itself is structured to facilitate this determination, with the inclusion in Schedule 1 of the calculation financial data of all entities within the holding company. Similar to exclusion from the calculation itself is data for cases in which subgroups of the larger group are completely excluded from the group, particularly with regard to Schedule 1; the rationale for the exclusion(s) should be provided in the GPS. The concept is that this Schedule 1 data should be utilized by the lead state in conjunction with their existing knowledge of the group and its activities (obtained from the Schedule Y, ORSA, Forms B/C, Form F, the non-insurance grid, etc.), and therefore likely material risks, to make this determination. To the extent the entities included in Schedule 1 differ from the analyst’s knowledge of the Group, further discussion and follow-up should be with the group.

The holding company structure and activities should also be utilized by the lead state in determining how to evaluate the GCC ratio. More specifically, information on structure can impact the flow of capital and resources among entities within the holding company structure. Therefore, understanding the following can assist in evaluating the flow of resources:

- Domestic insurance operations
- International insurance operations
- Banking or other financial services operations subject to regulatory capital requirements
- Financial and non-financial operations not subject to regulatory capital requirements*

*The GCC instructions provide examples of financial versus non-financial entities in this category. All financial entities should be included in the scope of application of the GCC. However, there can be a broad array of entities that could be considered financial. The lead-state should document the rationale for cases in which it concludes that a “financial” entity should be excluded.

While the GCC is intended to be used as an input into the GPS, where the expectation is that the GCC summary section is used to document a high-level summary of the analysts take away of the GCC, as well as the Strategic branded risk, since that is the area where capital measurement is reported. The manner in which the analyst determines what else should be documented beyond the GCC Summary and the Strategic branded risk should be based upon the following steps, since these steps contemplate the previously mentioned concept that the existing evaluation of the financial condition should be used in evaluating the depth of review of the GCC. From a high level, the following steps suggest in

- Procedure Step 1 suggests that a review of the components of the GCC is appropriate when either the GCC ratio is trending downward or the GCC ratio is below a predefined suggested threshold of 150% (equivalent to an RBC of 300% since that is the same threshold used in the sensitivity analysis in the GCC Template.
Summary of Comments on Outline of Holding Company
Analysis Framework
Page: 1

Number: 1  Author: Chuck Feinen  Date: 7/26/2021 1:24:00 PM
What are the potential avenues that material risk could be transferred between affiliates? Presumably any legitimate transfer of material risk would be in the form of a Holding Company filing, D-1. The original emphasis of the GCC was the evaluation of non-insurance entities within a group to provide an additional evaluation tool for regulators that are regulating the individual insurance entities. The statement of "potential to transmit material risk to the insurers" is elevating GCC beyond the original purpose and inferring that both capital and risk is freely transferable among the entities in the group which is simply not the regulatory or legal structure.

If the concern is that a non-regulated entity with identified risk could transfer that risk rather than attempting to regulate the non-regulated entity through the GCC, regulators should work to maintain the wall between the entities so that there are no transactions entered into or continue that would allow for that risk to be transferred.

Number: 2  Author: Chuck Feinen  Date: 7/26/2021 1:51:00 PM
If this sentence is stating that part of the determination to exclude an affiliate from the GCC based on the likely transfer of material risks, how is this to be determined?

Number: 3  Author: Chuck Feinen  Date: 7/28/2021 10:20:00 AM
There isn't a free "flow of capital" in the U.S., the characterization asserts a free moving, fungible capital but the creation and flow of capital is regulated requiring such transactions among insurance affiliates to be fair.

Number: 4  Author: Chuck Feinen  Date: 7/26/2021 2:01:00 PM
How is "Strategic branded risk" defined?
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

- Procedure Step 2 suggests from a high level determining the drivers of any decreases in the total available capital in the GCC. While there are numerous benefits of the GCC over consolidated approaches, the ability to drill down on the drivers is one of the more significant and is consistent with the state’s approach to not just looking at capital, but to the drivers of capital issues.

- Procedure Step 3 suggests from a high level determining the driver of any increases in operating leverage, which is typically what drives insurance capital requirements up, be it asset risk/leverage or writings leverage. Similar to drivers of capital decreases, the GCC has detailed information on financial figures and ratios that can be used to isolate the issues.

- Procedure Step 4 is similar in that it too utilizes detailed information on capital allocation patterns that are necessary to understand if there are negative trends in the GCC since these can become important if there are any issues that might require further distribution of capital across the entities.

- Procedure Steps 5: Depending upon the analysis performed in Steps 1-4, similar to the legal entity analysis, there is likely a need to determine what steps the company is taking or plans to take to address the issues seen in the analysis of the GCC. The guidance provided in these procedures is not intended to be exhaustive, but rather should give the analyst a starting point in better evaluating the various issues.

- If the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document the material risks of the group observable from the GCC (as well as the required information to be included in all GPS from the GCC), this should be documented by the analyst in any workpapers deemed appropriate by the state and include the general reason therefore. In making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner and judgment based upon existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that judgment decision.

Procedure Step 1-Evaluate the Adequacy of Group Capital

1. Determine if the group capital position presents a risk to the group and its insurance subsidiaries based upon its recent trends and/or current measures in the GCC ratio.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Is the GCC &lt;150%? If “yes”, determine the most significant risk factors causing the result.</td>
<td>ST</td>
</tr>
<tr>
<td>b. Has there been a decrease in the GCC ratio over last two years? If “yes”, determine the cause(s) of the decline.</td>
<td>ST</td>
</tr>
<tr>
<td>c. Has there been a decrease in the GCC Total Available Capital from prior year? If “yes”, determine the cause(s) of the decline.</td>
<td>ST</td>
</tr>
<tr>
<td>d. If the GCC &lt;150%, has there been a change from prior year? If so, determine the cause(s) of the change. If the GCC was &lt;150% in the prior years also, consider more carefully the causes.</td>
<td>ST</td>
</tr>
</tbody>
</table>
What is meant by further distribution of capital across entities in this sentence? Who’s capital is being distributed?

What is meant by “company” in this paragraph? If the individual insurance entities are not triggering intervention under RBC what authority does the regulator have to require action and what authority would there be to require a non-insurance to take action?

This assumes a risk that does not exist. There’s no group capital, the GCC does not create group capital and an insurer’s capital is not freely available for a non-insurance entity.
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

| e. Has there been a negative trend in the GCC ratio over the past five years suggesting an overall pattern of declining capital? | ST | N/A |

If the answer to any of the above questions is “yes”, the analyst should proceed with procedure step 2, evaluating decreases in total available capital and/or procedure step C, evaluating increases in leverage to determine the cause(s) of the negative trends.
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

Procedures Step 2-Evaluate Decreases in Total Available Capital

2. Determine the source(s) of decreases in the GCC ratio or the GCC Total Available Capital

Unlike step 1, the intent of the step 2 (and 3) is to determine the actual source of the negative issues. However, unless obvious from the information obtained in step 2, the analyst should proceed to step 5 to understand more fully the actions being taken by the group to address the issues identified in step 2. However, in some cases, it’s possible that no further follow-up with the group will be necessary and that the lead state should simply update the GPS to be certain the main understanding of the issues are known to all of the regulators utilizing the GPS.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Review the GCC ratio from each of the reported entities and compare to the same ratio from the prior year. Determine which entities may have led to the negative trends.</td>
<td>-10%</td>
</tr>
<tr>
<td>b. If the change in the GCC is not driven from a legal entity, and instead the change in allowable debt, note as such.</td>
<td>ST, N/A</td>
</tr>
<tr>
<td>c. Review the levels of profitability for each of the reported entities in the GCC in the current and prior years (as reported in the GCC) to determine if there are particular entities showing signs of decreasing profitability which may lead to future decreases in the GCC ratio or total available capital.</td>
<td>OP, PR/UW, &lt;10%</td>
</tr>
<tr>
<td>d. For each of the reported entities showing either, 1) a meaningful decrease in the GCC due to a decrease in the total available capital, or 2) negative profitability trends; request information that identifies the issues by inquiring from the legal entity regulator first or the group itself (e.g., non-insurance company), if applicable.</td>
<td>OP, PR/UW, ST, N/A</td>
</tr>
<tr>
<td>e. If due to pricing or underwriting issues, understand if the issues are the result of known pricing policies that are currently being modified or if the business is in runoff, recently identified products where metrics can quantify the issues whether new product lines, or geographic or other concentrations, volume/growth business strain, or other issues. When considering pricing that is being modified, include those products that the price is adjusted through crediting rates.</td>
<td>PR/UW, N/A</td>
</tr>
<tr>
<td>f. If due to reserve issues, understand the reserve development trends, whether reserve and pricing adjustments have been made as well as changes in business strategy apart from those products.</td>
<td>RV, ST, N/A</td>
</tr>
<tr>
<td>g. If due to market risk issues—i.e., capital losses—understand not only why the losses occurred, but the likely near-term future impact given current and likely prospective economic conditions. Market issues include not only changes in equity prices, but also impact/exposure to interest rates and other rates such as foreign currency exchange rates or rates on various hedging products used by the group.</td>
<td>MK, CR, N/A</td>
</tr>
<tr>
<td>Number</td>
<td>Author</td>
</tr>
<tr>
<td>--------</td>
<td>--------------</td>
</tr>
<tr>
<td>1</td>
<td>Chuck Feinen</td>
</tr>
<tr>
<td>2</td>
<td>Chuck Feinen</td>
</tr>
<tr>
<td>3</td>
<td>Chuck Feinen</td>
</tr>
<tr>
<td>4</td>
<td>Chuck Feinen</td>
</tr>
</tbody>
</table>
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

h. If due to strategic issues such as planned growth, planned decline in writings or changes in the investment strategy, utilize the business plan from the Form F to better understand the anticipated changes and how the actual changes compare. Understanding the variance from the business plan is important in assessing the ongoing risk either in projected future profitability or in some cases the investments.

| ST, PR/UW, OP | N/A |

i. If due to negative reputational issues, understand the issues more closely, whether potential ongoing changes in stock prices or financial strength ratings that may further impact market perception, or what the group is doing to address the potential future impact be it sales projections or access to the capital markets.

| RP | N/A |

j. If due to credit losses, understand the current and future concentration in credit risks, be it investments, reinsurance or other source of credit losses.

| CR, MK | N/A |

k. If due to operational issues, such as extremely large catastrophe events, IT or cybersecurity events or relationships, understand the current and prospective impact.

| OP, ST | N/A |

l. If due to legal losses, understand the underlying issues and degree of potential future legal losses.

| LG | N/A |

m. If due to non-insurance reported entities in the group, understand the relationship of the non-insurance operations to the insurance entities and the potential impact to the insurance operations (i.e. intercompany agreements, services, capital needs, etc.).

| ST, OP | N/A |

Procedure Step 3—Evaluate Increases in Operating Leverage

3. Determine the source(s) of any decreases in the GCC ratio due to increases in leverage

Like step 2, the intent of the step 3 is to determine the actual source of the negative issues. The difference between step 3 and step 2 is simply the types of issues. Step 2 is focused on issues that have resulted in negative capital trends. Step 3; however, is focused on the issues that impact the risk being measured in the GCC. In most cases that risk is either from the asset side or from the liability side where in both cases there has been an increase in such risk that has not been offset by a corresponding or equal increase in capital. In general, this is referred to as operating leverage, where this risk can manifest itself either through increased writings or exposure (e.g., the ratio of premiums to capital or liabilities to capital), or through increased assets that also carry risk. The expectation is that other regulated entities also have capital requirements that increase as these different types of risks increase, similar to how the NAIC RBC considers different types of products and assets that carry more risk.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>MK, CR, RV, ST, OP, RP</td>
<td>&lt;-10%</td>
</tr>
</tbody>
</table>
Step 3 seems to be written assuming that the change in operating leverage is due to a non-insurance entity. Is that intended?
 VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Responsible</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>b.</td>
<td>Review the levels of operating leverage for each of the reported entities in the GCC as well as the same for the prior years as reported in the GCC to determine if there are particular entities showing signs of increasing operating leverage which may lead to future decreases in the GCC ratio or total available capital.</td>
<td>MK, CR, RV, ST, OP, RP</td>
<td>&lt;-10%</td>
</tr>
<tr>
<td>c.</td>
<td>For each of the reported entities showing a meaningful decrease in the GCC due to an increase in operating leverage, request information that identifies the issues by inquiring first from the legal entity regulator or the group itself (e.g., non-insurance company), if applicable.</td>
<td>MK, CR, RV, ST, OP, RP</td>
<td>N/A</td>
</tr>
<tr>
<td>d.</td>
<td>If operating leverage has increased, consider if growth may have resulted from underpriced products or a change in underwriting. Specifically inquire to determine if pricing was reduced to increase sales, or whether the growth is in new product lines or new geographic focus where the group may not have expertise. When considering pricing being modified, include those products that the price is adjusted through crediting rates.</td>
<td>PR/UW, OP, ST</td>
<td>N/A</td>
</tr>
<tr>
<td>e.</td>
<td>If operating leverage has increased, consider if reserving risk has also increased, through potential underpricing that ultimately manifests itself into reserve adjustments. To do so, obtain current profitability information on the products leading to the increased leverage.</td>
<td>RV</td>
<td>N/A</td>
</tr>
<tr>
<td>f.</td>
<td>If operating leverage has increased, obtain current information on the asset mix to be certain that there is a corresponding decrease in riskier assets to mitigate the otherwise likely increase in market and credit risk.</td>
<td>CR, MK</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Unless obvious from the information obtained in step 3, the analyst should proceed to step 5 to understand more fully the actions being taken by the group to address the issues identified in step 3. However, in some cases, it's possible that no further follow up with the group will be necessary, and that the lead state should simply update the GPS to be certain the main understanding of the issues are known to all of the regulators utilizing the GPS.

**Procedure Step 4-Evaluate the Capital Allocation Patterns**

4. **Determine the capital allocation patterns to determine if some entities may put pressure on other legal entities.**

Steps 2 and 3 are critical in understanding the issues faced by the group and in identifying the source of negative trends; and while additional follow up with the group is expected, before proceeding to Step 5, the lead state should understand the historical capital allocation patterns or the likely future needed capital allocation patterns. The GCC includes data on historical capital allocation patterns (e.g., contributed capital received/paid or dividends received/paid), which help to illustrate which entities need capital and which entities have capital that can be provided. While these patterns do not necessarily repeat themselves from one period to the next, there is often consistency in terms of entities that need capital or have excess capital, which may or may not be driven by losses, but rather a change in strategy (e.g., increased writings at one company over another). These trends can also assist in discussions with the group on where capital may come from as a result of a future unexpected material event.
Just insurance products?

This seems to be inferring from the phrase “entities have capital that can be provided” that the regulators can force capitalization among affiliates. Is this intended to say that parent level holding companies are to volunteer to reshuffle capital among subsidiaries? There is a whole insurance regulatory scheme and legal system that needs to be contemplated.

Same comment as above
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

Where similar information is also disclosed in Form F, the detail in the GCC may confirm what is already known in this area and in some cases may provide greater detail.

<table>
<thead>
<tr>
<th>a. Review the data from the GCC to determine the historical capital allocation patterns within the group and summarize the result of this analysis.</th>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ST</td>
<td>N/A</td>
</tr>
</tbody>
</table>

b. Using this data, as well as any recent information on net losses, or likely expected funding, determine if it’s possible any of the insurance companies will be required to fund future possible losses from other entities in the group and potentially become troubled themselves, regardless of the current capital in excess of RBC requirements.

<table>
<thead>
<tr>
<th></th>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OP, ST</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Procedure Step 5 - Consider the Need for Reductions in Risk

5. **Determine the group’s plans for addressing source(s) of any meaningful decreases in the GCC ratio or total available capital. Please note, in some cases, the plan may be as simple as actions designed to reverse a single negative trend.**

Steps 5 is designed to assist a review of the insurance company’s plans for addressing any meaningful decreases in the GCC ratio or total available capital. The specific plans of the group may or may not fully address all the issues but ultimately what is most important is that such information and the regulators plan for evaluating and monitoring the situation is known to the other regulators. There is a multitude of possibilities and this guidance is not intended to address all of those, including the fact that in some cases some regulators may choose to put their legal entity into some type of supervision, conservation or some other form of receivership. Similar to other areas, where similar information is also disclosed in Form F, further information may already be known in this area.
Further explanation is needed to understand what is meant by “future possible losses and “required to fund future possible losses”. Is the obligation to fund the future possible loss already existing? If the obligation to fund a future loss already exists, wouldn’t it already be included in RBC?

Which insurance company? How is any insurance company required to address the total calculated capital derived from the GCC.

Based on the GCC? If the insurance entity is meeting RBC under what authority?
### VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

<table>
<thead>
<tr>
<th></th>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Obtain a copy of the group’s most recent business plan and compare it to the prior year plan for variances. (see Additional Procedures below for additional follow-up analysis)</td>
<td>ST</td>
</tr>
<tr>
<td>b.</td>
<td>Request information from the group on how it intends to address the issues or trends identified in Steps 1-3. More specifically, determine how the group intends to decrease risk, and by what means.</td>
<td>ST</td>
</tr>
<tr>
<td>c.</td>
<td>Based on information received in 5.b., determine the group’s capacity to reduce risks or raise additional capital.</td>
<td>ST</td>
</tr>
<tr>
<td>d.</td>
<td>Where the remaining capital is adequate, document the findings into the GPS (or another document) and make available to the supervisory college and or domestic states with the presumption no further action is deemed necessary.</td>
<td>ST</td>
</tr>
<tr>
<td>e.</td>
<td>Consider whether the collective information suggests that any of the U.S. legal entity regulators should deem the legal entity to be in a “Hazardous Financial Condition” and takes appropriate action to address based upon the facts and circumstances and the provisions of the state’s law (similar to NAIC Model 385).</td>
<td>N/A</td>
</tr>
<tr>
<td>f.</td>
<td>Where appropriate, consider holding a meeting of the supervisory college or of all the domestic states to fully understand the group’s plans. Where appropriate, require the group to present its plans to the supervisory college or all the domestic states.</td>
<td>N/A</td>
</tr>
<tr>
<td>g.</td>
<td>Where appropriate, determine if the plans proposed by the group are inadequate to any of the legal entity regulators, and more specifically if any are considering taking action over their applicable legal entity. If this is the case, hold a meeting of the supervisory college or of all the domestic states to provide this information.</td>
<td>N/A</td>
</tr>
<tr>
<td>h.</td>
<td>Where appropriate, consider holding a broader meeting of all impacted jurisdictions in which the group is selling insurance. Where appropriate, require the group to present its plans to all such regulators and for the regulators to announce their plans.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
 Capital is not fungible, risk is not transferable, legal insurance entities RBC triggers the authority of intervention how does the GCC create the authority?

 If the regulated insurer is meeting its RBC how would the Hazardous Financial Condition aspect get triggered?

 How is "legal entity regulator" defined?
Purpose of the Group Capital Calculation (GCC) in Holding Company Analysis

The following information is intended to provide background and context of the issues/considerations for analysts when utilizing the NAIC Group Capital Calculation (GCC) for an insurance holding company (hereafter referred to as “group”) completing the GCC where required.

Background Information

Beginning in 2008, the NAIC Solvency Modernization Initiative (SMI) began to consider whether there were any lessons learned from the financial crisis that would cause the solvency framework to be modified. The NAIC determined that changes should be made to the group supervision framework in the area of group supervision, starting with the new annual requirement for the Lead State of each group operating in the U.S. to complete a written holding company analysis. Since that time, other changes to state laws have been made to further enhance group supervision (e.g. Form F, ORSA, and Corporate Governance reporting). All of these new tools are inputs into the previously mentioned holding company analysis, which is now summarized into a consistent tool used by all states in what is known as the Group Profile Summary (GPS).

Benefits of the GCC & Methods for Achieving

The Group Capital Calculation Instructions describes the background, intent, and calculation for the GCC in detail. As stated in the Group Capital Calculation Instructions, the GCC and related reporting provides more transparency of an insurance group’s structure and related risks to insurance regulators and makes those risks more identifiable and more easily quantified. In this regard, the tool is intended to assist regulators in holistically understanding the financial condition of non-insurance entities, how capital is distributed across an entire group, and whether and to what degree insurance companies’ capital may be put at risk from the operations of non-insurance entities, potentially undermining the insurance company’s financial condition and/or placing upward pressure on premiums to the detriment of insurance policyholders.

The manner in which the GCC achieves some of these benefits varies. For example, with regard to understanding how capital is distributed across an entire group can be seen in two ways, both by viewing the Tab titled “Input 4-Analytics” as follows: 1) the display of the “Ratio of Actual to Required Capital”; 2) display of “Required Capital” in a separate column. The degree of subsidization can also be seen in the “Input 4-Analytics” tab, with the display of the columns as follows: 1) Capital Contributions Received/(Paid); 2) Net Income. While certainly one year of information can show this exists, most of this benefit will not be seen until after further years of the GCC are reported within the template. Once five years of data are displayed in this “Input 4-Analytics” tab, it will allow the analyst to better understand the financial condition of the group as a whole as well as the non-insurance entities. Of course, such conclusions can only be made once the analyst can both see such data as well as understand from the group what is occurring that is leading to such figures.

This calculation provides an additional early warning signal to regulators so they can begin working with a company to resolve any concerns in a manner that will ensure that policyholders will be protected. This early warning signal can be seen with the trending of the financial information in the “Input 4-Analytics” tab as well as through the application of sensitivity analysis in the Input 5 Tab and inclusion of other relevant information in the Input 6 Tab. However, the analyst should also understand that other “qualitative tools” such as the Form F, are capable of also providing early warning signals if properly reported by the group. In addition, since most holding company systems may have a larger percentage of their operations in the insurance businesses, the
Summary of Comments on Outline of Holding Company Analysis Framework

Page: 1

What is meant by "company" in this sentence?
insurance trends for the U.S. insurers in the group should already be known and made available to the lead-state by the legal entity regulator. However, in the context of added policyholder protection, this largely comes into play with respect to the added quantitative data on non-insurers.

The GCC is an additional reporting requirement but with important confidentiality protections built into the legal authority to require such reporting. State insurance regulators already have broad authority to take action when an insurer is financially distressed, and the GCC is designed to provide regulators with further insights to allow them to make informed decisions on both the need for action, and the type of action to take. While the new information from the GCC may offer new insights, it’s equally important to understand that it will be up to the analyst to work with the insurance group to actually understand what is leading to the figures reported in the GCC, and from that perspective, especially in the early years of the GCC, it will require learning by both the analyst and the group to really be able to utilize the GCC in a manner as suggested in these introductory paragraphs.

Other Considerations When Considering Such Benefits

Recent events and economic conditions (i.e., pandemic, recession, etc.) can create stresses on a group, reinforcing the value of the quantitative data included in the GCC. Some stresses are similar to those experienced during the financial crisis and others are more unique. However, because the GCC is based upon a methodology that gets its inputs from individual legal entities, the capital calculated for each legal entity certainly can only capture the allowed capital resources of the legal entities in the group. While such an aggregation-based methodology is an appropriate group-level capital measure, until experience is gained with the GCC, it is not known as to how the GCC will behave in response to business cycles and various risk events, given in part because it only recognizes limited diversification benefits among entities in the group except for the diversification embedded in existing entity specific regulatory capital requirements. And while the GCC is not meant to be used in a way that compares groups to each other, it’s also true that its unknown how it will behave across groups, peers and even sectors. This is true both because of its limited diversification benefit, the differences between group types (mutual v. stock holding company), grouping of entities, and scope of entities included in the calculation. But also because application of jurisdictional accounting principles and use of scalars could have an impact on this as well via the foreign insurer profile of the group. The quantitative data collected in the GCC will evolve as state insurance regulators and insurance groups increase their understanding of the impact on available capital and calculated capital.

The following guidance on the GCC is intended to be utilized in a manner that allows the GCC to enhance group-wide financial analysis and to be used as an additional input into the GPS. The GCC provides the quantification of risk within the group and when combined with the information from the ORSA on the amount of capital needed to run the company’s current business model, puts the regulator in a much better position to understand the available capital and calculated capital within a group, as well as the financial condition of the group. Both are complimentary tools to each other, with the ORSA providing management’s internal approach to capital management, and beneficial in understanding the economics of the group, the GCC provides a standard model that can better enable the analyst to understand where the entire group stands with respect to existing legal entity requirements as well as broad measures of risk for non-insurers.
What is meant by "legal entity regulator"?

It should be made clear that the authority is limited to the individual insurance entity.

Not sure how a group would need to do anything based on the GCC.

The nature and availability of capital is not changing nor is the authority given to the state regulator who as identified above is only authorized to regulate the individual legal insurance entity.

How is "company" defined?

Not sure a comment is needed here but the acknowledgment of the differentiation is good.
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

Utilization of the Group Capital Calculation in the Lead State’s Responsibilities

The lead state is responsible for completing the holding company analysis and documenting a summary of that analysis in the GPS. The depth and frequency of the holding company analysis will depend on the characteristics (i.e., sophistication, complexity, financial strength) of the insurance holding company (group) system (or parts thereof), and the existing or potential issues and problems found during review of the insurance holding company filings.

It can be summarized that the analysis of the GCC will be used in a similar fashion under this guidance since it provides the depth of the review in the “five-step process” will vary by group and situations where for example in some groups, very little if any work (inquiries of the group) will be done after the first step due to a generally strong GCC figure and generally positive trends of the ratio over time, while in other groups, the analyst may need to proceed through each of the five steps. Exactly how the analyst proceeds through the guidance will be dictated by a multitude of factors and requires judgement.

GCC Construction That Also Impact its Utilization and Review

Some decision points may be addressed prior to the submission of a GCC template. These include: the scope of application (e.g. whether segments of the holding company system should be excluded for financial conglomerates); whether a limited filing will be allowed (as permitted in Model Law #440 and Model Regulation #450); and whether subgroup reporting (as defined in the GCC instructions) of a foreign insurance group will be required. In general, the analytics provided by the GCC will be similar for all entities included in the template. See the end of this section (Primer on the Group Capital Calculation Formula) to better understand these points. These facts are also a consideration in determining the depth of the analysis of the GCC and subsequent correspondence with the group. Refer to chapter VI.B. Roles and Responsibilities of Group-wide Supervisor/Lead State for details on responsibilities for completing the GPS.

The utilization of the GCC can be summarized as an additional input into the GPS. More specifically, once the analyst completes their review of the GCC, the overall ratio, the trend of the ratio, a summary should be incorporated into the GPS to help support the assessment of strategic risk.

Documentation of Review of the GCC in the Group Profile Summary (GPS)

The purpose of procedures is to document the GCC into the GPS. The following provides an example of a GCC Summary that represents the minimum expected input of the GCC into the GPS, with additional information also reported within the Strategic branded risk classification. The other purpose of this section is to determine if more follow-up should be performed and, if so, to assess the results of that additional review. The following is intended to assist in understanding summary documentation of the GCC to be included in the GPS.
<table>
<thead>
<tr>
<th>Number</th>
<th>Author: Chuck Feinen</th>
<th>Date: 7/26/2021 2:51:00 PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How is strategic risk defined?</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>How is strategic branded risk defined?</td>
<td></td>
</tr>
</tbody>
</table>
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

Group Capital Calculation (GCC) Summary
Summarize your assessment of the GCC both quantitatively and qualitatively, including any such items as may not be applicable to a branded risk category. For example, it may be appropriate to indicate “The review of the group’s GCC indicated the scope of the application is consistent with the lead state’s determination” and if possible to summarize succinctly, the general scope of the GCC. For example, “the GCC includes all U.S. and Bermuda operations, but excludes ABC non-insurance operations in South American countries”. It may also be appropriate to identify key drivers of risks for the group within the GCC that are discussed later in the branded risk categories, as those risks may be related to and supplement existing risk assessments derived from holding company analysis or they may be new risks that warrant further review. “The group’s GCC of 201% in the current year was impacted by a decline in Total Available Capital of $X which is related to group’s non-insurance operations in Bermuda and as well as the negative impact of market risks in the U.S. insurance legal entity ratio components, which based on further analysis has resulted from the recent financial market volatility”.

Branded Risk Assessment

Strategic: The group’s Group Capital Calculation is assessed as low and stable, and is a positive consideration in the overall assessment of strategic risk. The GCC has generally been strong and consistent over the past five years as illustrated in the following table. Additionally, refer to the GCC Summary for further details.

<table>
<thead>
<tr>
<th>GCC Ratio</th>
<th>CY</th>
<th>PY</th>
<th>PY1</th>
<th>PY2</th>
<th>PY3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>201%</td>
<td>207%</td>
<td>163%</td>
<td>202%</td>
<td>197%</td>
</tr>
</tbody>
</table>

GCC Summary and Strategic Branded Risk Documentation:
The above information documented in a summary section of the GPS and into the Strategic branded risk is expected to be the primary type of information that is always documented into the GPS since the GCC does provide a capital measurement of the group and consistent with the branded risk categories, should be reported in the strategic risk section. Similar to how RBC for individual insurance company is helpful in allowing the analyst to better evaluate other potential issues given capital represents a relative measure of cushion for adverse risks, the GCC and inclusion herein helps regulators to understand the same relative to a group. While the GCC is not a capital requirement, with specified ladders of intervention, each of the insurance legal entity figures are relative to individual company requirements, and therefore the GCC can provide a relative measure of strength against such minimum capital levels of the insurers.

Other Branded Risk Documentation:
To the extent the ratio was trending negatively, or available capital was decreasing, the analyst may choose to include more information in the strategic section of the GPS that summarizes any key drivers of such if they did not fall into one of the branded risk categories. Those drivers of the change would likely be documented in other specific branded risk categories, for example Pricing/Underwriting if driven by weak insurance underwriting, or Reserving if the drivers were reserve deficiencies, etc. References to other branded risk categories may also be appropriate. However, practically speaking, this may not always occur or be possible for the analyst to pinpoint given the multitude of risks within any insurers regulatory capital requirement formulas. This guidance is simply meant to suggest that if the GCC does in fact appear to show particular trends that are noteworthy on specific
Page: 4

- Number: 1  Author: Chuck Feinen  Date: 7/26/2021 2:52:00 PM
  How is branded risk defined?

- Number: 2  Author: Chuck Feinen  Date: 7/26/2021 2:53:00 PM
  How is "Total Available Capital" defined? Maybe use "Total Calculated Capital".

- Number: 3  Author: Chuck Feinen  Date: 7/26/2021 4:01:00 PM
  While the first portion of this sentence is spot on I am not tracking how GCC is a relative measure of strength against such minimum capital levels. This sounds like source of strength under the Federal Reserve but that is not how it works for insurance entities.
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

risks such as the underwriting branded risk, further documentation into that (applicable) branded risk may be appropriate.

A determination for when documentation of risks from the GCC into other branded risk categories may be appropriate is driven by both the question of whether any of the thresholds in Procedures 1a-1e were met, and the information obtained from the rest of the GCC information as described in Procedures 2-4. The GCC Summary is intended to be high-level, therefore other more detailed observations from reviewing the GCC should generally not be documented into the GPS unless they are specifically insightful, add to a high-level understanding of the group’s financial condition, as shown in the example above, or are specific to a branded risk category as stated.

Other Considerations:
In addition to the broad guidance provided herein on the documentation of the GCC into the GPS, the analyst should also understand the following more general points that could impact the GCC result for a particular group, judgement is required when considering these points:

- If the group has a significant amount of business in legal entities that are domiciled in jurisdictions whose capital regime is based on market-based valuations, the GCC will inherently be more volatile (as compared to a pure U.S.-based group for which RBC and statutory valuations are the norm).
- Similarly, a group may have legal entities that are solely based in jurisdictions that utilize a standard model for capital requirements or have entities in jurisdictions where the use of internal models has been approved. All else being equal, the manner in which capital measures quantify requirements and behave over time will differ to some extent between the two. Also, a change from a standard method to one based on internal models for a key subsidiary will likely produce a noticeable change in the GCC that is not reflective of changes in the entity’s underlying business.
- The GCC provides a means for analysts to identify non-insurance operations outside of the insurance group and to determine the extent of risk they may pose to the insures within the group. However, in doing so, analysts should understand that findings from review of Forms B, D and F might be equally valuable in these situations.
- When evaluating capital requirements for non-insurer financial entities that are not subject to regulatory capital requirements, consideration should be given to the appropriateness of the GCC’s capital charge for a specific entity’s financial operations (e.g. an entity conducting large volume or size of complex transactions but with little net revenue or equity).
- When evaluating capital requirements for non-insurer / non-financial entities consideration should be given to the appropriateness of the level of risk assigned to specific entities.

Detailed Observation Documentation:
More detailed observations shall be documented separately from the GPS and in a form not dictated by the NAIC. As in all holding company analysis, the level of documentation is determined by the state insurance department and is dependent on the characteristics and complexity of the group and its risks. These detailed observations generally need to only note observations that are indicative of drivers of trends and/or actions being taken by the group to mitigate risks. In some cases, these points can be easily summarized into the GPS, in other cases they are too detailed and should be documented instead within the separate document not dictated in form by the NAIC. The analysts are not expected, nor should they spend time documenting subtle
If there are no capital requirements for a non-insurer financial entity, what are the capital requirements being evaluated?

Same as above. Could this really mean the capital charge under the GCC and not requirement?
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

changes within either the GCC or individual company movements that either do not create a trend at the group level or identify a growing weakness in the group. However, judgment is required to make this determination. For example, a 10% decrease in an RBC ratio of one of the smaller insurers within the group generally would not be documented, although a 10% decrease in an RBC ratio in one of the larger insurers in the group that causes, or jointly with other insurers, causes a 10% decrease in the GCC should be noted. However, it should be understood also that this 10% threshold is not intended to be a used as a “bright-line”, and in fact it’s possible the 10% is not necessarily indicative of any negative trends at all. This could be the case when for example there was a change in the regulatory capital requirement. Therefore, again, judgement is required in making these determinations and this, as well as other thresholds used in this guidance are not meant to be bright-lines. As the GCC is used more, both by the individual analyst, as well as all of the states, using judgement around these threshold are expected to become easier.

Specific Procedures for Completing Analysis of the GCC

It should be understood that if the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document the material risks of the group observable from the GCC (as well as the required information to be included in all GPS from the GCC), this should be documented by the analyst in any workpapers deemed appropriate by the state and the general reasons therefore. In making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner and judgement based upon existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that judgement decision.

Procedures Step 1a-1e

The purpose of procedures 1a-1e is to assess the GCC level and to identify the drivers of any changes in the GCC, in order to summarize and to document that overall assessment in the GPS and its strategic risk category, which is the minimum expected input of the GCC into the GPS. However, the analyst should understand that in the early years of the GCC, limited amount of prior year(s) comparative data will be available, therefore requiring more judgement in determining where further analysis is warranted. Such judgement may need to be based upon various factors, including but not limited to other known information regarding the applicable group obtained from other sources (e.g. ORSA, Form F, Form B, etc).

Procedure 1 is also intended to help the analyst determine if more follow-up analysis work should be performed. However, if the answer to any of the questions in 1a-1e is “yes”, the analyst should proceed with step 2, evaluating decreases in total available capital and/or step 3, evaluating increases in leverage to determine the cause(s) of the negative trends. In the example provided above, the ratio is above 150%, which suggests further review may not be necessary. In addition, the trends are positive with no decreases in the base ratio and the only year below the 150% benchmark being in PY1 where presumably the analyst may have performed some level of inquiry to the holding company to understand the driver of the drop. Even then the drop was below the Handbook’s predefined threshold of 10% and may not have been necessary.

Procedures Step 2a-2m

Unlike step 1, the intent of the step 2 (and 3) is to determine the actual source of the negative issues and where to document them in the GPS. Procedure 2a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by looking at the ratio of actual-to-required capital for the legal entity insurers over the available years reported. The following sample of a table from the GCC calculation completed by the group from the data in Schedule 1 can be helpful in determining the source of the issues.
<table>
<thead>
<tr>
<th>Number</th>
<th>Author</th>
<th>Date</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chuck Feinen</td>
<td>7/26/2021 4:11:00 PM</td>
<td>Are there risks to the group or to entities within the group?</td>
</tr>
<tr>
<td>2</td>
<td>Chuck Feinen</td>
<td>7/26/2021 4:12:00 PM</td>
<td>Total calculated capital, please</td>
</tr>
</tbody>
</table>
### VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

#### Insurance Capital Table

<table>
<thead>
<tr>
<th>Template Groupings</th>
<th>Ratio of Actual to Required Capital</th>
<th>2024</th>
<th>2023</th>
<th>2022</th>
<th>2021</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>XXXX XXXX XXXX</td>
<td>[1]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>XXXX XXXX</td>
<td>[2]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>XXXX XXXX</td>
<td>[3]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>XXXX XXXX</td>
<td>[4]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>XXXX XXXX</td>
<td>[5]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada - Life</td>
<td>XXXX XXXX</td>
<td>[6]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>XXXX XXXX</td>
<td>[7]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>XXXX XXXX</td>
<td>[8]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>XXXX XXXX</td>
<td>[9]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Japan - Life</td>
<td>XXXX XXXX</td>
<td>[10]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Japan - Non-Life</td>
<td>XXXX XXXX</td>
<td>[11]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>XXXX XXXX</td>
<td>[12]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solvency II -- Composite</td>
<td>XXXX XXXX</td>
<td>[13]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>XXXX XXXX</td>
<td>[14]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia - All</td>
<td>XXXX XXXX</td>
<td>[15]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>XXXX XXXX</td>
<td>[16]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>XXXX XXXX</td>
<td>[17]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Procedure 2b recognizes that the GCC does allow some debt to be included in capital up to a predetermined limit and can drive the overall GCC ratio. The following sample table taken from the GCC calculation using the data in Schedule 1 can be helpful in making this determination. Cases where debt is issued to address risk driven reductions in the GCC ratio, may not offset those reductions. This data metric may not be available in the case of a “limited filing”.

#### Debt/Equity Table

<table>
<thead>
<tr>
<th>Template Groupings</th>
<th>Debt/Equity ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2024</td>
</tr>
<tr>
<td>Total</td>
<td>XXXX</td>
</tr>
</tbody>
</table>

Procedure 2c recognizes that profitability is generally one of the biggest drivers of changes in capital and utilizing the following table from the GCC can assist in identifying if there are entities reporting net losses that may be driving the decreases in capital. The following table taken from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues.

#### Income & Leverage Table

<table>
<thead>
<tr>
<th>Template Groupings</th>
<th>Net Income ($)</th>
<th>Return on Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Ins</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
</tbody>
</table>
If the source of the issues is the insurers, the following sample from a table from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues among the insurers.

<table>
<thead>
<tr>
<th>Core Insurance Table 1 Template Groupings</th>
<th>Net Income ($)</th>
<th>Return on Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Japan - Non-Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Australia - All</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
</tbody>
</table>

Procedure 2d is focused on requesting more specific information from the legal entity regulator or the group to better identify the source of the issue(s). Procedures 2e-2l simply contemplates that if the source of the issues can be identified into one of the branded risk categories, to document as such in the detailed workpapers and into the appropriate category of the GPS. However, it’s recognized that the source of issues may be in
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

multiple branded risk categories, in which case documentation of each of the sources into the detailed workpapers is still appropriate. However, documentation into one of the single branded risk classifications of the GPS is only appropriate if that risk category is a material driver of the negative trends. Procedure 2m is intended to identify if the source of the issues is related to non-insurance operations. The GCC is intended to provide for more consistent analysis of risks to the insurer that may originate from non-insurance entities within the holding company system.

Procedures Step 3a-3f

Procedure 3a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by looking at the leverage ratios. The following sample of a table from the GCC calculation using the data in Schedule 1 can be helpful in determining the source of the issues.

<table>
<thead>
<tr>
<th>Insurance Leverage Table</th>
<th>Net Premium Written ($)</th>
<th>Liabilities ($) / Capital &amp; Surplus</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>[1] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>[2] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>[3] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>[4] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>[5] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>[6] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>[7] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>[8] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>[9] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>[10] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>[12] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Solvency II – Composite</td>
<td>[13] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>[14] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Australia - All</td>
<td>[15] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>[16] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>[17] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Hong Kong - Life</td>
<td>[18] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Hong Kong - Non-Life</td>
<td>[19] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Singapore - All</td>
<td>[20] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Chinese Taipei - All</td>
<td>[21] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>South Africa - Life</td>
<td>[22] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
</tbody>
</table>
Assumption that the insurer’s capital is somehow impacted by another affiliate.
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

<table>
<thead>
<tr>
<th>Composite</th>
<th>South Africa - Non-Life</th>
<th>Mexico</th>
<th>China</th>
<th>South Korea</th>
<th>Malaysia</th>
<th>Chile</th>
<th>Brazil</th>
<th>India</th>
<th>Other Regime</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>[23]</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX XXXX</td>
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<td>XXXX XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>[24]</td>
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<td>XXXX XXXX</td>
<td>XXXX XXXX</td>
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<td>XXXX XXXX</td>
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<tr>
<td>[25]</td>
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<td>XXXX XXXX</td>
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<td>XXXX XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>[26]</td>
<td>XXXX XXXX XXXX</td>
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<td>XXXX</td>
<td>XXXX XXXX</td>
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<td>XXXX XXXX</td>
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</tr>
<tr>
<td>[27]</td>
<td>XXXX XXXX XXXX</td>
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<td>XXXX XXXX</td>
<td>XXXX XXXX</td>
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<tr>
<td>[28]</td>
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<td>XXXX XXXX</td>
<td>XXXX XXXX</td>
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<td>XXXX</td>
<td>XXXX XXXX</td>
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</tr>
<tr>
<td>[29]</td>
<td>XXXX XXXX XXXX</td>
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<td>XXXX XXXX</td>
<td>XXXX XXXX</td>
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</tr>
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<tr>
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</tr>
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<td>[32]</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX</td>
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<td>XXXX XXXX</td>
<td>XXXX XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>[33]</td>
<td>XXXX XXXX XXXX</td>
<td>XXXX</td>
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<td>XXXX XXXX</td>
<td>XXXX XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX XXXX</td>
<td>XXXX</td>
</tr>
</tbody>
</table>

Procedure 3b is more forward looking by suggesting the analyst look at the same leverage ratios used in 3a to determine if the trends might continue and lead to further decreases in the GCC ratio. Procedure 3c simply requests the analyst use the leverage information to target questions to the group to better identify the drivers. Procedure 3d-3f are all questions designed to help the analyst consider whether the changes in leverage will lead to greater underwriting risk, asserting risk, or market and credit risk. Procedures 3d-3f provide general inquiries for additional information for the analysis, however, these inquiries may also appropriately provide a basis for the analyst to enter conversations with the group on the same topics to understand how the group views these topics and how the group is managing and monitoring these risks. For groups filing an ORSA, see also documentation within the ORSA report for additional information on the identified risks and the group’s monitoring of risks, as well as consistency of the discussion with management and management’s observations in the ORSA Summary report.

Procedures Step 4a-4b. Procedure 4a is intended to help the lead state understand the historical capital allocation patterns or the likely future needed capital allocation patterns by simply documenting in the detail analysis workpapers. This includes, for example, noting that there is consistency in the entities generating net income and distributing it further through the group, and in some cases may require distribution through other insurers, which in the US often requires approval if considered extraordinary. Procedure 4a is intended to utilize that knowledge, along with other planned actions of the group, to understand whether problems with repaying debt or other obligations in the group could occur. The intent is to be in a better position for discussions with the group on where capital may come from to support future expected activity or future unexpected material events. The following sample of tables from the GCC calculation using data in Schedule 1 can be helpful in determining the source of the issues.

<table>
<thead>
<tr>
<th>Insurance Capital Table Template Groupings</th>
<th>Capital Contributions $ Received/(Paid)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2024</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>[1]</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>[2]</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>[3]</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>[4]</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>[5]</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>[6]</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>[7]</td>
</tr>
</tbody>
</table>
The group or the individual entities?

What about DT filings that don’t require extraordinary.

“Groups” don’t take action, legal entities take action. This is sounding like source of strength under the Federal Reserve process.
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

<table>
<thead>
<tr>
<th>Insurance Capital Table Template Groupings</th>
<th>Intragroup Dividends $ Received/(Paid)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2024</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>XXXX</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>XXXX</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>XXXX</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>XXXX</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>Japan - Non-Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II -- Composite</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>Australia - All</td>
<td>XXXX</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>XXXX</td>
</tr>
</tbody>
</table>

Procedures Step 5a-5h. Procedures 5a-5h are designed for those rare situations where the group has a need to reduce risk given the alternative of raising capital may be unlikely (see appendix for further discussion on that topic). In performing this procedure, it should be understood that procedure 2 (Evaluating Decreases in Total Capital) and Procedure 3 (Evaluating Increases in Operating Leverage) have already been considered, and therefore it has been concluded that either capital is decreasing or operating leverage is increasing. As such, after considering information that may already be available to the regulator on the business plan, Procedure 5b is largely focused on better understanding directly from the group the drivers of the apparent negative trends. It should be understood that some of these trends may have already been known, through for example the ORSA, and discussions by the lead state regarding such takeaways from such ORSA discussions. In fact, if already known, the key takeaways may already be documented in the GPS and therefore the remaining procedures in this section may be irrelevant and could be skipped if recently already considered and evaluated. In addition, to be sure, such trends from Procedure 2 and 3 may not suggest anything more needs to be done, in fact that is why the first procedure is focused on an existing business plan since its possible these trends may have been expected. In fact, Procedure 5a is based upon the belief that reducing risk by the group may have already been
A group has no capital requirements as stated on page 4 of this document so why would a group be required to reduce risk?
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

incorporated into the group’s latest business plan, which may have already been obtained from the Annual Form F Filing.

Procedure 5b on the other hand contemplates that the manner to address any negative trends may not have already been incorporated into the latest business plan and simply contemplates the analyst speaks with the group to understand how the group intends to address the issue. The existence of this procedure is not meant to suggest action must be taken by any regulator, rather to understand what the group is already doing to address the issue. To be sure, some of what the group is already doing may already be known by the lead state, either through the ORSA, the Form F, or a periodic meeting with the group that some states conduct annually with all groups. Rather, the procedure provides an opportunity for the analyst to make sure they understand the drivers and what if anything the group is doing to address. To be clear, increases in operating leverage are often planned, and often come with them expected future actions by the group, such as capital injections or future transactions that may reduce risk. Therefore, these discussions would allow these actions to be completely documented and understood. Meanwhile, decreases in capital sometimes are not expected, and may not result in immediate action if any, but it’s possible that it may lead to the group to take future actions, or contemplate future possible actions. Therefore, these discussions would allow these potential actions to be completely documented and understood.

Procedure 5c contemplates assessing if the group has the ability and resources to either reduce its risks or to raise additional capital. See the section below for further Considerations of the Group’s Capacity to Raise Capital. This procedure is not intended to suggest the analyst has the capacity to make this determination on their own, but rather to question the reasonableness of the possibility. Procedure 5d contemplates that the group may believe no action is necessary because it believes current capital is adequate to meet its business plan and is more likely to be the case when the company experienced a one-time reduction of capital as opposed to a growth in leverage that may continue. Procedure 5c is for the rare situation where the legal entity insurers have been strained enough or face impending pressure contemplated within NAIC Model 385—Model Regulation to Define Standards and Commissioner’s Authority for Companies Deemed to be in Hazardous Financial Condition that would suggest one or more of the insurers may be in a hazardous financial condition. Procedure 5f is designed to suggest the analyst bring the collective supervisors of the legal entity insurers together for a supervisory college to fully understand what is occurring and the group’s plans for addressing the issues it is facing. Procedure E6 is an extension of Procedure E5 as it contemplates the regulators discussing whether they believe the proposed actions from the group are adequate. This action could represent something either informally done before an insurer is in a regulatory action level, or formally once an insurer is in a regulatory action level. Procedure E7 is similar to the other actions contemplated within a supervisory college or, for example, to address a troubled insurance company under Accreditation requirements regarding communication with other states.

Additional Procedures – Business Plans

While there is a multitude of possibilities and this guidance is not intended to address all of those, the following provides some summary of related issues that may be helpful to the analyst (See also section 6 to consider the structure of the group and capital infusion issues).

**Group’s Business Plan:**

**Planning Process:**
<table>
<thead>
<tr>
<th>Number</th>
<th>Author</th>
<th>Date</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chuck Feinen</td>
<td>7/26/2021 4:22:00 PM</td>
<td>This bothers me as I just don’t see the group formulating a business plan.</td>
</tr>
<tr>
<td>2</td>
<td>Chuck Feinen</td>
<td>7/26/2021 4:23:00 PM</td>
<td>Again what issue, there is no required capital and if the individual entities meet RBC on what authority is this being asked?</td>
</tr>
<tr>
<td>3</td>
<td>Chuck Feinen</td>
<td>7/26/2021 4:24:00 PM</td>
<td>Same as above.</td>
</tr>
<tr>
<td>4</td>
<td>Chuck Feinen</td>
<td>7/26/2021 4:25:00 PM</td>
<td>The whole paragraph is beyond legal authority.</td>
</tr>
<tr>
<td>5</td>
<td>Chuck Feinen</td>
<td>7/26/2021 4:39:00 PM</td>
<td>Not sure if this is accreditation standard. It is not as broadly worded as I believe the NAIC would like it to be.</td>
</tr>
<tr>
<td>6</td>
<td>Chuck Feinen</td>
<td>7/26/2021 4:26:00 PM</td>
<td>The whole paragraph is beyond legal authority.</td>
</tr>
</tbody>
</table>
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

- Group system’s overall planning process (e.g., who is involved, how frequently it occurs, etc.) and how the overall initiatives are determined
- Understand the group’s estimate of the impact of the proposed actions on financial results
- Review the plan’s assumptions for reasonableness. Consider the likelihood of variations in the assumptions and the resulting impact on the future financial results
  - Consider subcategories of changes including:
    - Overall potential changes in investment strategy
    - Overall potential changes in underwriting strategy or existing concentrations
    - Overall impact on financing matters (e.g., debt, requirements, etc.)
    - Overall impact on derivatives to mitigate economic conditions
    - Overall changes in governance or risk management procedures
    - Increased ceded reinsurance transactions (common approach to reducing risk/increasing surplus):
      - Details regarding the revised strategy
      - Specifics on types of coverage such as assumption reinsurance, loss portfolio transfers
      - Transfer of risk considerations

Variance to Projections:

- Consider the group’s history of explanations regarding variances in projected financial results and the insurer’s actual results. If analysts determine the goals of the business plan are not attainable and/or projections are unreasonable, a revised business plan may be requested;
- Identify any internal or external problems not considered in the plan that may affect future financial results. Examples of such problems include the following: 1) the existence of competitors to limit future sales levels; 2) recent state legislation restricting the company’s product designs; or 3) the loss of key marketing personnel.

Evaluating a Business Plan:

Analysts should consider further detail where necessary in evaluating the proposed revised business plan but also monitor, on a periodic basis, the insurer’s progress in achieving the initiatives included in the group’s plan. The goal of any plan is the improvement of the underlying causes that led to the issues and an improvement in subsequent GCC base ratio results. Detail considerations for improving the plan may include the following (where considered inadequate):

- Trending comparative measures of targeted risk exposures including (where applicable):
  - Asset mix by detailed types
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

- Credit risk by detailed types
- Business writings/ratios by detailed product

**Impacts on financing items:**
- Projected cash flow movements for ongoing principal and interest payments on debt
- Impact on debt interest coverage ratio, other debt covenants, rating agency ratings
- Discussion of impact on parental guarantees and/or capital maintenance agreements
- Expected source and form of liquidity should guarantees be called upon

**Impact of reasonable possible stress scenarios**

**How the legal entities capital will be maintained at required levels**

Consultation with Other Regulators
- Consult with members of the supervisory college (if applicable) or other domestic states for input in evaluating the revised business plan

**Considerations of Group’s Capacity to Raise Capital**

The following is designed simply as a reminder of considerations the lead-state would contemplate when discussing the group system response to the issues identified in this section. More specifically, in most situations a group will first consider ways to reduce risk but in limited situations they may consider trying to raise additional capital. While this is typically not an option for a group that is currently not performing as it anticipated, in some situations alternative sources of capital can be raised if the holders of the new capital are given rights that are attractive to the holder. In addition, in some cases the group may have the ability to issue other forms of capital (e.g., debt), which can be used to inject into the insurance subsidiaries. While these facts are not unique to the utilization of the group capital calculation, they are worth a reminder along with relevant other related details.

**New Equity Considerations**

**Public Holding Company**
While no two groups are the same, issuing public stock may be limited for the reasons previously identified. In addition, regulators are reminded that a public holding company may be obligated to pay dividends in order to maintain expectations of their shareholders, making the reduction of risk a more viable action under the circumstances.

**Private Holding Company**
While no two groups are alike, a private company has some of the same characteristics as a public company in terms of owners’ expectations, but usually such expectations differ from a public company and it may be more
<table>
<thead>
<tr>
<th>Number</th>
<th>Author</th>
<th>Date</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chuck Feinen</td>
<td>7/26/2021 4:44:00 PM</td>
<td>The group doesn’t raise capital.</td>
</tr>
<tr>
<td>2</td>
<td>Chuck Feinen</td>
<td>7/26/2021 4:44:00 PM</td>
<td>If Illinois ever asks this of the State Farm group we should not respond unless a legal insurance entity is identified.</td>
</tr>
<tr>
<td>3</td>
<td>Chuck Feinen</td>
<td>7/26/2021 4:46:00 PM</td>
<td>Now they are breaking it down to maybe the parent entity but still if SF Mutual meets RBC we are done.</td>
</tr>
</tbody>
</table>
feasible for a private company given their access to specific individuals that may have a higher interest in higher capital rights.

**Mutual Insurance Company**
A mutual insurer is limited in terms of its access to capital because it cannot issue new stock.

**Mutual Holding Company**
Because mutual holding companies have characteristics of both public companies and mutual companies, there are implications of how such a structure affects its operations.

**Non-profit Health Company**
Insurers that are non-profits are generally charitable organizations and it is not uncommon that some types of insurers, particularly those that provide health insurance, to have some history as a non-profit. It may be helpful to understand these types of dynamics when considering a group structure.

**Fraternal Associations**
Regulators often find similarities between a fraternal benefit society and a mutual insurer because both can be limited in terms of their ability to raise additional funds.

**Reciprocal Exchanges**
Regulators often find similarities between reciprocal exchanges and fraternal benefit societies and mutual insurers because they can be limited in terms of their ability to raise additional funds. Although this is a general consideration for the regulator when evaluating the group system, there is generally much more that must be understood before coming to this conclusion because in some cases, the reciprocal may be able to assess policies that can serve a similar purpose as raising capital.

**New Debt Considerations**
Through discussions with the group, understand the potential impact of any new debt on the group system, including specifically the extent of future additional reliance on the insurance operations and whether those insurers have the capacity for such. Consider also an updated review on the following:
- Total debt service requirements.
- Revenue streams expected to be utilized to service the debt.
- Any new guarantees for the benefit of affiliates.
- Any new pledge assets for the benefit of affiliates.
- Any new contingent liabilities on behalf of its affiliates

**International Holding Company Considerations**
This section is applicable only to those international groups that are required to complete the GCC, which may be relatively small considering many international holding companies have a non-US groupwide supervisor and are exempt from the GCC. Those foreign groups that are required to complete the GCC will generally file a “subgroup” GCC that included entities that are part of the group’s U.S. operations. In those situations, the
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

Analysts should understand the structure to determine if it has any impact on this analysis. For example, a German-based holding company may have advisory boards established to communicate with U.S. regulators. Analysts should direct any regulatory concerns to the appropriate organization contact to ensure a prompt reply or resolution if the insurance regulator is not responding.

**Capital / Operational Commitment to U.S. Operations**

Some foreign holding companies may consider their U.S. enterprises non-core and consequently show weaker commitment to their ongoing business operations or financial support. In recent years, after sustaining continued losses from U.S. subsidiaries, several prominent foreign holding companies decided to cease their U.S. operations and liquidate their assets. Analysts should be aware of a holding company’s stated commitment to ensure the continued stability of U.S. operations. This commitment may include a written or verbal parental guarantee.
Primer on the Group Capital Calculation Formula

The National Association of Insurance Commissioners (NAIC) began development of the Group Capital Calculation (GCC) in late 2015 following extensive deliberation on potential measurement models and methodologies. The GCC uses a bottom-up aggregation approach, accounting for all available capital/financial resources, and the required regulatory capital based on the measurement of assets and liabilities of the various corporate entities, including insurers, financial and non-financial businesses.

The GCC Aggregation Methodology

As illustrated in the sample tables above, the proposed GCC is an aggregation or grouping of the available financial resources and calculated required capital of all legal entities in an insurance group that potentially pose material risk to the insurers in the group. The GCC allows some discretion in determining what entities under common control but outside of the defined Insurance Group may be excluded from the scope of application in the GCC. When reviewing a group’s choice of entities to be excluded from application of the GCC, the following points should be considered:

- The regulatory evaluation should be based on the criteria for material risk (e.g. structural separation; no history of cross subsidies, or other criteria as defined in the GCC instructions);
- Group requests for reducing the scope of application of the base GCC should be based on supporting information and rationale provided by the Group;
- Information on excluded entities should be made available upon request by the analyst.

The GCC includes the following types of entities and sets forth the general approach of calculated capital toward each.

U.S. Insurers – The available capital of U.S. domiciled insurers is determined by statutory accounting principles (SAP) as defined by state law and the NAIC Accounting Practices and Procedures Manual, which defines assets, liabilities, and in-turn net available capital/financial resources, sometimes referred to as policyholder surplus. The calculated capital for these insurers is subject to state law that requires these insurers to maintain minimum capital based on the applicable NAIC Risk-Based Capital formula at 200% x Authorized Control Level (Trend Test level).

Non-U.S. insurers – Similar to the available capital and calculated required capital of U.S. insurers, the available and calculated capital of non-U.S. insurers is determined by reference to the home jurisdiction’s basis of accounting and capital requirements converted to U.S. dollars. While most non-U.S. jurisdictions do not possess the same level of industry specific technical guidance, as included in the NAIC Accounting Practices and Procedures Manual, all jurisdictions have established accounting standards that insurers are required to follow to determine available capital/financial resources. In some cases, this represents local Generally Accepted Accounting Principles (GAAP), which may or may not be consistent with International Financial Reporting Standards (IFRS).

DRAFTING NOTE: While the GCC utilizes the available capital and home jurisdictions’ capital requirement, for jurisdictions where data is available appropriate scalars are currently being explored to produce comparable measures for risk which can be aggregated into the group-wide measure. One such scaling methodology is included as part of sensitivity Analysis in the GCC template. That scalar methodology uses aggregated data from
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

the U.S. and other jurisdictions at first intervention level to recognize that (for example), state regulators often have much higher reserve requirements that are required to be carried as required capital in other jurisdictions. For jurisdictions where the data is not available, the full jurisdictional requirement at first intervention level is used.

**U.S. Insurers Not Subject to RBC** – Some types of U.S. insurers are not subject to an RBC formula (e.g., Financial Guaranty Insurers, Title Insurers). For these entities, the available capital/financial resources is determined by reference to state law and the NAIC Accounting Practices and Procedures Manual. However, since an RBC formula does not exist, calculated capital is determined by reference to the state minimum capital requirements set out in state law (or 300% of reserves for Title insurers). For U.S. captive insurers, available capital is determined based upon the states accounting requirements, but the calculated capital is required to be calculated using the applicable RBC formula even if RBC does not apply to that entity in their state of domicile.

**Banking or Other Financial Service Operations Subject to Regulatory Capital Requirements** – Non-insurers such as banks are subject to their own regulatory valuation methods (typically GAAP with tiering of available capital) and their own regulatory capital requirements (e.g. OCC, Federal Reserve, FDIC or other requirements for banks). These regulatory values are used for the GCC.

**Financial and non-financial operations not subject to regulatory capital requirements** – In general, financial entities (as defined in the GCC Instructions) are subject to a higher capital charge in the GCC than the non-financial entities. However, the GCC does require available capital/financial resources and calculated capital to be gathered for all such entities that pose a material risk to insurers. In both cases the GCC will utilize the valuation used by such legal entities (typically U.S. GAAP) and a calculated capital based upon a risk factor. There are two important exceptions:

- All entities within the defined insurance group (definition included in GCC Instructions) must be included
- All financial entities (definition included in GCC Instructions) must be included
- The level of risk (low / medium / high) and associated capital calculation assigned to a financial entity will be selected by the group and evaluated by the lead-State reviewer
- Non-financial entities that are subsidiaries of U.S. insurers, foreign insurers or banks where a capital charge for the non-financial entity is included in the regulated Parent’s capital formula will remain with the Parent and will not be inventoried. Regulators already have access to the financials of these entities if needed (if causing unrealized losses within the insurer).

**Eliminations**

The GCC uses an aggregation and elimination approach, where each of the above legal entities’ available capital/financial resources and calculated capital are combined, then eliminations are utilized to prevent any double counting of available capital/financial resources or calculated capital. The following example illustrates the use of eliminations for both available capital/financial resources and calculated capital. However, in practice the GCC only requires the foreign insurers and other financial entities owned by an insurance company to be “de-stacked” so if AA Holding Company was a U.S. insurer (e.g. AA Insurance Company) the capital required and calculated capital for DD Insurance Agency as a nonfinancial entity would remain in the values of AA Insurance Company and not be de-stacked.
EE Insurance Group (EEIG)

### Calculation of ARC

<table>
<thead>
<tr>
<th>Entity</th>
<th>TAC</th>
<th>Less: Subs’ TAC</th>
<th>Adjusted TAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Holding Co.</td>
<td>50.0M</td>
<td>(38.0M)(^1)</td>
<td>12.0M</td>
</tr>
<tr>
<td>BB Life Ins. Co.</td>
<td>30.0M</td>
<td>0</td>
<td>30.0M</td>
</tr>
<tr>
<td>CC Insurance Co.</td>
<td>6.0M</td>
<td>0</td>
<td>6.0M</td>
</tr>
<tr>
<td>DD Ins. Agency</td>
<td>2.0M</td>
<td>0</td>
<td>2.0M</td>
</tr>
<tr>
<td>ARC (EEIG Group Total)</td>
<td>50.0M</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Amount of TAC for Subs as follows: (30.0M + 6.0M + 2.0M)

#### EEIG Financial Information

<table>
<thead>
<tr>
<th>Entity</th>
<th>Total Available Capital</th>
<th>Minimum Regulatory Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Holding Company</td>
<td>50.0 Million</td>
<td>0(^2)</td>
</tr>
<tr>
<td>BB Life Insurance Company</td>
<td>30.0 Million</td>
<td>3.0 Million(^3)</td>
</tr>
<tr>
<td>CC Insurance Company</td>
<td>6.0 Million(^3)</td>
<td>1.6 Million(^3)</td>
</tr>
<tr>
<td>DD Insurance Agency</td>
<td>2.0 Million(^3)</td>
<td>0(^2)</td>
</tr>
</tbody>
</table>

1. For Non-RBC filers this is regulatory available capital or stockholder equity
2. There is no regulatory capital for these entities when owned by a non-regulated entity.
3. Authorized Control Level (ACL) RBC or Prescribed Capital Requirement for non-U.S. insurers

### Calculation of MRC

1. Estimated post covariance factor of 10.5% @ CAL x ARC per GCC added for AA
2. Holding Co. and DD Ins. Agency
3. Amount of Calculated Capital for Subs as follows: (3.0M + 1.6M + 0.21M)
4. Applies to U.S. insurer only to increase level to Company Action Level (CAL) RBC

<table>
<thead>
<tr>
<th>Entity</th>
<th>ACL or Calculated Capital</th>
<th>Less: Subs’ Calculated Capital</th>
<th>Adjusted Calculated Capital</th>
<th>Multiply by 2.0(^5)</th>
<th>MRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Holding Co.</td>
<td>6.07M</td>
<td>(4.81M)(^2)</td>
<td>1.26M</td>
<td>NA</td>
<td>1.26M</td>
</tr>
<tr>
<td>BB Life Ins. Co.</td>
<td>3.0M</td>
<td>0</td>
<td>3.0M</td>
<td>6.0M</td>
<td>6.0M</td>
</tr>
<tr>
<td>CC Insurance Co.</td>
<td>1.6M</td>
<td>0</td>
<td>1.60M</td>
<td>NA</td>
<td>1.6M</td>
</tr>
<tr>
<td>DD Ins. Agency</td>
<td>0.21M</td>
<td>0</td>
<td>0.21M</td>
<td>NA</td>
<td>0.21M</td>
</tr>
<tr>
<td>MRC Total</td>
<td>9.07M</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In the above example, available capital/financial resources are referred to as available regulatory capital (ARC) and total authorized capital (TAC\(^1\)) and minimum calculated capital is referred to as minimal regulatory capital (MRC) and authorized control level (ACL\(^2\)). The GCC will allow non-insurance / non-financial entities owned by RBC filers in the group to remain within the available capital and regulatory capital so no eliminations are required for these entities. As shown, since AA Holding Company owns each of the other business entities in the organizational chart, $38 million (which is the amount of available capital/financial resources in the subsidiaries of AA) is eliminated from the TAC column since accounting methods include those as an asset on AA Insurance Company’s balance sheet. Also, the GCC includes capital calculations for AA Holding Company and DD Insurance Agency as part of the MRC in addition to the regulatory capital already included for the insurance subsidiaries. The MRC of the subsidiaries is eliminated from the parent’s (AA Holding Company) calculated capital. Therefore, in this example $4.81 million of calculated capital is eliminated from the MRC. Finally, the MRC of U.S. insurance subsidiary is multiplied by 2 in order to reflect Company Action Level (CAL) RBC as required in the GCC.

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1. Terminology used in RBC for available capital/financial resources
2. Terminology used in RBC for calculated regulatory capital
Debt: It is important to note that the available capital used in deriving the GCC recognizes a portion of the group’s senior and hybrid debt as capital. This allowance recognizes that debt that is not already recognized as available capital/financial resources under all known accounting principles (SAP, U.S. GAAP or IFRS) may have some value to the group under the U.S. insurance regulatory requirements where such is dividend down to the insurance companies and where extraordinary dividends must be approved by the state. Qualifying debt along with limitations thereon is described in the GCC instructions as is the calculation for the additional available capital. In addition to looking at the group’s debt leverage overall consideration should be given to how the allowance for additional capital from debt interacts with changes in available capital and capital requirements from year to year. The impact of procyclical changes in the allowance for debt as capital should be assessed.

Other Information Included in the GCC
The GCC includes selected financial information (net income, premiums, liabilities, debt, etc.) that are captured in Schedule 1 and in the “Analytics” tabs of the GCC that are meant to be used to help isolate potential strengths and weaknesses of the group and more specifically where such exist among the entities in the group. Some important information related to other features in the GCC also should be considered and are discussed below. Schedule 1, a simplified version of the Inventory Tab, and most analytics are required in the case of a “limited filing”. However, data is not required for the capital instruments, sensitivity analysis and other information tabs in a limited filing.

Grouping - The GCC separately allows certain financial entities (e.g. asset managers) and non-financial entities included in the GCC to have their values and capital calculation combined (grouped) for more efficient reporting and analysis. Although the GCC instructions set parameters for such grouping, the general expectation is that regulators will work with each applicable GCC filer in determining where grouping is and is not appropriate outside of what is allowed within the GCC Instructions. Grouping should be viewed in context of materiality. A single entity conducting a given activity may not be material, but when all entities conducting the same activity are combined, they can be material.

Excluded entities – The GCC provides two mechanisms for the exclusion of non-financial entities in Schedule 1 and in the Inventory Tab at the discretion of the lead state. State regulators should consider whether any of the information collected in the GCC template in support of, is collected for an entity or group of similar entities that would otherwise be excluded from the GCC ratio calculation. Regulators should separately monitor increases in the level of activity of an “excluded” entity or group of similar entities for purposes of materiality and potential subsequent inclusion in the GCC.

Sensitivity analysis – A tab devoted to individual sensitivity analysis is included in the GCC. These informational items provide the regulator with impact of discretion in excluding listed entities and alternative perspectives on risk charges for non-financial entities and foreign insurers. Monitoring of these items can help the regulator identify areas where the GCC may be improved or capital calculations adjusted in the future. A sensitivity analysis increases the overall calibration of the capital requirements in the GCC from its normal 200% x ACL RBC calibration to 300% x ACL. This should be used as an initial benchmark to conduct further analytical review. No other cushion should be applied.

Accounting Adjustments - The impact of accounting adjustments and related detailed information is collected in the GCC template in the Inventory Tab and in the Other Information Tab respectively. Such adjustments can be material during the de-stacking process. For example, a consolidated holding company may include GAAP values for entities that would otherwise be valued under regulatory accounting rules (e.g., Statutory Accounting Principles - SAP) on a stand-alone basis. When the regulated entity is de-stacked the difference between the GAAP values and SAP values will be removed from the group’s available capital. These “lost” values can result in a
material reduction in the inventoried available capital compared to consolidated available capital. Understanding the impact and the components of this adjustment can help the regulator when considering the impact of issuing new debt or when evaluating the allowance for debt as capital calculated in the GCC template.

Intangible Assets – Acquisitions, mergers and reorganization often can create significant intangible assets at a holding company level or possibly at an operating company (other than a regulated entity) level. The GCC template collects information on intangible assets held by inventoried entities in the Other Information Tab. The available capital associated with the value of entities whose assets are materially comprised of intangible assets should be evaluated in the context of fungible resources and in assessing the adequacy of the capital calculation assessed on such entities.

Dividend pass-thru (gross view of dividends) – Schedule 1D collects information on dividends paid and received within the group. It also includes a column that indicates whether dividends were declared but not yet paid, as well as cases where dividends received where retained or “passed thru” to another affiliate or paid out in dividends to shareholders. This information will assist the regulator in evaluating the movement of capital within the group to fund strategic insurance and non-insurance operations or activities (e.g. expansion of activities) or to fund entity specific capital shortfalls. It also provides a window to capital leaving the group (e.g. debt repayment, stock repurchase, or dividends to shareholders).
July 31, 2021

Dan Daveline, Director, Financial Regulatory Services, NAIC
By e-mail at: ddaveline@naic.org


Mr. Daveline:

This submission is on behalf of a group of seven interested parties (IP Group) and in response to a May 18, 2021 exposure by the Group Capital Calculation (E) Working Group (GCCWG) and by the Financial Analysis Solvency Tools (E) Working Group (FASTWG). The exposure relates to proposed guidance about the Group Capital Calculation (GCC) that has been drafted for inclusion in the NAIC’s Financial Analysis Handbook (FAH) for eventual use by financial analysts of state insurance departments.

First, the IP Group appreciates the opportunity to engage with you and with members of the GCCWG and FASTWG on this important matter. The GCC is the outcome of a significant effort that has been underway at the NAIC since 2015. Each of the individual organizations that comprise the IP Group have been actively engaged with the GCCWG and NAIC staff over that period to assure that the GCC is appropriate for the state-based insurance regulatory regime and the insurance market in the United States.

In addition to the GCC itself as a metric, it will be critical that the way it will be analyzed and used by state insurance departments is consistent with the GCC’s intended purpose, design, and related measures that are now incorporated into the NAIC’s model Insurance Holding Company System Regulatory Act (#440) and corresponding model Insurance Holding Company System Model Regulation (#450). It is with that important goal in mind that the IP Group has focused its efforts to provide you and working group members with feedback on the subject exposure.

As you are aware, the IP Group had the opportunity to review an earlier draft of the proposed FAH changes and to respond to your request that it determine if the draft guidance was consistent with the IP Group’s understanding of the intended use of the GCC. The IP Group shared its comments with you in an e-mail and attachment that was submitted on May 17, 2021, noting some inconsistencies between the draft guidance and the IP Group’s understanding of the GCC or of its intended use, as well as other concerns involving the following areas described herein:

- Calibration of the GCC and the FAH threshold for more in-depth analysis
- Representations about the benefits that analysts may realize from use of the GCC
- The five-step approach to determining the extent of the analysis
- A suggested “exit ramp” to include in the five-step approach
- The process to finalize and adopt the proposed text
- Clarity of text
In many respects, the comments herein, and as reflected in marked text changes in the attachments (Attachment A – Analyst Reference Guide; and Attachment B – FAH Guidance), are aligned with our prior comments submitted on May 17. Accordingly, the topics covered in the prior letter help to frame the IP Group’s current comments, noting where changes have been made to alleviate our prior concerns if such is the case.

The undersigned members of the IP Group hope that you will find these findings and recommendations to be constructive and look forward to discussing them with you and GCCWG/FASTWG members.

Sincerely, and on behalf of the IP Group:

America’s Health Insurance Plans – Bob Ridgeway
American Council of Life Insurers – Mariana Gomez
American International Group, Inc. – Marty Hansen
American Property Casualty Insurance Association – Steve Broadie
Anthem, Inc. – Doug Wright
Blue Cross and Blue Shield Association – Joseph Zolecki
UnitedHealth Group – Jeff Martin
Findings and Recommendations of the IP Group  
Submission of July 31, 2021

Calibration of the GCC and the FAH threshold for more in-depth analysis

We observe that the FAH draft uses 150% GCC as a benchmark, below which the 5-step process advances into deeper inquiries and analysis of the group’s situation. Further, references in the FAH text link the 150% to the RBC trend test and/or the GCC sensitivity test. In that regard, we have the following concerns and recommendations:

1. The FAH includes a benchmark that is intended to help analysts determine whether additional degrees of analysis are needed. While the stated benchmark may appear similar to the measures used in the trend or sensitivity tests, those measures were determined for very different purposes than the GCC and are each calibrated differently. The RBC trend test is a measure (in addition to other action levels in the RBC model act) that can result in regulatory action at the legal entity level. The sensitivity test helps GCCWG members assess the impact of the change in calibration (300% to 200% of ACL RBC) that was made to the GCC in October 2020. The GCC on the other hand is an analytical tool designed to provide regulators with more insight into risks in a group. Linking the GCC benchmark to the RBC trend test – while also referencing the GCC sensitivity test – will give rise to the same confusion and other concerns that were noted in the fall of 2020. Therefore, any proposed benchmark value must align with the GCC ratio’s basis of calibration and reflect the Working Group’s decision to adopt as a basis for the GCC calibration 200% ACL RBC, which is reflected in the October 30, 2020 meeting minutes, along with the Chair’s instruction to update the FAH accordingly. We also recommend that the FAH strike references to the sensitivity test to avoid confusion.

2. We are not aware of any quantitative analysis that was performed to determine an appropriate benchmark level for the GCC. It appears that the use of 150% in the current draft of the FAH was a judgment call or an attempt to mirror the RBC capital adequacy assessment in the FAH. Meanwhile, the current trial implementation process is about to enter its analysis phase. We have also recommended that the FAH guidance as to how a proposed GCC benchmark would be used to trigger additional in-depth analysis be subjected to a similar trial or further quantitative analysis by lead states in parallel with the submission of data by trial implementation participants, before any GCC thresholds are adopted in the FAH. The first filings of GCC data are not expected until 2023 based on year-end 2022 data, so there is no pressing need to establish a particular benchmark in the meantime. The additional two years of filings will provide meaningful data to inform any proposed benchmarks. Incorporating GCC results from those filings will give regulators a greater understanding of the distribution of GCC results across a

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1 The RBC trend test is calibrated at 100% ACL RBC, the GCC ratio is calibrated at 200% ACL RBC, the GCC sensitivity “test” is calibrated at 300% ACL RBC.
2 A 300% GCC sensitivity analysis ratio is not the same as a 300% RBC trend test because they are each calibrated using different denominators (300% ACL vs. 100% ACL).
greater number of insurance groups than those that are involved in the current implementation trial.

Going forward, experience with annual filings made beyond the trial and initial implementation will provide additional feedback and any benchmark should be periodically assessed to assure that it remains at an appropriate level. Given the need for further evaluation of GCC results – including the degree to which GCC results compare to underlying RBC amounts given that, currently, there are some differences in their respective underlying risk calculations/requirements -- we recommend that a GCC benchmark not be established pending further analysis of actual GCC results. If a GCC benchmark is included in the exposed FAH, the text should clearly note that the benchmark is a placeholder, pending further analysis. We suggest that the GCCWG and NAIC staff avail themselves of the additional information that will be forthcoming in the near future through the trial and initial implementation to evaluate proposed benchmarks – including whether one is necessary for the GCC and, if so, to form the basis for a more informed determination of the benchmark.

Consequently, the IP recommends including the following in the proposed guidance, as shown in marked text on page 1-2 of the Regulatory Guidance (Attachment B):

Procedure Step 1 suggests that a review of the components of the GCC is appropriate when either the GCC ratio is trending downward or the GCC ratio is below an initial suggested threshold. Analysts should be mindful at all times that any stated threshold is for analysis purposes only and does not constitute a trigger for regulatory action (nor is such a trigger provided at any GCC level in the provisions of the Model Holding Company Act and Model Holding Company Regulation. Further, they should be mindful that the respective calibration levels differ between the GCC and RBC. When a threshold is provided, it should be viewed as an opportunity for an analyst to understand issues and concerns that may be emerging and address them with the group, if needed.

Finally, as experience in gained with the GCC and with these analysis procedures, the threshold for analytical purposes will be revisited periodically and remains subject to change.

In addition to that change, the IP’s redlined documents include corresponding edits to make each description of Step 1 consistent with the text above.

Representations about the benefits that analysts may realize from use of the GCC

As reported to you in our prior submission of May 17, 2021, the IP Group believes that in various passages of the proposed text, the benefits that regulatory financial analysts may receive from use of the GCC are overstated. Some of the draft text seems to put more credence in the GCC as a metric than is believed to be appropriate without the benefit of actual experience over at least a couple of annual reporting cycles.

The IP Group provided examples of areas where the text could be more fully descriptive or caveated in order to articulate the GCC in a more appropriate context. In the current draft exposure, we note that some of the examples that the IP previously provided have now been incorporated in the text, and we appreciate that. However, the IP Group continues to believe that other passages can be improved with additional context so that analysts can better understand not just the purported benefits of the GCC, but also the various factors that, if not adequately considered as well, may lead to inappropriate
conclusions. Therefore, the IP Group has included in the attachments marked text changes intended to address other concerns raised in its prior letter, including the following:

- The metrics used for analysis (e.g., 10% change or “trend”) may need to be updated based on experience working with the GCC over time.
- A decline in the GCC could be due, at least in part, to a change in regulatory capital requirements of one or more legal entities within the group and would not necessarily represent a “negative” development.
- The draft language states: “While there are numerous benefits of the GCC over consolidated approaches, the ability to drill down on the drivers is one of the more significant and is consistent with the states approach to not just looking at capital, but to the drivers of capital issues.” The IP Group has included this recommended text as well for additional context: “While the mechanics of the GCC approach will introduce some opportunities for analysis, potential limitations do exist depending on the extent of de-stacking and grouping of entities in the GCC template. While the data will provide a “road map” of sorts as to the location of capital and risks within the group, the level of detail will vary by group. Thus, the GCC will provide a quantifiable means to decomposing group components for analysis, but qualitative considerations by the analyst will be necessary as well, the extent and nature of which will inherently vary by group. Again, this highlights the need to assure that analysts consider information from other analytical tools, not just the GCC in isolation.”

The five-step approach to determining the extent of the analysis

The proposed five-step process is a somewhat simplistic approach, and the IP Group sees the benefit in terms of providing a consistent approach and methodology for analysts to use, as well as for accreditation review teams to independently assess that documented procedures have been followed. The IP Group also is of the view that the approach is generally consistent with the stated intent of the GCC as an analytical tool, and that it is appropriate to “dig deeper” in certain cases for further analysis.

The IP Group’s May 17, 2021 letter expressed some concern that the approach may appear in some instances to cross over from analysis and into regulatory action. Upon further consideration, the approach seems reasonable if it is viewed in the broader context of a regulatory tool that is not intended to serve as a prescribed capital requirement that would trigger regulatory action, rather as an analytical tool; the GCC should be considered along with various inputs from the totality of sources and tools available to the analyst and that any such conclusions (e.g., regarding the need to reduce risk and/or raise capital) would be based holistically in an overall context.

With that in mind, the IP Group has included at the outset of Attachment A the following marked text:

The purpose of including the GCC in the lead state’s holding company analysis is to provide the analyst’s understanding and rationale for the scope of application of the GCC (which entities within the holding company structure are included in the GCC calculation); whether the level of the GCC or recent trends evidence concerns that should be addressed with the group’s management; whether the supporting schedules of underlying legal entity data show indications of concern that should similarly be addressed with the group or with the respective legal entity’s supervisor; and whether such information which is presented in the GCC filing is generally
aligned with other information available to the analyst, and if not, why not, and whether that
evidences other questions or concerns that should be addressed, or how they may already have
been resolved.

Notably, the purpose of the GCC is not to trigger regulatory action. The GCC-related provisions
in the Model Holding Company Act and the Model Holding Company Regulation do not provide
for such a trigger; the GCC thus is not actionable in and of itself. Any regulatory action would
have to result from other information available to the regulator and based on existing legislated
authority. Thus, even though the GCC is intended as a group-wide measure and provides insights
as to capital adequacy and risks across the group, state insurance regulatory authority to take
action remains largely focused at the legal entity level.

The insertion of the above text also serves to describe the “Purpose of the Group Capital Calculation
(GCC) in Holding Company Analysis.” While that is the heading of the subject section of the document,
absent the inclusion of the above text a “purpose” does not otherwise appear to be articulated in the
document.

A suggested “exit ramp” to include in the five-step approach

Again, the five-step process provides a means to incrementally “dive deeper” into further areas of
analysis. The IP Group would however like some clarity as to whether all the steps necessarily have to be
completed; for example, if the analyst has completed the step 1 analysis and there is no indication of
concerns, there would seem to be no need to perform step 2 (and, by extension, other steps). With that
in mind, the IP Group suggests that the guidance also provide indicators that would lead to an
appropriate “exit ramp” from those detailed levels. In other words, if a deeper dive results in additional
findings that enable the analyst to conclude that initial concerns are unwarranted, then the analysis
process should “reset” at the next higher level.

The process to finalize and adopt the proposed text

The IP Group has some questions and potential concerns about the process to finalize and adopt the
proposed guidance. With a 2021 data collection and trial implementation exercise set to commence this
spring, an opportunity arises for participating lead states to test the proposed FAH guidance as they
review data submissions from volunteer groups. The IP Group encourages lead states to do so, not just
to test the proposed procedures solely in the context of the GCC, but also in the broader context of how
well inputs from other analytical tools (ORSAs, Enterprise Risk Reports, etc.) can inform the GCC (or vice
versa) to yield a more comprehensive analysis.

Moreover, many existing analytical tools are applied at the legal entity level, whereas the GCC gives an
aggregated view of the group but also eliminates intracompany investments and balances, has
allowances for qualifying debt as capital, and incorporates capital resources and capital charges from
regulated and non-regulated entities outside the insurance group. Thus, how the GCC will relate to the
RBC of underlying insurance legal entities (e.g., of the flagship insurer in the group) will depend on a
number of factors which will vary from one group to the next. Gaining an understanding of that
relationship will take time and experience and can inform further modifications to the FAH text that
could be useful to analysts.
Feedback from testing the proposed FAH guidance can then be used to improve its text with respect to the five-step process and integration of processes and findings with other analytical tools. While the current proposed text is a good start and instructive as a proof of concept, the IP Group believes that it should not be considered final until it has also been subjected to trials and testing by lead state analysts.

The IP Group would also like to better understand whether, and if so, through what process, the FAH guidance will consider the work of certain international workstreams at the NAIC (or vice versa). For example, the E.U.-U.S. Covered Agreement has already influenced to some extent the timing of completion and adoption of the GCC by the NAIC, and the timing of its proposed implementation by lead states of U.S.-based groups that are engaged in cross-border business in the E.U. Another example involves the comparability of the Aggregation Method with the IAIS Insurance Capital Standard, and what that may imply about the GCC and how it will be used by lead states.

Clarity of text

In the IP Group’s previous submission, it was noted that draft text would benefit from a thorough editing process to improve its clarity and readability. In this current submission, the IP Group has made numerous marked text changes in both attachments, in order to improve clarity; incorporate the matters described above; incorporate additional items that also stem from our prior comments; and to adjust the text where we have come across passages that appear to deviate from our understanding of the intended use of the GCC.
Purpose of the Group Capital Calculation (GCC) in Holding Company Analysis

The purpose of including the GCC in the lead state’s holding company analysis is to provide the analyst’s understanding and rationale for the scope of application of the GCC (which entities within the holding company structure are included in the GCC calculation), whether the level of the GCC or recent trends evidence concerns that should be addressed with the group’s management; whether the supporting schedules of underlying legal entity data show indications of concern that should similarly be addressed with the group or with the respective legal entity’s supervisor; and whether such information which is presented in the GCC filing is generally aligned with other information available to the analyst, and if not, why not, and whether that evidence other questions or concerns that should be addressed, or how they may already have been resolved.

Notably, the purpose of the GCC is not to trigger regulatory action. The GCC-related provisions in the Model Holding Company Act and the Model Holding Company Regulation do not provide for such a trigger; the GCC thus is not actionable in and of itself. Any regulatory action would have to result from other information available to the regulator and based on existing legislated authority. Thus, even though the GCC is intended as a group-wide measure and provides insights as to capital adequacy and risks across the group, state insurance regulatory authority to take action remains largely focused at the legal entity level.

The following information is intended to provide background and context for concerns when utilizing the NAIC Group Capital Calculation (GCC) for an insurance holding company group (hereafter referred to as “group”) completing the GCC where required.

Background Information

Beginning in 2008, the NAIC Solvency Modernization Initiative (SMI) began to consider whether there were any lessons learned from the financial crisis that would cause the solvency framework to be modified. The NAIC determined that changes should be made to the group supervision framework in the area of group supervision, starting with the new annual requirement for the Lead State of each group operating in the U.S. to complete a written holding company analysis. Since that time, other changes to state laws have been made to further enhance group supervision (e.g., Form F, ORSA, and Corporate Governance reporting). All of these new tools are inputs into the previously mentioned holding company analysis, which is now summarized into a consistent tool used by all states known as the Group Profile Summary (GPS).

Benefits of the GCC & Methods for Achieving Them

The Group Capital Calculation Instructions describes the background, intent, and calculation for the GCC in detail. As stated in the Group Capital Calculation Instructions, the GCC and related reporting provides more transparency of an insurance group’s structure and related risks to insurance regulators and makes those risks more identifiable and more easily quantified. In this regard, the tool is intended to assist regulators in holistically better understanding the financial condition of risks that non-insurance entities may pose to the group, how capital is distributed across an entire group, and whether and to what degree insurance companies’ capital may be at risk from the operations of non-insurance entities, potentially undermining the insurance company’s financial condition and placing upward pressure on premiums to the detriment of insurance policyholders.

The manner in which the GCC achieves some of these benefits varies. For example, with regard to understanding how capital is distributed across an entire group, this can be seen in two ways. One is by viewing the Tab titled “Input4-Analytics” as follows: 1) the display of the “Ratio of Actual to Required Capital”; 2)
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The display of “Required Capital” in a separate column. The degree of subsidization can also be seen in the “Input 4-Analytics” tab, with the display of the columns as follows: 1) Capital Contributions Received/(Paid); 2) Net Income. While certainly one year of information can show this exists, most analyst benefit will not be seen until after further years of the GCC are reported within the template. Once at least five years of data are displayed in this “Input 4-Analytics” tab, it will allow the analyst to better understand the financial condition of the group as a whole as well as the risks posed by non-insurance entities in the group. Of course, such conclusions can only be made once the analyst can both see the columns as well as understand what is occurring that is leading to such figures.

Recognizing that legal entity supervision and related tools (e.g., RBC) is the primary means to address concerns about policyholder protection, the GCC may provide additional early warning signals to regulators so they can begin working with a company to resolve any concerns in a manner that will ensure regarding risks or activities of non-insurers within the group that policyholders will be protected. This early warning signal can be seen with the trending of the financial information in the “Input 4-Analytics” tab as well as through the application of sensitivity analysis in the Input 5 Tab and inclusion of other relevant information in the Input 6 Tab. However, the analyst should also understand that other “qualitative tools,” such as the Form F, are capable of also providing early warning signals if properly reported by the group. In addition, since most holding company systems may have a larger percentage of their operations in the insurance businesses, the...
insurance trends for the U.S. insurers in the group should already be known and made available to the lead-state by the legal entity regulator or by the domestic state regulator of the insurer(s). However, in the context of added policyholder protection, this may largely come into play with respect to the added quantitative data on non-insurers.

The GCC is an additional reporting requirement but with important confidentiality protections built into the legal authority to require such reporting. State insurance regulators already have broad authority to take action when an insurer is financially distressed, and the GCC is designed to provide regulators with further insights to allow them to make informed decisions on both the need for action, and the type of action to take. That said, the GCC and the related provisions in the NAIC’s Model Holding Company Act and corresponding regulation are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group’s GCC. Regulators will use other existing tools and authorities to take action, primarily at the legal entity level.

While the new information from the GCC may offer new insights, it is equally important to understand that it will be up to the analyst to work with the insurance group to actually understand what is leading to the figures reported in the GCC, and from that perspective, especially in the early years of the GCC, it will require learning by both the analyst and the group to really be able to utilize the GCC in a manner as suggested in these introductory paragraphs.

**Other Considerations When Considering Such Benefits**

Recent unforeseen events and economic conditions (i.e., like the recent pandemic, recession, etc.) can also create stresses on a group, reinforcing the value of the quantitative data included in the GCC. Some stresses are similar to those experienced during the financial crisis and others are more unique. However, because the GCC is based upon a methodology that gets its inputs from individual legal entities, the capital calculated for each legal entity certainly can only capture the allowed capital resources of the legal entities in the group. While such an aggregation-based methodology is an appropriate group-level capital measure, until experience is gained with the GCC, it is not known as to how the GCC will behave in response to business cycles and various risk events, given in part because it only recognizes limited diversification benefits among entities in the group except for the diversification embedded in existing entity specific regulatory capital requirements. And while the GCC is not meant to be used in a way that compares groups to each other, it also true that unknown how it will behave across groups, peers and even sectors. This is true because of its limited diversification benefit, the differences between group types (mutual v. stock holding company), grouping of entities, and scope of entities included in the calculation.

The following guidance on the GCC is intended to be utilized in a manner that allows the GCC to enhance group-wide financial analysis and to be used as an additional input into the GPS. The GCC provides the quantification of risk within the group and when combined with the information from the ORSA on the amount of capital needed to run the company’s current business model, puts the regulator in a much better position to understand the available capital and calculated capital within a group, as well as the financial condition of the group. Both are complimentary tools to each other, with the ORSA providing management’s internal approach to capital management, and beneficial in understanding of the economics of the group. The GCC provides a standard model that can better enable the analyst to understand where the entire group stands with respect
That said, analysts should be mindful of the differences between regimes and in the insights that can be gained by various tools. For example, in the case of a group with predominantly U.S. operations, the GCC will largely be based on the standard model/RBC of the U.S. subsidiaries. However, the ORSA is not constrained by a standard model; rather, the ORSA reflects management’s internal approach to capital management, and may utilize or benefit from economic capital models, other internal models, stress testing and other means. As a result, while the GCC is an additional input to the ORSA, it may provide data and signals that do not align with the risk measures within the ORSA.
Utilization of the Group Capital Calculation in the Lead State’s Responsibilities

The lead state is responsible for completing the holding company analysis and documenting a summary of that analysis in the GPS. The depth and frequency of the holding company analysis will depend on the characteristics (i.e., sophistication, complexity, financial strength) of the insurance holding company (group) system (or parts thereof), and the existing or potential issues and problems found during review of the insurance holding company filings.

It can be summarized that Similarly, in the analysis of the GCC will be used in a similar fashion under this guidance since it provides the depth of the review in the “five-step process” and specific inquiries will vary by group and situations where the GCC is based on each group’s unique situation. For example, in some groups, very little if any work (inquiries of the group) will be done after the first step due to a generally strong GCC figure and generally positive trends of the ratio over time. While in other groups, the analyst may need to proceed through each of the five steps. Exactly how the analyst proceeds through the guidance will be dictated by a multitude of factors and requires judgement.

GCC Construction That Also Impact its Utilization and Review

Some decision points may be addressed prior to the submission of a GCC template. These include: the scope of application (e.g., whether segments of the holding company system (group) should be excluded for financial conglomerates); whether a limited filing will be allowed (as permitted in Model Law #440 and Model Regulation #450); and whether subgroup reporting (as defined in the GCC instructions) of a foreign insurance group will be required. In general, the analytics provided by the GCC will be similar for all entities included in the template. (See the end of this section (Primer on the Group Capital Calculation Formula) to better understand these points.) These factors are also a consideration in determining the depth of the analysis of the GCC and subsequent correspondence with the group. Refer to chapter VI.B. Roles and Responsibilities of Group-wide Supervisor/Lead State for details on responsibilities for completing the GPS.

The utilization of the GCC can be summarized as an additional input into the GPS. More specifically, once the analyst completes their review of the GCC, the overall ratio, the trend of the ratio, a summary should be incorporated into the GPS to help support the assessment of strategic risk.

Documentation of Review of the GCC in the Group Profile Summary (GPS)

The purpose of procedures is to document the GCC into the GPS. The following provides an example of a GCC Summary that represents the minimum expected input of the GCC into the GPS, with additional information also reported within the Strategic branded risk classification. The other purpose of this section is to determine if more follow-up should be performed and, if so, to assess the results of that additional review. The following is intended to assist in documenting the analysts’ understanding summary documentation of the group’s GCC to be included in the GPS.
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Group Capital Calculation (GCC) Summary

Summarize your assessment of the GCC both quantitatively and qualitatively, including any such items as may not be applicable to a branded risk category. For example, it may be appropriate to indicate “The review of the group’s GCC indicated the scope of the application is consistent with the lead state’s determination,” and if possible to summarize succinctly, the general scope of the GCC. For example, “the GCC includes all U.S. and Bermuda operations, but excludes ABC non-insurance operations in South American countries.” It may also be appropriate to identify key drivers of risks for the group within the GCC that are discussed later in the branded risk categories, as those risks may be related to and supplement existing risk assessments derived from holding company analysis or they may be new risks that warrant further review. The group’s GCC of 201% in the current year was impacted by a decline in...
Group Capital Calculation (GCC) Summary

Summarize your assessment of the GCC both quantitatively and qualitatively, including any such items that may not be applicable to a branded risk category. For example, it may be appropriate to indicate "The review of the group’s GCC indicated the scope of the application is consistent with the lead state’s determination" and, if possible, to summarize succinctly, the general scope of the GCC. For example, "the GCC includes all U.S. and Bermuda operations, but excludes ABC non-insurance operations in South American countries". It may also be appropriate to identify key drivers of risks for the group within the GCC that are discussed later in the branded risk categories. Those risks may be related to and supplement existing risk assessments derived from holding company analysis or they may be new risks that warrant further review. "The group’s GCC ratio of 201% in the current year was impacted by a decline in Total Available Capital of SX which is related to group’s non-insurance operations in Bermuda and as well as the negative impact of market risks in the U.S. Insurance legal entity ratio components, which based on further analysis has resulted from the recent financial market volatility".

Branded Risk Assessment

Strategic: The group’s Group Capital Calculation is assessed as low and stable, and is a positive consideration in the overall assessment of strategic risk. The GCC has generally been strong and consistent over the past five years as illustrated in the following table. Additionally, refer to the GCC Summary for further details.

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<tr>
<td>GCC Ratio</td>
<td>201%</td>
<td>207%</td>
<td>163%</td>
<td>202%</td>
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</tbody>
</table>

GCC Summary and Strategic Branded Risk Documentation:

The above information documented in a summary section of the GPS and into the Strategic branded risk classification is expected to be the primary type of information that is always documented into the GPS. Since the GCC provides a capital measurement of the group and, consistent with the branded risk categories, should be reported in the strategic risk section. Similar to how RBC for an individual insurance company entity is helpful in allowing the analyst to better evaluate other potential issues given capital represents a relative measure of cushion for adverse risks, the GCC and inclusion herein helps regulators to understand the same relative to a group. While the GCC is not a capital requirement, with specified ladders of intervention, each of the insurance legal entity figures are relative to individual company requirements, and therefore the GCC can provide a relative measure of strength against such minimum capital levels of the insurers.

Other Branded Risk Documentation:

To the extent the ratio was trending negatively, or available capital was decreasing, the analyst may choose to include more information in the strategic branded risk section of the GPS that summarizes any key drivers of such findings if they did not fall into one of the branded risk categories. Those drivers of the change would likely be documented in other specific branded risk categories, for example Pricing/Underwriting if driven by weak...
insurance underwriting, or Reserving if the drivers were reserve deficiencies, etc. References to other branded risk categories may also be appropriate. However, *practically speaking*, this may not always occur or be possible for the analyst to pinpoint given the multitude of risks within any *insurer’s* regulatory capital requirement formulas. This guidance is simply meant to suggest that if the GCC does in fact appear to show particular trends that are noteworthy on specific risks such as the underwriting branded risk.
risks, further documentation into that (applicable) branded risk may be appropriate.

A determination for when documentation of risks from the GCC into other branded risk categories may be appropriate is driven by both the question of whether any of the thresholds in Procedures 1a-1e were met, and the information obtained from the rest of the GCC information as described in Procedures 2-4. The GCC Summary is intended to be high-level, therefore other more detailed observations from reviewing the GCC should generally not be documented into the GPS unless they are specifically insightful, add to a high-level understanding of the group’s financial condition, as shown in the example above, or are specific to a branded risk category as stated.

Other Considerations:

In addition to the broad guidance provided herein on the documentation of the GCC into the GPS, the analyst should also understand the following more general points that could impact the GCC result for a particular group, judgement. Judgement is required when considering these points:

- If the group has a significant amount of business in legal entities that are domiciled in jurisdictions whose capital regime is based on market-based valuations, the GCC will inherently be more volatile (as compared to a pure U.S.-based group for which RBC and statutory valuations are the norm).
- Similarly, a group may have legal entities that are solely based in jurisdictions that utilize a standard model for capital requirements or have entities in jurisdictions where the use of internal models has been approved. All else being equal, the manner in which capital measures quantify requirements and behave over time will differ to some extent between the two. Also, a change from a standard method to one based on internal models for a key subsidiary will likely produce a noticeable change in the GCC that is not reflective of changes in the entity’s underlying business.
- The GCC provides a means for analysts to identify non-insurance operations outside of the insurance group and to determine the extent of risk they may pose to the insures within the group. However, in doing so, analysts should understand that findings from review of Forms B, D and F might be equally valuable in these situations.
- When evaluating capital requirements for non-insurer financial entities that are not subject to regulatory capital requirements, consideration should be given to the appropriateness of the GCC’s capital charge for a specific entity’s financial operations (e.g., an entity conducting large volume or size of complex transactions but with little net revenue or equity).
- When evaluating capital requirements for non-insurer / non-financial entities, consideration should be given to the appropriateness of the level of risk assigned to specific entities.

Detailed Observation Documentation:

More detailed observations shall be documented separately from the GPS and in a form not dictated by the NAIC. As in all holding company analysis, the level of documentation is determined by the lead state insurance department and is dependent on the characteristics and complexity of the group and its risks. These detailed observations generally need to only note observations that are indicative of drivers of trends and/or actions being taken by the group to mitigate risks. In some cases, these points can be easily summarized into the GPS, in other cases, they are too detailed and should be documented instead within the separate document not dictated in form by the NAIC. The analysts are not expected, nor should they spend time documenting
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changes within either the GCC or individual company movements that either do not create a trend at the group level or identify a growing weakness in the group. However, judgment is required to make this determination.

For example, a 10% decrease in an RBC ratio of one of the smaller insurers within the group generally would not be documented, although, by contrast, a 10% decrease in an RBC ratio in one of the larger insurers in the group that causes either alone or jointly with other insurers, causes a 10% decrease in the GCC should be noted. However, it should be understood also that this 10% threshold is not intended to be a used as a "bright-line", and in fact, it is possible the 10% is not necessarily indicative of any negative trends at all. This could be the case when for example there was a change in the regulatory capital requirement. Therefore, again, judgement is required in making these determinations and this, as well as other thresholds used in this guidance are not meant to be bright-lines. As the GCC is used more, both by the individual analyst, as well as all of and by the various states, using the use of judgement around these threshold are expected to become easier, as it will be better informed by experience.

Specific Procedures for Completing Analysis of the GCC.

Specific Procedures for Completing Analysis of the GCC.

It should be understood that The following procedures should be used by the analyst in their review and documentation of results of the GCC. However, if the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document the material risks of the group observable from the GCC (as well as the required information to be included in the GPS from the GCC), this should be documented by the analyst in any workpapers deemed appropriate by the state and the general reasons for supporting that conclusion. In making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner and judgement based upon existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that judgement decision.

Procedures Step 1a-1e

The purpose of procedures 1a-1e is to assess the GCC level and to identify the drivers of any changes in the GCC, in order to summarize and to document that overall assessment in the GPS and its strategic risk category, which is the minimum expected input of the GCC into the GPS. However, the analyst should understand that in the early years of the GCC, limited amounts of prior year(s) comparative data will be available, therefore requiring more judgement in determining where further analysis is warranted. Such judgement may need to be based upon various factors, including but not limited to other known information regarding the applicable group obtained from other sources (e.g., ORSA, Form F, Form B, etc.).

Procedure 1 is also intended to help the analyst determine if more follow-up analysis work should be performed. However, if the answer to any of the questions in 1a-1e is "yes", the analyst should proceed with step 2, evaluating decreases in total available capital, and/or step 3, evaluating increases in leverage to determine the cause(s) of the negative trends. In the example provided above, the GCC ratio is above this handbook’s GCC benchmark [value to be determined], further review may be necessary. If above 150%, which suggests further review may not be necessary. In addition, the trends are positive with no decreases in the base ratio and the only year below the 150% suggested benchmark being in PY1 where presumably the analyst may have performed some level of inquiry to the holding company to understand the driver of the drop. Even then the drop was below the Handbook’s predefined threshold of 10% and may not have been necessary.

Procedures Step 2a-2m

Unlike step 1, the intent of step 2a-2m is to determine the actual source of the negative issues and where to document them. They should be documented in the GPS. Procedure 2a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

Attachment Two-B1
Financial Condition (E) Committee
12/13/21

Looking at the ratio of actual-to-required capital for the legal entity insurers over the available years reported. The following sample of a table from the GCC calculation completed by the group from the data in Schedule 1 can be helpful in determining the source of the issues.
<table>
<thead>
<tr>
<th>Insurance Capital Table Template Groupings</th>
<th>Ratio of Actual to Required Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2024</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Healths)</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>XXXX</td>
</tr>
<tr>
<td>Non-RBC Filing US. Insurers</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>XXXX</td>
</tr>
<tr>
<td>Bermuda - Commercial. Insurers</td>
<td>XXXX</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>Japan - Non-Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>Australia - All</td>
<td>XXXX</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>XXXX</td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>XXXX</td>
</tr>
</tbody>
</table>
Procedure 2b recognizes that the GCC does allow some debt to be included in capital up to a predetermined limit and can drive the overall GCC ratio. The following sample table taken from the GCC calculation using the data in Schedule 1 can be helpful in making this determination. Cases where debt is issued to address risk-driven reductions in the GCC ratio, may not offset those reductions. This data metric may not be available in the case of a “limited filing”.

<table>
<thead>
<tr>
<th>Debt/Equity Table</th>
<th>Debt/Equity ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Template Groupings</td>
<td>2024 2023 2022 2021 2020</td>
</tr>
<tr>
<td>Total [6] XXXX</td>
<td></td>
</tr>
</tbody>
</table>

Procedure 2c recognizes that profitability is generally one of the biggest drivers of changes in capital and utilizing the following table from the GCC can assist in identifying if there are entities reporting net losses that may be driving the decreases in capital. The following table taken from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues.

<table>
<thead>
<tr>
<th>Income &amp; Leverage Table</th>
<th>Net Income ($)</th>
<th>Return on Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Ins [3] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
<td></td>
</tr>
</tbody>
</table>
If the source of the issues is the insurers, the following sample from a table from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues among the insurers:

<table>
<thead>
<tr>
<th>Core Insurance Table 1</th>
<th>Net Income ($)</th>
<th>Return on Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>[1]</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>[2]</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>[3]</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captives)</td>
<td>[4]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>[5]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>[6]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>[7]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>[8]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>[9]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>[10]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Japan - Non-Life</td>
<td>[11]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>[12]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>[13]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>[14]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Australia - All</td>
<td>[15]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>[16]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>[17]</td>
<td>XXXX</td>
</tr>
</tbody>
</table>

Procedure 2d is focused on requesting more specific information from the legal entity regulator or the group to better identify the source of the issue(s). Procedures 2e-2l simply contemplates that if the source of the issues
can be identified into one of the branded risk categories, to document as such it should be documented in the detailed workpapers and into that the appropriate branded risk category of the GPS. However, if it is recognized that the source of issues may be in multiple branded risk categories, in which case documentation of each of the sources into the detailed workpapers is still appropriate. However, documentation into one of the single branded risk classifications of the GPS is only appropriate if that risk category is a material driver of the negative trends. Procedure 2m is intended to identify if the source of the issues is related to non-insurance operations. The GCC is intended to provide for more consistent analysis of risks to the insurer that may originate from non-insurance entities within the holding company system.

Procedures Step 3a-3f

Procedure 3a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by looking at the leverage ratio indicators of leverage, e.g., leverage, where this risk may manifest itself either through increased writings or exposure, or through increased balances relative to capital and surplus. The following sample of a table from the GCC calculation using the data in Schedule 1 can be helpful in determining the source of the issues.

<table>
<thead>
<tr>
<th>Insurance Leverage Table Template Groupings</th>
<th>Net Premium Written ($)</th>
<th>Liabilities ($) / Capital &amp; Surplus</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>1[1]</td>
<td></td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>2[2]</td>
<td></td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>3[3]</td>
<td></td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>4[4]</td>
<td></td>
</tr>
<tr>
<td>Non-RBC Filing US. Insurer</td>
<td>5[5]</td>
<td></td>
</tr>
<tr>
<td>Canada - Life</td>
<td>6[6]</td>
<td></td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>7[7]</td>
<td></td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>8[8]</td>
<td></td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>9[9]</td>
<td></td>
</tr>
<tr>
<td>Japan - Life</td>
<td>10[10]</td>
<td></td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>12[12]</td>
<td></td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>13[13]</td>
<td></td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>14[14]</td>
<td></td>
</tr>
<tr>
<td>Australia - All</td>
<td>15[15]</td>
<td></td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>16[16]</td>
<td></td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>17[17]</td>
<td></td>
</tr>
<tr>
<td>Hong Kong - Life</td>
<td>18[18]</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Hong Kong - Non-Life</td>
<td>XXX XXX XXX</td>
<td>XXX XXX XXX</td>
</tr>
<tr>
<td>Singapore - All</td>
<td>XXX XXX XXX</td>
<td>-</td>
</tr>
<tr>
<td>Chinese Taipei - All</td>
<td>XXX XXX XXX</td>
<td>XXX XXX XXX</td>
</tr>
<tr>
<td>South Africa - Life</td>
<td>XXX XXX XXX</td>
<td>-</td>
</tr>
</tbody>
</table>
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

Procedure 3b is more forward looking by suggesting the analyst look at the same leverage ratios used in 3a to determine if the trends might continue and lead to further decreases in the GCC ratio. Procedure 3c simply requests the analyst use the leverage information to target questions to the group to better identify the drivers. Procedure 3d-3f are all questions designed to help the analyst consider whether the changes in leverage will lead to greater underwriting risk, reserving risk, or market and credit risk. Procedures 3d-3f provide general inquiries for additional information for the analysis, however these inquiries may also appropriately provide a basis for the analyst to enter into conversations with the group on the same topics to understand how the group views these topics and how the group is managing and monitoring these risks. For groups filing an ORSA, see also documentation within the ORSA report for additional information on the identified risks and the group’s monitoring of risks, as well as consistency of the discussion with management and management’s observations in the ORSA Summary report.

Procedures Step 4a-4b. Procedure 4a is intended to help the lead state understand the historical capital allocation patterns or the likely future needed capital allocation patterns by simply documenting in the detail analysis workpapers. This includes, for example, noting that there is consistency in the entities generating net income and distributing it further through the group, and in some cases may require distribution through other insurers, which in the US often requires approval if considered extraordinary. Procedure 4a is intended to utilize that knowledge, along with other planned actions of the group, to understand whether problems with repaying debt or other obligations in the group could occur. The intent is to be in a better position for discussions with the group on where capital may come from to support future expected activity or future unexpected material events. The following sample of tables from the GCC calculation using data in Schedule 1 can be helpful in determining the source of the issues.

<table>
<thead>
<tr>
<th>South Africa - Composite</th>
<th>[23] XXXX XXXX XXXX</th>
<th>XXXX XXXX XXXX</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa - Non-Life</td>
<td>[24] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Mexico</td>
<td>[25] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>China</td>
<td>[26] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>South Korea</td>
<td>[27] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Malaysia</td>
<td>[28] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Chile</td>
<td>[29] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Brazil</td>
<td>[30] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>India</td>
<td>[31] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>Other Regime</td>
<td>[32] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
<tr>
<td>TOTAL</td>
<td>[33] XXXX XXXX XXXX</td>
<td>XXXX XXXX XXXX</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insurance Capital Table</th>
<th>Template Groupings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
</tr>
<tr>
<td></td>
<td>XXXX XXXX XXXX</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th></th>
<th>[6]</th>
<th>[7]</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Non-RBC filing U.S. Insurer</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Template Groupings</td>
<td>2024</td>
<td>2023</td>
</tr>
<tr>
<td>--------------------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td></td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>[6]</td>
<td>[7]</td>
</tr>
<tr>
<td></td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td></td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Non-RBC filing U.S. Insurer</td>
<td>[16]</td>
<td>[17]</td>
</tr>
<tr>
<td></td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>[21]</td>
<td>[22]</td>
</tr>
<tr>
<td></td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>[26]</td>
<td>[27]</td>
</tr>
<tr>
<td></td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>[31]</td>
<td>[32]</td>
</tr>
<tr>
<td></td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>[36]</td>
<td>[37]</td>
</tr>
<tr>
<td></td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Japan - Non-Life</td>
<td>[41]</td>
<td>[42]</td>
</tr>
<tr>
<td></td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>[46]</td>
<td>[47]</td>
</tr>
<tr>
<td></td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>[51]</td>
<td>[52]</td>
</tr>
<tr>
<td></td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>[56]</td>
<td>[57]</td>
</tr>
<tr>
<td></td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Australia - All</td>
<td>[61]</td>
<td>[62]</td>
</tr>
<tr>
<td></td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
</tbody>
</table>
### Procedures Step 5a-5h

Procedures 5a-5h are designed for those rare/uncommon situations where the group has a need to reduce risk given the alternative of raising capital may be unlikely (see appendix for further discussion on that topic). In performing this procedure, it should be understood that Procedure 2 (Evaluating Decreases in Total Capital) and Procedure 3 (Evaluating Increases in Operating Leverage) have already been considered, and therefore it has been concluded that either capital is decreasing, or operating leverage is increasing. As such, after considering information that may already be available to the regulator on the business plan, Procedure 5b is largely focused on better understanding directly from the group the drivers of the apparent negative trends. It should be understood that some of these trends may have already been known, through for example the ORSA review and discussions by the lead state regarding such takeaways from such ORSA discussions of the ORSA. In fact, if already known, the key takeaways may already be documented in the GPS and therefore the remaining procedures in this section may be irrelevant and could be skipped if recently already considered and evaluated. In addition, to be sure, such trends from Procedure 2 and 3 may not suggest anything more needs to be done, in fact that no additional evaluation is why necessary. It is for this reason the first procedure is focused on an existing business plan since it is possible these trends may have been expected. In fact, Procedure 5a is based upon the belief that reducing risk by the group may have already been incorporated into the group’s latest business plan, which may have already been obtained from the Annual Form F Filing.

<table>
<thead>
<tr>
<th></th>
<th>Switzerland - Life</th>
<th>Switzerland - Non-Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
</tbody>
</table>
previously incorporated into the group’s latest business plan, which may have been obtained from the Annual Form F Filing.

Procedure 5b on the other hand contemplates that the manner to address any unexpected negative trends may not have already been incorporated into the latest business plan and simply further contemplates that the analyst speaks with the group to understand how the group intends to address the issue. The existence of negative trends that may appear to be “negative”, e.g., a decline in the reported GCC, may actually be the result of a conscious determination by the group to more efficiently deploy capital yet remaining at sufficient levels from an ERM perspective. Thus, this procedure is not meant to suggest action must be taken by any regulator, rather to understand whether a trend is in fact “negative” or not, and if so, what the group is already doing to address the issue. To be sure, some of what the group is currently doing may already be known by the lead state, either through the ORSA, the Form F, or a periodic meeting with the group that some states conduct annually with all groups. Rather, the procedure provides an opportunity for the analyst to make sure they understand the drivers and what, if anything, the group is doing to address the underlying issues. To be clear, increases in operating leverage are often planned, and often come with expected future actions by the group, such as capital injections or future transactions, that may reduce risk. Therefore, these discussions would allow these actions to be completely documented and understood. Meanwhile, decreases in capital sometimes are not expected, and may not result in immediate action if any, but it is possible that it may lead the group to take future actions, or contemplate future possible actions to take. Therefore, these discussions would allow these potential actions to be completely understood by the analyst and documented.

Procedure 5c contemplates assessing if the group has the ability and resources to either reduce its risks or to raise additional capital. See the section below for further Considerations of the Group’s Capacity to Raise Capital. This procedure is not intended to suggest the analyst has the capacity to make this determination on their own, but rather to question the reasonableness of the possibility. Further, the GCC and the related provisions in the NAIC’s Model Holding Company Act and corresponding regulation are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group’s GCC; regulators will use other existing tools and authorities to take action, primarily at the legal entity level.

Procedure 5d contemplates that the group may believe no action is necessary because it believes current capital is adequate to meet its business plan and is more likely to be the case when the company experienced a one-time reduction of capital as opposed to a growth in leverage that may continue. Procedure 5f is for the rare situation where the legal entity insurers have been strained or face impending pressure contemplated within NAIC Model 385–Model Regulation to Define Standards and Commissioner’s Authority for Companies Deemed to be in Hazardous Financial Condition that would suggest one or more of the insurers may be in a hazardous financial condition. Procedure 5f is designed to suggest the analyst bring the collective supervisors of the legal entity insurers together for a supervisory college to fully understand what is occurring and the group’s plans for addressing the underlying issues it is facing. Procedure 6f is an extension of Procedure 5f as it contemplates the regulators discussing whether they believe the proposed actions from the group are adequate. This action could represent something either informally done before an insurer is in a regulatory action level, or formally once an insurer is in a regulatory action level. Procedure 7f is similar to the other actions contemplated within a supervisory college or, for example, to address a troubled insurance company under Accreditation requirements regarding communication with other states.

Additional Procedures – Business Plans
While there is a multitude of possibilities and which are beyond the scope of this guidance, it is not intended to address all of those. The following provides some summary of the related issues that may be helpful to the analyst to consider (see also section 6 for consideration of the structure of the group and capital infusion issues).

Group’s Business Plan:
Planning Process:
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

**Group’s Business Plan:**

**Planning Process:**
- Group system’s overall planning process (e.g., who is involved, how frequently it occurs, etc.) and how the overall initiatives are determined
- Understand the group’s estimate of the impact of the proposed actions on financial results
- Review the plan’s assumptions for reasonableness. Consider the likelihood of variations in the assumptions and the resulting impact on the future financial results
- Consider subcategories of changes including:
  - Overall potential changes in investment strategy
  - Overall potential changes in underwriting strategy or existing concentrations
  - Overall impact on financing matters (e.g., debt, requirements, etc.)
  - Overall impact on derivatives to mitigate economic conditions
  - Overall changes in governance or risk management procedures
  - Increased ceded reinsurance transactions (common approach to reducing risk/increasing surplus):
    - Details regarding the revised strategy
    - Specifics on types of coverage such as assumption reinsurance, loss portfolio transfers.
  - Transfer of risk considerations

**Variances to Projections:**
- Consider the group’s history of explanations regarding variances in projected financial results and the insurer’s actual results. If analysts determine the goals of the business plan are not attainable and/or projections are unreasonable, a revised business plan may be requested.
- Identify any internal or external problems not considered in the plan that may affect future financial results. Examples of such problems include the following: 1) the existence of competitors to limit future sales levels; 2) recent state legislation restricting the company’s product designs; or 3) the loss of key marketing personnel.
Evaluating a Business Plan:

Analysts should consider further detail where necessary in evaluating the proposed revised business plan but also monitor, on a periodic basis, the insurer’s progress in achieving the initiatives included in the group’s plan. The goal of any plan is assuming that the analyst has determined that a decline in the GCC is to be considered a “negative” event, i.e., it was not the result of capital management and planning to more efficiently utilize capital while staying within sound levels to achieve ERM objectives, the goal of the plan would then be to address the improvement of the underlying causes that led to the issues and an improvement in subsequent GCC base ratio results. Detail considerations for improving the plan may include the following (where considered inadequate):

- Trending comparative measures of targeted risk exposures including (where applicable):
  - Asset mix by detailed types
Consultation with Other Regulators

- Consult with members of the supervisory college (if applicable) or other domestic states for input in evaluating the revised business plan

Considerations of Group’s Capacity to Raise Capital

The following is designed simply as a reminder of considerations the lead state would contemplate when discussing the group system response to the issues identified in this section. More specifically, in most situations a group will first consider ways to reduce risk but in limited situations they may consider trying to raise additional capital. While this is typically not an option for a group that is currently not performing as it anticipated, in some situations alternative sources of capital may be raised if the holders of the new capital are given rights that are attractive to the holder. In addition, in some cases the group may have the ability to issue other forms of capital (e.g., debt), which can be used to inject into the insurance subsidiaries. While these facts are not unique to the utilization of the group capital calculation, they are worth a reminder along with relevant other related details.

New Equity Considerations

Public Holding Company
While no two groups are the same, issuing public stock may be limited for the reasons previously identified. In addition, regulators are reminded that a public holding company may be obligated to pay dividends in order to maintain expectations of their shareholders, making the reduction of risk a more viable action under the circumstances.

Private Holding Company
While no two groups are alike, a private company has some of the same characteristics as a public company in
terms of owners’ expectations, but usually such expectations differ from a public company and it may be more feasible for a private company given their access to specific individuals that may have a higher interest in higher capital rights.
feasible for a private company given its access to specific individuals that may have a higher interest in higher capital rights.

Mutual Insurance Company
A mutual insurer is limited in terms of its access to capital because it cannot issue new stock.

Mutual Holding Company
Because mutual holding companies have characteristics of both public companies and mutual companies, there are implications of how such a structure affects its operations.

Non-profit Health Company
Insurers that are non-profits are generally charitable organizations and it is not uncommon that some types of insurers, particularly those that provide health insurance, to have some history as a non-profit. It may be helpful to understand these types of dynamics when considering a group structure.

Fraternal Associations
Regulators often find similarities between a fraternal benefit society and a mutual insurer because both can be limited in terms of their ability to raise additional funds.

Reciprocal Exchanges
Regulators often find similarities between reciprocal exchanges and fraternal benefit societies and mutual insurers because they can be limited in terms of their ability to raise additional funds. Although this is a general consideration for the regulator when evaluating the group system, there is generally much more that must be understood before coming to this conclusion because in some cases, the reciprocal may be able to assess policies that can serve a similar purpose as raising capital.

New Debt Considerations
Through discussions with the group, understand the potential impact of any new debt on the group system, including specifically the extent of future additional reliance on the insurance operations and whether those insurers have the capacity for such. Consider also an updated review of:

- Total debt service requirements.
- Revenue streams expected to be utilized to service the debt.
- Any new guarantees for the benefit of affiliates.
- Any new pledge assets for the benefit of affiliates.
- Any new contingent liabilities on behalf of its affiliates

International Holding Company Considerations

International Holding Company Structure
This section is applicable only to those international groups that are required to complete the GCC, which may be relatively small considering many international holding companies have a non-US groupwide supervisor and are exempt from the GCC. Those foreign groups that are required to complete the GCC will generally file a “subgroup” GCC that included entities that are part of the group’s U.S. operations in those situations, the-
analysts should understand the structure to determine if it has any impact on this analysis. For example, a German-based holding company may have advisory boards established to communicate with U.S. regulators. Analysts should direct any regulatory concerns to the appropriate organization contact to ensure a prompt reply or resolution if the insurance regulator is not responding.

**Capital / Operational Commitment to U.S. Operations**

Some foreign holding companies may consider their U.S. enterprises non-core and consequently show weaker commitment to their ongoing business operations or financial support. In recent years, after sustaining continued losses from U.S. subsidiaries, several prominent foreign holding companies decided to cease their U.S. operations and liquidate their assets. Analysts should be aware of a holding company’s stated commitment to ensure the continued stability of U.S. operations. This commitment may include a written or verbal parental guarantee.
Primer on the Group Capital Calculation Formula

The National Association of Insurance Commissioners (NAIC) began development of the Group Capital Calculation (GCC) in late 2015 following extensive deliberation on potential measurement models and methodologies. The GCC uses a bottom-up aggregation approach, accounting for all available capital/financial resources, and the required regulatory capital based on the measurement of assets and liabilities of the various corporate entities, including insurers, financial and non-financial businesses.

The GCC Aggregation Methodology

As illustrated in the sample tables above, the proposed GCC is an aggregation or grouping of the available financial resources and calculated required capital of all legal entities in an insurance group that potentially pose material risk to the insurers in the group. The GCC allows some discretion in determining what entities under common control but outside of the defined Insurance Group may be excluded from the scope of application in the GCC. When reviewing a group’s choice of entities to be excluded from application of the GCC, the following points should be considered:

- The regulatory evaluation should be based on the criteria for material risk (e.g., structural separation; no history of cross subsidies, or other criteria as defined in the GCC instructions);
- Group requests for reducing the scope of application of the base GCC should be based on supporting information and rationale provided by the Group;
- Information on excluded entities should be made available upon request by the analyst.

The GCC includes the following types of entities and sets forth the general approach of calculated capital toward each:

U.S. Insurers - The available capital of U.S. domiciled insurers is determined by statutory accounting principles (SAP) as defined by state law and the NAIC Accounting Practices and Procedures Manual, which defines assets, liabilities, and in-turn net available capital/financial resources, sometimes referred to as policyholder surplus. The calculated capital for these insurers is subject to state law that requires these insurers to maintain minimum capital based on the applicable NAIC Risk-Based Capital formula at 200% x Authorized Control Level.

Non-U.S. insurers – Similar to the available capital and calculated required capital of U.S. insurers, the available and calculated capital of non-U.S. insurers is determined by reference to the home jurisdiction’s basis of accounting and capital requirements converted to U.S. dollars. While most non-U.S. jurisdictions do not possess the same level of industry specific technical guidance, as included in the NAIC Accounting Practices and Procedures Manual, all jurisdictions have established accounting standards that insurers are required to follow to determine available capital/financial resources. In some cases, this represents local Generally Accepted Accounting Principles (GAAP), which may or may not be consistent with International Financial Reporting Standards (IFRS).

DRAFTING NOTE: While the GCC utilizes the available capital and home jurisdictions’ capital requirement, for jurisdictions where data is available, the use of appropriate scalars are currently being explored to produce more comparable measures for risk which can be aggregated into the group-wide measure. One such scaling
methodology is included as part of sensitivity Analysis in the GCC template. That scalar methodology uses aggregated data from.
the U.S. and other jurisdictions at first intervention level to recognize that (for example), state regulators often have much higher reserve requirements that are required to be carried as required capital in other jurisdictions. For jurisdictions where the data is not available, the full jurisdictional requirement at first intervention level was used.

U.S. Insurers Not Subject to RBC – Some types of U.S. insurers are not subject to an RBC formula (e.g., Financial Guaranty Insurers, Title Insurers). For these entities, the available capital/financial resources is determined by reference to state law and the NAIC Accounting Practices and Procedures Manual. However, since an RBC formula does not exist, calculated capital is determined by reference to the state minimum capital requirements set out in state law (or 300% of reserves for Title insurers). For U.S. captive insurers, available capital is determined based upon the states accounting requirements, but the calculated capital is required to be calculated using the applicable RBC formula even if RBC does not apply to that entity in their state of domicile.

Banking or Other Financial Service Operations Subject to Regulatory Capital Requirements – Non-insurers such as banks are subject to their own regulatory valuation methods (typically GAAP with tiering of available capital) and their own regulatory capital requirements (e.g., OCC, Federal Reserve, FDIC, or other requirements for banks). These regulatory values are used for the GCC.

Financial and non-financial operations not subject to regulatory capital requirements – In general, financial entities (as defined in the GCC Instructions) are subject to a higher capital charge in the GCC than the non-financial entities. However, the GCC does require available capital/financial resources and calculated capital to be gathered for all such entities that pose a material risk to insurers. In both cases the GCC will utilize the valuation used by such legal entities (typically U.S. GAAP) and a calculated capital based upon a risk factor. There are two important exceptions:

- All entities within the defined insurance group (definition included in GCC Instructions) must be included.
- Non-financial entities that are subsidiaries of U.S. insurers, foreign insurers, or banks where a capital charge for the non-financial entity is included in the regulated Parent’s capital formula will remain with the Parent and will not be inventoried. Regulators already have access to the financials of these entities if needed (if causing unrealized losses within the insurer).

Eliminations

The GCC uses an aggregation and elimination approach, where each of the above legal entities’ available capital/financial resources and calculated capital are combined, then eliminations are utilized to prevent any double counting of available capital/financial resources or calculated capital. The following example illustrates the use of eliminations for both available capital/financial resources and calculated capital. However, in practice the GCC only requires the foreign insurers and other financial entities owned by an insurance company to be "de-stacked" so if AA Holding Company was a U.S. insurer (e.g., AA Insurance Company) the capital required and calculated capital for DD Insurance Agency as a nonfinancial entity would remain in the values of AA Insurance Company and not be de-stacked.
EE Insurance Group (EEIG)

Calculation of ARC

<table>
<thead>
<tr>
<th>Entity</th>
<th>TAC</th>
<th>Less</th>
<th>Adjusted TAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Holding Co. (Non-op)</td>
<td>50.0M</td>
<td>(38.0M)</td>
<td>12.0M</td>
</tr>
<tr>
<td>BB Life Ins Co. (U.S. RBC)</td>
<td>30.0M</td>
<td>0</td>
<td>30.0M</td>
</tr>
<tr>
<td>CC Insurance Co. (Non-U.S)</td>
<td>6.0M</td>
<td>0</td>
<td>6.0M</td>
</tr>
<tr>
<td>DD Ins. Agency</td>
<td>2.0M</td>
<td>0</td>
<td>2.0M</td>
</tr>
<tr>
<td>ARC (EEIG Group Total)</td>
<td>58.8M</td>
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</tr>
</tbody>
</table>

EEIG Financial Information

<table>
<thead>
<tr>
<th>Entity</th>
<th>TAC</th>
<th>Less</th>
<th>Adjusted TAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Holding Co. (Non-op)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BB Life Ins Co. (U.S. RBC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CC Insurance Co. (Non-U.S)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD Ins. Agency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARC (EEIG Group Total)</td>
<td>58.8M</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Minimum Regulatory Capital

1 For Non-RBC filers this is regulatory available capital or stockholder equity.
2 There is no regulatory capital for these entities when owned by a non-regulated entity. Calculated Capital is added @ 10.5% x standalone ARC.

Authorized Control Level (ACL) RBC or Prescribed Capital Requirement for non-U.S. insurers

Calculation of MRC

<table>
<thead>
<tr>
<th>Entity</th>
<th>MRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Holding Co. (Non-op)</td>
<td>6</td>
</tr>
<tr>
<td>BB Life Ins Co. (U.S. RBC)</td>
<td>3</td>
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<tr>
<td>CC Insurance Co. (Non-U.S)</td>
<td>1</td>
</tr>
<tr>
<td>DD Ins. Agency</td>
<td>0</td>
</tr>
<tr>
<td>MRC Total</td>
<td>10</td>
</tr>
</tbody>
</table>

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### VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) – Analyst Reference Guide

**Calculation of MRC**

<table>
<thead>
<tr>
<th>Entity</th>
<th>TAC 1</th>
<th>Adjusted Calculated Capital 2</th>
<th>MRC 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA Holding Co.</td>
<td>2.07M</td>
<td>1.26M</td>
<td>NA</td>
</tr>
<tr>
<td>BB Life Ins. Co.</td>
<td>3.0M</td>
<td>3.0M</td>
<td>6.0M</td>
</tr>
<tr>
<td>CC Insurance Co.</td>
<td>1.6M</td>
<td>1.60M</td>
<td>NA</td>
</tr>
<tr>
<td>DD Ins. Agency</td>
<td>0.21M</td>
<td>0.21M</td>
<td>NA</td>
</tr>
<tr>
<td><strong>MRC Total</strong></td>
<td>9.07M</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. For non-RBC filers this is regulatory available capital (ARC).
2. Terminology used in RBC for calculated regulatory capital.
3. Terminology used in RBC for available capital/financial resources.

In the above example, available capital/financial resources are referred to as available regulatory capital (ARC) and total authorized capital (TAC1), and minimum calculated capital is referred to as minimal regulatory capital (MRC) and authorized control level (ACL2). The GCC will allow non-insurance/non-financial entities owned by RBC filers to remain within the available capital and regulatory capital so no eliminations are required for these entities. As shown, since AA Holding Company owns each of the other business entities in the organizational chart, $38 million (which is the amount of available capital/financial resources in the subsidiaries of AA) is eliminated from the TAC column since accounting methods include those as an asset on AA Insurance Company’s balance sheet. Also, the GCC includes capital calculations for AA Holding Company and DD Insurance Agency as part of the MRC in addition to the regulatory capital already included for the insurance subsidiaries. The MRC of the subsidiaries is eliminated from the parent’s (AA Holding Company) calculated capital. Therefore, in this example $4.81 million of calculated capital is eliminated from the MRC. Finally, the MRC of U.S. insurance subsidiary is multiplied by 2 in order to reflect Company Action Level (CAL) RBC as required in the GCC.
Debt—It is important to note that the available capital used in deriving the GCC recognizes a portion of the group’s senior and hybrid debt as capital. This allowance recognizes that debt that is not already recognized as available capital/financial resources under all known accounting principles (SAP, U.S. GAAP or IFRS) may have some value to the group under the U.S. insurance regulatory requirements where such is dividend down to the insurance companies and where extraordinary dividends must be approved by the state. Qualifying debt along with limitations thereon is described in the GCC instructions as is the calculation for the additional available capital. In addition to looking at the group’s debt leverage overall consideration should be given to how the allowance for additional capital from debt interacts with changes in available capital and capital requirements from year to year. The impact of procyclical changes in the allowance for debt as capital should be assessed.

Other Information Included in the GCC
The GCC includes selected financial information (net income, premiums, liabilities, debt, etc.) that are captured in Schedule 1 and in the “Analytics” tabs of the GCC that are meant to be used to help isolate potential strengths and weaknesses of the group and more specifically where such exist among the entities in the group. Some important information related to other features in the GCC also should be considered and are discussed below. Schedule 1, a simplified version of the Inventory Tab, and most analytics are required in the case of a “limited filing”. However, data is not required for the capital instruments, sensitivity analysis and other information tabs in a limited filing.

Grouping—The GCC separately allows certain financial entities (e.g., asset managers) and non-financial entities included in the GCC to have their values and capital calculation combined (grouped) for more efficient reporting and analysis. Although the GCC instructions set parameters for such grouping, the general expectation is that regulators will work with each applicable GCC filer in determining where grouping is and is not appropriate outside of what is allowed within the GCC Instructions. Grouping should be viewed in context of materiality. A single entity conducting a given activity may not be material, but when all entities conducting the same activity are combined, they can be material.

Excluded entities—The GCC provides two mechanisms for the exclusion of non-financial entities in Schedule 1 and in the Inventory Tab at the discretion of the lead state. State regulators should consider whether any of the information collected in the GCC template in support of, is collected for an entity or group of similar entities that would otherwise be excluded from the GCC ratio calculation. Regulators should separately monitor increases in the level of activity of an “excluded” entity or group of similar entities for purposes of materiality and potential subsequent inclusion in the GCC.

Sensitivity analysis—A tab devoted to individual sensitivity analysis is included in the GCC. These informational items provide the regulator with impact of discretion in excluding listed entities and alternative perspectives on risk charges for non-financial entities and foreign insurers. Monitoring of these items can help the regulator identify areas where the GCC may be improved, or capital calculations adjusted in the future. One item included in the GCC sensitivity analysis is a “sensitivity test” that increases the overall calibration of the calculated capital requirements in the GCC from its normal 200% x ACL RBC calibration to 300% x ACL RBC. This should be used as an initial benchmark to conduct further analytical review. No other exclusions should be applied.

Accounting Adjustments—The impact of accounting adjustments and related detailed information is collected in the GCC template in the Inventory Tab and in the Other Information Tab respectively. Such adjustments can be material during the de-stacking process. For example, a consolidated holding company may include GAAP values for entities that would otherwise be valued under regulatory accounting rules (e.g., Statutory Accounting Principles - SAP) on a stand-alone basis. When the regulated entity is de-stacked the difference between the GAAP values and SAP values will be removed from the group’s available capital. These “lost” values can result in a...
material reduction in the inventoried available capital compared to consolidated available capital. Understanding the impact and the components of this adjustment can help the regulator when considering the impact of issuing new debt or when evaluating the allowance for debt as capital calculated in the GCC template.

Intangible Assets – Acquisitions, mergers and reorganization often create significant intangible assets at a holding company level or possibly at an operating company (other than a regulated entity) level. The GCC template collects information on intangible assets held by inventoried entities in the Other Information Tab. The available capital associated with the value of entities whose assets are materially comprised of intangible assets should be evaluated in the context of fungible resources and in assessing the adequacy of the capital calculation assessed on such entities.

Dividend pass-thru (gross view of dividends) – Schedule 1D collects information on dividends paid and received within the group. It also includes a column that indicates whether dividends were declared but not yet paid, as well as cases where dividends received where retained or “passed thru” to another affiliate or paid out in dividends to shareholders. This information will assist the regulator in evaluating the movement of capital within the group to fund strategic insurance and non-insurance operations or activities (e.g., expansion of activities) or to fund entity specific capital shortfalls. It also provides a window to capital leaving the group (e.g., debt repayment, stock repurchase, or dividends to shareholders).
Review of the Group Capital Calculation

Consideration of the Insurance Holding Company System Structure

As the lead state begins to review the annual Group Capital Calculation filing for a particular group, it is important for the lead state to do so with consideration of the existing knowledge of both the organizational structure of the group, including changes in the structure from year to year, but more importantly the overall activities of each of the entities in the group which otherwise have the potential to transmit material risk to the insurers within the group. While the GCC will provide additional quantitative information on the entities in the group; the actual activities of the entities are also important in determining the scope of application of the GCC. Specific to that point, the lead state is responsible for determining if any of the entities in the holding company structure should be excluded from the calculation. The filing includes a column for the group to propose what should be excluded as well as an additional column for the final determination made by the lead state. In general, the determination of scope of the application is suggested by the group but made in consultation and agreement with the lead state. This exercise should be undertaken in a manner that yields a clearly documented rationale for excluding entities or subgroups of the larger group. The Group Capital Calculation Instructions describes the basis for making this determination and the calculation itself is structured to facilitate this determination, with the inclusion in Schedule 1 of the calculation of financial data for all entities within the holding company. Similar to exclusion from the calculation itself is review of data for cases in which subgroups of the larger group are completely excluded from the larger group, particularly with regard to Schedule 1; the rationale for the exclusion(s) should be provided in the GPS. The concept is that this Schedule 1 data should be utilized by the lead state in conjunction with their existing knowledge of the group and its activities (obtained from the Schedule Y, ORSA, Forms B/C, Form F, the non-insurance grid, etc.), and therefore likely material risks, to make this determination. To the extent the entities included in Schedule 1 differ from the analyst’s knowledge of the Group, further discussion and follow-up should be held with the group.

The holding company structure and activities should also be utilized by the lead state in determining how to evaluate the GCC ratio. More specifically, information on structure can impact the flow of capital and resources among entities within the holding company structure. Therefore, understanding the following can assist in evaluating the flow of resources:

- Domestic insurance operations
- International insurance operations
- Banking or other financial services operations subject to regulatory capital requirements
- Financial and non-financial operations not subject to regulatory capital requirements*

*The GCC instructions provide examples of financial versus non-financial entities in this category. All financial entities should be included in the scope of application of the GCC. However, there can be a broad array of entities that could be considered financial. The lead state should document the rationale for cases in which it concludes that an entity should be classified in the group’s GCC filing as “non-financial” and thus excluded, from the scope of the GCC.

While the GCC is intended to be used as an input into the GPS, the expectation is that the GCC summary section will document a high-level summary of the analyst’s take away of the GCC, as well as the Strategic branded risk, since that is the area where capital measurement is reported. The manner in which the analyst determines what else should be documented beyond the GCC Summary and the Strategic branded risk should be based upon the following steps, since these steps contemplate the previously mentioned concept that the existing evaluation of the financial condition should be used in evaluating the depth of review of the GCC. From a high level, the following steps suggest:

- Document the information from the GCC Summary section.
- Review the material risk identified in the GCC.
- Assess the impact of the material risk on the financial condition of the insurer.
- Determine the depth of review required for the material risk.
- Document the results of the depth of review in the Strategic branded risk section.
Inasmuch as the GCC is a new analytical tool for use by regulators and that it will take a number of years before there is both (1) sufficient data to prove for trends and (2) experience by regulators with its use, it is thus recognized that the specific measures (levels of GCC, degree of change in the GCC, what constitutes a trend, etc) may, over time, need to be revised. Nonetheless, the following procedures provide analysts with a framework to consider GCC results in conjunction with other data and tools at their disposal, and to begin to gain and benefit from experience in utilizing the GCC as a new analytical tool.

- Procedure Step 1 suggests that a review of the components of the GCC is appropriate when either the GCC ratio is trending downward or the GCC ratio is below an initial suggested threshold. Analysts should be mindful at all times that any stated threshold is for analysis purposes only and does not constitute a trigger for regulatory action (nor is such a trigger provided at any GCC level in the provisions of the Model Holding Company Act and Model Holding Company Regulation). Further, they should be mindful that the respective calibration levels differ between the GCC and RBC. When a threshold is provided, it should be viewed as an opportunity for an analyst to understand issues and concerns that may be emerging and address them with the group, if needed. Finally, as experience in gained with the GCC and with these analysis procedures, the threshold for analytical purposes will be revisited periodically and remains subject to change.

- Procedure Step 2 suggests from a high level determining the drivers of any decreases in the total available capital in the GCC. While there are numerous benefits of the GCC over consolidated approaches, the ability to drill down on the drivers is one of the most significant and is consistent with the states’ approach to not just looking at capital, but to the drivers of capital issues. While the mechanics of the GCC approach will introduce some opportunities for analysis, potential limitations do exist depending on the extent of de-stacking and grouping of entities in the GCC template. While the data will provide a “road map” of sorts as to the location of capital and risks within the group, the level of detail will vary by group. Thus, the GCC will provide a quantifiable means to decomposing group components for analysis, but qualitative considerations by the analyst will be necessary as well, the extent and nature of which will inherently vary by group. Furthermore, legal entity data that is the result of “destacking” for purposes of the GCC template may result in anomalous amounts are trends, e.g., potentially showing materially reduced equity due to the destacking of a subsidiary which is then separately listed in the template. The process to analyze data in the template should provide for potentially anomalous observations at the legal entity level which are the result of the destacking process, and not an indication of potentially negative developments or trends. Again, this highlights the need to assure that analysts consider information from other analytical tools, not just the GCC in isolation.

- Procedure Step 3 suggests from a high level determining the driver of any increases in operating leverage, which is typically what drives insurance capital requirements up, be it asset risk/leverage or writings leverage. Similar to drivers of capital decreases, the GCC has detailed information on financial figures and ratios that can be used to isolate the issues.

- Procedure Step 4 is similar in that it too utilizes detailed information on capital allocation patterns that are necessary to understand if there are negative trends in the GCC since these can become important if there are any issues that might require further distribution of capital across the entities.

- Procedure Steps 5: Depending upon the analysis performed in Steps 1-4, similar to legal entity analysis, there is likely a need to determine what steps the company is taking or plans to take to address the issues seen in the analysis of the GCC. The guidance provided in these procedures is not intended to be exhaustive, but rather should give the analyst a starting point in better evaluating the various issues.

- If the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document the material risks of the group observable from the GCC (as well as the required information to be included in all GPS from the GCC), this should be documented by the analyst in any workpapers deemed appropriate by the state and include the general reason therefore. In making this
determination, it should be reiterated these procedures are not intended to be used in a checklist manner, and judgement based upon existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that judgement decision.

### Procedure Step 1 - Evaluate the Adequacy of Group Capital

1. **Determine if the group capital position may present a risk to the group and its insurance subsidiaries based upon its recent trends and/or current measures in the GCC ratio.**

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST</td>
<td>&lt;150%</td>
</tr>
</tbody>
</table>

- **a.** Has there been an increase in the GCC ratio over last two years? If "yes", determine the cause(s) of the increase.
  - ST <10%

- **b.** Has there been an increase in the GCC Total Available Capital from prior year? If "yes", determine the cause(s) of the increase.
  - ST <10%

- **c.** If the GCC <150%, has there been a change from prior year? If so, determine the cause(s) of the change. If the GCC was <150% in the prior years also, consider more carefully the causes.
  - ST >10 pts or <10 pts

- **d.** Has there been a negative trend in the GCC ratio over the past five years suggesting an overall pattern of declining capital?
  - ST N/A

If the answer to any of the above questions is “yes”, the analyst should proceed with procedure step 2, evaluating decreases in total available capital and/or procedure step C3, evaluating increases in leverage to determine the cause(s) of the negative trends.

### Procedures Step 2 - Evaluate Decreases in Total Available Capital

2. **Determine the source(s) of decreases in the GCC ratio or the GCC Total Available Capital.**

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST</td>
<td>&lt;150%</td>
</tr>
</tbody>
</table>

- **a.** Has there been a decrease in the GCC ratio over last two years? If "yes", determine the cause(s) of the decline.
  - ST <10%

- **b.** Has there been a decrease in the GCC Total Available Capital from prior year? If "yes", determine the cause(s) of the decline.
  - ST <10%

- **c.** Has there been a decrease in the GCC ratio in the last three years from the prior year? If the GCC <150%, has there been a change from prior year? If so, determine the cause(s) of the change. If the GCC was <150% in the prior years also, consider more carefully the causes.
  - ST >10 pts or <10 pts

- **d.** Has there been a negative trend in the GCC ratio over the past three years suggesting an overall pattern of declining capital?
  - ST N/A

Recognizing that not all declines in capital ratios are necessarily "negative", i.e., they may be the result of sound capital management and ERM to more efficiently utilize capital, approved changes in the scope of application, or changes in underlying regulatory requirements, the intent of step 2 (and step 3) is to determine the actual source of the negative issues. However, unless obvious from the information obtained in step 2, the analyst should proceed to step 5 to understand more fully the actions being taken by the group to address the issues identified in step 2. However, in some cases, it is possible that no further follow-up with the group will be necessary and that the lead state should simply update the GPS to be certain the main understanding of the issues are known to all of the regulators utilizing the GPS.
<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Review the GCC ratio of available capital to calculated capital from each of the reported entities and compare to the same ratio from the prior year. Determine which entities may have led to the negative trends.</td>
<td>&lt;-10%</td>
</tr>
<tr>
<td>b. If the change in the GCC is not driven from a legal entity, and instead the change in allowable debt, note as such.</td>
<td>ST N/A</td>
</tr>
<tr>
<td>c. Review the levels of profitability for each of the reported entities in the GCC in the current and prior years (as reported in the GCC) to determine if there are particular entities showing signs of decreasing profitability which may eventually lead to losses and future decreases in the GCC ratio or total available capital.</td>
<td>OP, PR/UW N/A</td>
</tr>
<tr>
<td>d. For each of the reported entities showing either 1) a meaningful decrease in the GCC due to a decrease in the total available capital, or 2) negative profitability trends, request information that identifies the issues by inquiring from the legal entity regulator first or the group itself (e.g., non-insurance company), if applicable.</td>
<td>OP, PR/UW, ST N/A</td>
</tr>
<tr>
<td>e. If due to pricing or underwriting issues, understand if the issues are the result of known pricing policies that are currently being modified or if the business is in runoff, recently identified products where metrics can quantify the issues whether new product lines, or geographic or other concentrations, volume/growth business strain, or other issues. When considering pricing that is being modified, include those products for which the price is adjusted through crediting rates.</td>
<td>PR/UW N/A</td>
</tr>
<tr>
<td>f. If due to reserve issues, understand the reserve development trends, whether reserve and pricing adjustments have been made as well as changes in business strategy apart from those products.</td>
<td>RV, ST N/A</td>
</tr>
<tr>
<td>g. If due to market risk issues—i.e., capital losses—understand not only why the losses occurred, but the likely near-term future impact given current and likely prospective economic conditions. Market issues include not only changes in equity prices, but also impact/exposure to interest rates and other rates such as foreign currency exchange rates or rates on various hedging products used by the group.</td>
<td>MK, CR N/A</td>
</tr>
<tr>
<td>h. If due to strategic issues such as planned growth, planned decline in writings or changes in the investment strategy, utilize the business plan from the Form F to better understand the anticipated changes and how the actual changes compare. Understanding the variance from the business plan is important in assessing the ongoing risk either in projected future profitability or in some cases the investments.</td>
<td>ST, PR/UW, OP N/A</td>
</tr>
</tbody>
</table>
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

1. If due to negative reputational issues which may, for example, have adversely impacted new business or retention of existing business, understand the issues more closely, whether potential ongoing changes in stock price or financial strength ratings that may further impact market perception, or what the group is doing to address the potential future impact be it sales projections or access to the capital markets.

<table>
<thead>
<tr>
<th>RP</th>
<th>N/A</th>
</tr>
</thead>
</table>

2. If due to credit losses, understand the current and future concentration in credit risks, be it investments, reinsurance or other sources of credit losses.

<table>
<thead>
<tr>
<th>CR, MK</th>
<th>N/A</th>
</tr>
</thead>
</table>

3. If due to operational issues, such as extremely large catastrophe events, IT or cybersecurity events or relationships, understand the current and prospective impact.

<table>
<thead>
<tr>
<th>OP, ST</th>
<th>N/A</th>
</tr>
</thead>
</table>

4. If due to legal losses, understand the underlying issues and degree of potential future legal losses.

<table>
<thead>
<tr>
<th>LG</th>
<th>N/A</th>
</tr>
</thead>
</table>

5. If due to non-insurance reported entities in the group, understand the relationship of the non-insurance operations to the insurance entities and the potential impact to the insurance operations (i.e. intercompany agreements, services, capital needs, etc.).

<table>
<thead>
<tr>
<th>ST, OP</th>
<th>N/A</th>
</tr>
</thead>
</table>

Procedure Step 3-Evaluate Increases in Operating Leverage.

3. Determine the source(s) of any decreases in the GCC ratio due to increases in leverage

Like step 2, the intent of step 3 is to determine the actual source of the negative issues. The difference between step 3 and step 2 is simply the types of issues. Step 2 is focused on issues that have resulted in negative capital trends. Step 3, however, is focused on the issues that impact the risk being measured in the GCC. In most cases, risk that is either from the asset side or from the liability side where in both cases there has been an increase in such risk that has not been offset by a corresponding or equal increase in capital. In general, this is referred to as operating leverage, where this risk can manifest itself either through increased writings or exposure (e.g., the ratio of premiums to capital or liabilities to capital), or through increased assets that also carry risk. The expectation is that other regulated entities also have capital requirements that increase as these different types of risks increase, similar to how the NAIC RBC considers different types of products and assets that carry more risk.

<table>
<thead>
<tr>
<th>Procedure Step 3</th>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Review the levels of operating leverage for ratio of available capital to calculated capital from each of the reported entities in the GCC as well as and compare to the same ratio for the prior years as reported in the GCC to determine if there are particular year. Determine which entities showing signs of increasing operating leverage which may lead to future decreases in the GCC ratio or total available capital have led to the negative trends, based upon corresponding increases in leverage.</td>
<td>MK, CR, RV, ST, OP, RP</td>
<td>≤10%</td>
</tr>
</tbody>
</table>

Commented (TF1): Should clarify here, and in other tables, whether this is the change in the reported GCC or the change in leverage (and if the latter, how that is to be measured).
b. Review the levels of operating leverage for each of the reported entities in the GCC as well as the same for the prior years as reported in the GCC to determine if there are particular entities showing signs of increasing operating leverage which may lead to future decreases in the GCC ratio or total available capital.

| MK, CR, RV, ST, OP, RP | < -10% |

b. For each of the reported entities showing a meaningful decrease in the GCC due to an increase in operating leverage, request information that identifies the issues by inquiring first from the legal entity regulator or the group itself (e.g., non-insurance company), if applicable.

| MK, CR, RV, ST, OP, RP | N/A |

c. If operating leverage has increased, consider if growth may have resulted from underpriced products or a change in underwriting. Determine if pricing was reduced to increase sales, or whether the growth is in new product lines or new geographic focus where the group may not have expertise. When considering pricing being modified, include those products for which the price is adjusted through crediting rates.

| PR/UW, OP, ST | N/A |

d. If operating leverage has increased, consider if reserving risk has also increased, through potential underpricing that ultimately manifests itself in reserve adjustments. To do so, obtain current profitability information on the products leading to the increased leverage.

| RV | N/A |

e. If operating leverage has increased, obtain current information on the asset mix to be certain that there is a corresponding decrease in riskier assets to mitigate the otherwise likely increase in market and credit risk.

| CR, MK | N/A |

Unless obvious from the information obtained in step 3, the analyst should proceed to step 5 to understand more fully the actions being taken by the group to address the issues identified in step 3. However, in some cases, it is possible that no further follow up with the group will be necessary, and that the lead state should simply update the GPS to be certain the main understanding of the issues are known to all of the regulators utilizing the GPS.

4. Determine the capital allocation patterns to determine if some entities may put pressure on other legal entities.

Steps 2 and 3 are critical in understanding the issues faced by the group and in identifying the source of negative trends; and while additional follow up with the group is expected, before proceeding to Step 5, the lead state should understand the historical capital allocation patterns or the likely future needed capital allocation patterns. The GCC includes data on historical capital allocation patterns (e.g., contributed capital received/paid or dividends received/paid), which help to illustrate which entities need capital and which entities have capital that can be provided. While these patterns do not necessarily repeat themselves from one period to the next, there is often consistency in terms of entities that need capital or have excess capital, which may or may not be driven by losses, but rather by a change in strategy (e.g., increased writings at one company over another). These trends can also assist in discussions with the group about where capital may come from as a result of a future unexpected material event.
Where similar information is also disclosed in Form F, the detail in the GCC may confirm what is already known in this area and in some cases may provide greater detail.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Procedure Step 5—Consider the Need for Reductions in Risk.**

5. Determine the group’s plans for addressing source(s) of any meaningful decreases in the GCC ratio or total available capital. Please note, in some cases, the plan may be as simple as actions designed to reverse a single negative trend.

Steps 5 is designed to assist a review of the insurance company’s plans for addressing any meaningful decreases in the GCC ratio or total available capital. The specific plans of the group may, or may not fully address all the issues but ultimately what is most important is that such information and the regulators plan for evaluating and monitoring the situation is known to the other regulators. There is a multitude of possibilities, and this guidance is not intended to address all of those, including the fact that in some cases, some regulators may choose to put their legal entity into some type of supervision, conservation or some other form of receivership. Similar to other areas, where similar information is also disclosed in Form F, further information may already be known in this area.

Steps 5 is designed to assist a review of the insurance group’s plans for addressing any meaningful decreases in the GCC ratio or total available capital that are not otherwise planned (i.e., that are not the results of capital management so as to efficiently utilize capital while still maintaining sufficient levels for Enterprise Risk Management needs). The specific plans of the group may, or may not fully address all the issues but ultimately what is most important is that such information and the regulator’s plan for evaluating and monitoring the situation is known to the other regulators. There is a multitude of possibilities and this guidance is not intended to address all of those, including the fact that in some cases, some regulators may choose to put their legal entity into supervision, conservation or some other form of receivership (which, by necessity and intent, would presumably be done based on the legal entity’s RBC and other tools and authority at the legal entity level—not the group’s GCC). Similar to other areas, where similar information is also disclosed in Form F, further information may already be known in this area.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST</td>
<td>N/A</td>
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<tr>
<td></td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td>b.</td>
<td>Request information from the group on how it intends to address the issues or negative trends (i.e., those that are not planned or due to approved changes to the GCC scope of application or the result of changes in underlying legal entity capital requirements) identified in Steps 1-3. More specifically, determine how the group intends to decrease risk, and by what means.</td>
</tr>
<tr>
<td>c.</td>
<td>Based on information received in 5.b., determine the group’s capacity to reduce risks or raise additional capital.</td>
</tr>
<tr>
<td>d.</td>
<td>Where the remaining capital is adequate, document the findings on the GPS (or another document) and make available to the supervisory college and or domestic states with the presumption no further action is deemed necessary.</td>
</tr>
<tr>
<td>e.</td>
<td>Consider whether the collective information suggests that any of the U.S. legal entity regulators should deem the legal entity to be in a “Hazardous Financial Condition” and take appropriate action to address based upon the facts and circumstances and the provisions of the state’s law (similar to NAIC Model 385).</td>
</tr>
<tr>
<td>f.</td>
<td>Where appropriate, consider holding a meeting of the supervisory college or of all the domestic states to fully understand the group’s plans. Where appropriate, require the group to present its plans to the supervisory college or all the domestic states.</td>
</tr>
<tr>
<td>g.</td>
<td>Where appropriate, determine if the plans proposed by the group are considered inadequate by any of the legal entity regulators, and more specifically if any are considering taking action over their applicable legal entity. If this is the case, hold a meeting of the supervisory college or of all the domestic states to provide this information.</td>
</tr>
<tr>
<td>h.</td>
<td>Where appropriate, consider holding a broader meeting of all impacted jurisdictions in which the group is selling insurance. Where appropriate, require the group to present its plans to all such regulators and for the regulators to announce their plans.</td>
</tr>
</tbody>
</table>
July 31, 2021

Mr. John Rehagen, Chair
NAIC Group Capital Calculation Working Group
Via e-mail: ddaveline@naic.org


Dear Mr. Rehagen,

The American Council of Life Insurers appreciates the opportunity to comment on the NAIC Group Capital Calculation (GCC) Working Group’s (the Working Group) proposed revisions to the Financial Analysis Handbook (FAH). We appreciate the significant and thoughtful work being done by the NAIC on throughout the GCC project and the Working Group’s receptivity to discussing our members’ views on various elements of the framework.

While we are largely supportive of themes conveyed in the feedback provided by the Interested Party group, there a few topics we feel warranted additional detail provided in a distinct ACLI response:

- The proposed threshold of 150%, which we believe is inconsistent with the Working Group’s decision to use 200% ACL RBC as the calibration level for the GCC;
- The timeliness of establishing a GCC threshold before further analysis of GCC results are completed.

1. The proposed threshold of 150%, based on the “sensitivity analysis” test, is inconsistent with the Working Group’s decision to use 200% ACL RBC as the calibration level for the GCC and should be revised.

The FAH includes a GCC threshold, below which a regulator may conduct a more in-depth analysis of the group. According to text in both the exposed documents, the GCC sensitivity analysis test, which is calibrated at 300%, is the threshold regulators should use as their benchmark to determine if additional analysis is warranted. This decision is inconsistent with the Working Group’s decision in October 2020: following multiple rounds of consultation on the GCC instructions and template, the Working Group endorsed a decision to use 200% ACL RBC as the calibration level and to include a “sensitivity analysis” tab that calculated a GCC ratio using a 300% ACL RBC calibration. The minutes of the October 30 Working Group meeting document the agreement, as well as instruction from the Chair to NAIC staff to update the draft FAH to reflect the decision. We believe the FAH must be revised to align it with this pivotal decision.

Mariana Gomez-Vock
Vice President & Deputy, Policy Development
Marianagomez-vock@acli.com | 202 624 2313
ACLI members continue to strongly support the decision the Working Group made in October and believe introducing a disconnect between the reported GCC and approved template and the FAH would create the same concerns and challenges we voiced in the fall. We have appended two comment letters, for reference, that explain why it would have been highly problematic to calibrate the GCC to 300%. Our concerns have not changed, so we are appending the letters in lieu of repeating them in this letter.

2. It is premature to establish a GCC threshold until further analysis of GCC results is completed.

Additionally, we fully support the IP group’s call for the Working Group and NAIC to undertake additional analysis and evaluation of GCC results prior to identifying a specific threshold in the FAH. There is no immediate need to immediately establish a threshold, given the GCC’s intent to serve as a tool that provides regulators with enhanced transparency into the risk within a group rather than a standard that triggers supervisory action or requirements for insurers. In the interim period, in lieu of a pre-defined, hard-wired GCC threshold, the FAH could instead advise analysts to focus on downward trends – the analyst could consider performing the additional steps when a GCC ratio is trending downward over several years or if it has experienced a material decline in the current year. Alternatively, the FAH could use 100% GCC as a placeholder in Step 1, at least until more data is analyzed.

Regardless of whether there is a predetermined threshold value in Step 1, we encourage the Working Group to consider whether additional analytical steps should be added to Step 1 of the GCC. For example:

- **Step 1X** – If the GCC ratio is trending downward over multiple years or has experienced a material decline in the current year, determine which entities may have led to the negative trends.
- **Step 1Y** – If the GCC ratio is trending downward over multiple years or has experienced a material decline in the current year and the change in the GCC is not driven from a legal entity, but rather the change in allowable debt, note as such.

These steps would help the analyst quickly identify false positives and focus the in-depth analysis of available and required capital (i.e., steps 2 and 3) on entities that are the major source[s] of the GCC change or trend. This would preserve limited regulatory resources by allowing the analyst to quickly zero-in on the cause of the declining GCC. In some cases, like the example below, the change may have resulted from a relatively benign cause. For example, consider how a benign corporate tax change might impact a GCC ratio:

1. Regulators notice that an insurance group, **Alpha Group**, has a significant one-year drop in group solvency.
2. Rather than doing an analysis of all entities within **Alpha Group**, regulators follow Step 1X and identify that **Alpha Group’s** declining group solvency trend is due entirely to **Alpha Japan**. So, the analysis now focuses on **Alpha Japan** to identify the cause of the decline.
3. The regulator discovers that the change in **Alpha Japan’s** solvency levels is due to a change in Japan’s corporate tax rate.
4. The analyst could validate this effect by looking at the group solvency impact of another US group with a material Japanese subsidiary.
Conclusion

As such, the ACLI recommends striking all references to 300% and 150% until further analytical work is completed. If a threshold must be referenced in the FAH, we recommend using 100% GCC as a temporary placeholder. We also recommend consideration of adding one or two more group-wide inquiries in Step 1 that could help focus the additional, in-depth analysis (Steps 2 and 3), on areas of concern and potentially eliminate false positives in GCC results.

Thank you for your consideration of our comments. As always, we would be happy to discuss them with you or your staff at your convenience.

Regards,

Mariana Gomez-Vock
Dear Commissioner Altmaier,

The North American CRO Council (CRO Council) is a professional association of Chief Risk Officers (CROs) from leading insurers based in the United States, Canada, and Bermuda. Member CROs currently represent 32 of the largest Life and Property and Casualty (P&C) insurers in North America. The CRO Council seeks to develop and promote leading practices in risk management throughout the insurance industry and provide thought leadership and direction on the advancement of risk-based solvency and liquidity assessments.

The CRO Council supports the NAIC’s decision to leverage existing solvency frameworks as the basis for its GCC framework. By leveraging existing solvency frameworks, the GCC will benefit from their proven ability to capture the unique risks across various lines of insurance and jurisdictional market specificities. More broadly, leveraging existing solvency frameworks will ensure continuity across existing supervisory tools, including those that are of greatest import to the CRO community.

Notwithstanding its basis in existing jurisdictional capital regimes, the GCC is an innovative – and therefore unprecedented – metric for assessing an insurance group’s capital position. As CROs, we believe it is essential for any group capital metric to be designed and implemented in a manner that coherently assesses the interactive components of the underlying methodology, as well as the metric’s quantitative impact and behavior across scenarios.

We recognize that the NAIC has been working diligently to finalize the GCC in advance of important international milestones in the recognition of US modalities for assessing risks at the group level. We commend the NAIC for both its high degree of transparency in developing the GCC methodology, as well as the care and deliberation it’s taken in evaluating each of the component methodological issues. At this juncture, there are, rightly, several open issues that the NAIC is still considering, including treatment of senior debt, scalars, and calibration. As we approach a critical stage in the finalization of the GCC methodology, it is vital to ensure that the ongoing resolution of these and other methodology issues are also evaluated and tested collectively, to ensure that GCC provides a coherent and meaningful group measure.

In this vein, the CRO Council is concerned with the proposal to introduce a new regulatory tool for analyzing an insurer’s capital adequacy and risks by calibrating the GCC at a level that is inconsistent with existing regulatory and industry practices even if a group’s GCC would remain

Appendix

Commissioner David Altmaier, Chair
NAIC Group Capital Calculation Working Group
National Association of Insurance Commissioners
[via-email: LFelice@naic.org]

October 20, 2020

Re: Comments on Proposed Group Capital Calculation (GCC) Instructions

Dear Commissioner Altmaier,

The North American CRO Council (CRO Council) is a professional association of Chief Risk Officers (CROs) from leading insurers based in the United States, Canada, and Bermuda. Member CROs currently represent 32 of the largest Life and Property and Casualty (P&C) insurers in North America. The CRO Council seeks to develop and promote leading practices in risk management throughout the insurance industry and provide thought leadership and direction on the advancement of risk-based solvency and liquidity assessments.

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In this vein, the CRO Council is concerned with the proposal to introduce a new regulatory tool for analyzing an insurer’s capital adequacy and risks by calibrating the GCC at a level that is inconsistent with existing regulatory and industry practices even if a group’s GCC would remain
confidential. We believe that, rather than better enabling the GCC to provide insight into risks, such a move would create risks. For example:

- It could undermine the market’s perception of the solvency levels insurers are subject to at the entity level and stakeholders would be left to decipher why state regulators feel the need to assess risk at the group level in a manner than is different than the system they have developed for supervising the same risks at the entity level. Given the increased prominence of group capital assessments since the great financial crisis, we believe the GCC will receive broad interest and uptake by the stakeholder community and in turn, the disconnect will become a point of focus.

- Even though the GCC will serve as an analytical tool and results will remain confidential, introducing a new calibration level could undermine the market’s perception of the capital adequacy of the sector. Stakeholders may interpret the move to increase the level of required capital regulators focus on for assessing capital adequacy and risks at the group level as an effort to promote more prudent capital levels across the sector, despite no change in the economics of the risks they are exposed to. This in turn could give rise to an unlevel playing field and arbitrage between insurers that are subject to the GCC, and the related heightened capital expectations it could create, and those that are not.

- It could result in misinterpretations. Stakeholders would be forced to learn a new scale for assessing risks despite no change in the underlying risk exposures.

When it comes to supervisory assessments of risks, regulatory clarity is vital for policyholders and the insurers that are subject to the assessment and tools. Actions that create uncertainty should be avoided unless they are anchored to a strong risk-based rationale. Thus, we strongly encourage the NAIC to calibrate the GCC at a level that is consistent with existing regulatory and industry tools and conventions.

The issue of calibration is inextricably linked with other facets of the GCC’s overarching design and methodology, including the development of scalars. The treatment of scalars is, appropriately, the subject of ongoing in-depth study. By contrast, the choice of a target calibration - a decision with potentially more significant consequences than scalars – is being decided in fairly short order and with substantially less consideration of its interplay with the rest of the GCC framework or potential unintended consequences that may arise.

In addition, we note that the current debt limit structure could cause the GCC ratio to be more volatile than RBC ratios in recessionary environments. During times of stress, when solvency capital declines, the amount of admissible debt is expected to be reduced using the current guidelines. This would lead to a larger reduction in available capital in the GCC than under an RBC assessment and consequently a larger decline in the GCC ratio. Furthermore, the GCC debt limits would disincentivize insurers to raise capital through debt issuances during times of stress because only a fraction of the debt would be treated as capital under the GCC. We believe the heightened volatility and potential influence on capital management during times of stress are unintended consequences that should be remediated by raising the debt admissibility limits.
Finally, the CRO Council recommends that the NAIC perform additional voluntary GCC data calls and coherent analysis of its final methodological decisions prior to adopting and implementing a final version in late 2021. This work, which should include consideration of the framework’s ability to deliver appropriate risk insights during stress events, would help to ensure the final product is fit for purpose and credible to end users.

Sincerely,

Chair of North American CRO Council
October 15, 2020

Re: Comments on Group Capital Calculation Working Group’s GCC Instructions Document

Dear Commissioner Altmaier:

Our Coalition ("we"), which consists of American International Group, Inc., Global Atlantic Financial Group, Hannover Life Reassurance Company of America, Liberty Mutual Insurance Group, MetLife, Inc., Principal Financial Group, Protective Life Corporation, Prudential Financial, Inc., Reinsurance Group of America, Incorporated, Transatlantic Reinsurance Company, thank the Group Capital Calculation Working Group ("Working Group") for the opportunity to provide input on key elements of the GCC. We strongly support the development of the Group Capital Calculation ("GCC") as a tool to enhance state regulators’ ability to protect policyholders and insurance markets. We also strongly support the Working Group’s decision to "build on existing legal entity capital requirements where they exist rather than developing replacement / additional standards." As the Working Group has rightfully noted, such an approach strikes an ideal balance of "satisfying regulatory needs while at the same time having the advantages of being less burdensome and costly to regulators and industry and respecting other jurisdictions' existing capital regimes."

During the public call the Working Group held on September 29, you noted that development of the first iteration of the GCC is approaching the “fatal flaws” stage. With the fatal flaws stage on the horizon, our Coalition felt the need to collectively express the following shared perspectives:

- We view the proposal to “calibrate the GCC” using 300% Authorized Control Level ("ACL") Risk Based Capital ("RBC") – i.e., to use 300% ACL RBC as the denominator of the ratio – as a fatal flaw.

- We believe 2021 should serve as a period of study and analysis to ensure the various design elements come together in a coherent manner and enable the GCC to accomplish its objective of providing state regulators a "panoramic, transparent view of the interconnectedness, business activities, and underlying capital support for an insurance group."

**Calibration of the GCC**

We believe the GCC should be calibrated using 200% ACL RBC in order to adhere to the considerations the Working Group has advised are guiding its efforts – i.e. develop a tool that provides state regulators greater insight into insurance groups in a manner that leverages and respects existing capital frameworks and practices and is less burdensome and costly. Calibrating the GCC at 300% ACL RBC would be inconsistent with longstanding industry norms for reporting and discussing solvency which use 200% ACL RBC. Further, it would also be inconsistent with state regulatory requirements for reporting and assessing capital adequacy and risks. State regulatory requirements for solvency reporting are based on 100% ACL RBC (i.e., what is filed in the Annual Statement).

Establishing an entirely new basis for reporting insurer solvency will create confusion and burden:

- Reporting processes (internal and external) would need to adapt to accommodate the inconsistency;
significant stakeholder education would be necessary to mitigate the confusion created by inconsistent reporting basis between entity and group level ratios, between companies that are and are not subject to the GCC, etc.;

- Market forces could lead to the establishment of 300% ACL RBC as a new basis for reporting and assessing the financial strength of insurers, and in doing so, impact existing capital management practices and expectations;

- It would create confusion over how state regulators assess and take action for solvency purposes – the ladders of intervention are anchored to 100% ACL RBC, and

- It would create a wider inconsistency between the aggregation based group capital framework developed by state regulators and the Federal Reserve Board.

More broadly, we do not believe the proposal to use 300% ACL RBC for calibration purposes would strengthen the ability of the GCC, or is necessary, to accomplish its objective of delivering state regulators transparency into insurance groups and protecting policyholders. Rather, we believe this decision would serve to undermine the time-tested practices of state regulators and the industry.

During the public call the Working Group held on September 29, NAIC staff had shared potential justifications for calibrating the GCC at 300% ACL RBC, which were mostly related to international considerations rather than the ability of the tool to accomplish its regulatory objective. In the annex to this letter, we provide our perspectives on these justifications.

**Using 2021 as a period of study and analysis**

While development of the GCC has been informed by a generous amount of public consultation and dialogue, quantitative study has been relatively limited (2 baseline exercises and 1 field test). In addition, consideration of the various design decisions has not been performed on the framework as a whole. We believe these factors raise the importance of using 2021 to perform a holistic review of the framework that is approved later this year to ensure the various design elements come together in a coherent manner and allow it to accomplish its regulatory objective. We believe this review should also include consideration of how the framework would perform in times of stress and any potential unintended consequences it could give rise to, including the potential for the proposed debt limit structure to create procyclicality. Following this analysis, the Working Group, in consultation with the industry, should implement any modifications determined to be necessary before approving a final version of the GCC.
We again thank the Working Group for seeking stakeholder input on key elements of the GCC and would welcome the opportunity to discuss the information included in this response should the Working Group or NAIC staff engaged in the GCC project wish to do so.

Sincerely,

American International Group, Inc.
Global Atlantic Financial Group
Hannover Life Reassurance Company of America
Liberty Mutual Insurance Group
MetLife, Inc.
Principal Financial Group
Protective Life Corporation
Prudential Financial, Inc.
Reinsurance Group of America, Incorporated
Transatlantic Reinsurance Company
Annex

Perspectives on NAIC Staff Comments on GCC Calibration

During the public call the Working Group held on September 29, NAIC staff had shared a few potential justifications for calibrating the GCC at 300% ACL RBC, which were mostly related to international considerations rather than the ability of the tool to accomplish its regulatory objective. Below we offer our perspectives on why we believe the NAIC justifications are not sufficient or appropriate grounds for calibrating the GCC at 300% ACL RBC.

- Calibrating to 300% ACL RBC would reinforce that the GCC is an analytical tool rather than a standard or requirement

    
    **Coalition Perspective**

    We support the intent to reinforce the point that the GCC is an analytical tool as opposed to a standard however, we do not believe establishing a distinct calibration level is an effective or appropriate means for doing so and further that the point would be lost on most stakeholders. Rather than serving to reinforce the “tool versus standard” point, we believe establishing a new basis for solvency reporting in the U.S. would only serve as a source of confusion over how state based insurance supervision works by adding further complexity to the system. We believe framing of the GCC as a tool should be explicit in the GCC Instructions, the guidance to be included in the Financial Analysis Handbook, and other communications by the NAIC and state regulators.

- 300% ACL RBC has been used as a reference point in the Credit for Reinsurance Models and the Covered Agreements with the EU and UK

    
    **Coalition Perspective**

    The Credit for Reinsurance Models and Covered Agreements establish a relationship between supervisory intervention points in different jurisdictions – specifically that the ability to apply the Trend Test at 300% ACL RBC, and subsequent actions that could be taken, aligns with the supervisor actions that may be pursued at 100% Solvency Capital Requirement (“SCR”) under Solvency II or 200% Solvency Margin Ratio (“SMR”) for Japan, etc. While these initiatives established relationships between intervention levels, they do not call for, or warrant, establishing a distinct calibration level for the GCC. Rather, we believe the initiatives reinforce the existing ladders of intervention approach that guides how state regulators assess insurer solvency and is anchored to a 100% ACL RBC calibration. As noted above, we believe establishing a distinct calibration basis for the GCC would only serve as a source of confusion over how state based insurance supervision works by adding further complexity system – including the inconsistency introduced between the GCC the Credit for Reinsurance Models and Covered Agreements.

    More broadly, we believe it may be appropriate to consider the relationships the Credit for Reinsurance Models and Covered Agreements established when establishing scalars between the respective regimes that are encompassed by the various agreements.

- 300% ACL calibration may help with efforts to advance the Aggregation Method (“AM”) at the global level

    
    **Coalition Perspective**

    We fully support the effort to advance the Aggregation Method at the global level and believe that, as the world’s largest insurance market, the International Association of Insurance Supervisors (IAIS) must recognize and accept the U.S. state based approach to assessing group capital adequacy. While the GCC and AM are related, we believe
they must be developed separately given differences in how they will be applied and their different time horizons for development.

Decisions on the design of the GCC should be guided by the objective of making sure it is appropriate for the U.S. market and will meet the needs of U.S. stakeholders – regulators, policyholders, insurers, etc. Where they exist, the time-tested frameworks and practices state regulators and U.S. insurers employ should serve as the foundation of the GCC. Deviations from these practices should be avoided unless there is a clear and objective rationale for how an alternative approach will better enable the GCC to provide state regulators insight into risks within insurance groups and protect policyholders. We believe it would be inappropriate to base GCC design decisions – especially for core elements – on what “could” help advance AM comparability discussions:

- Catering the design of the GCC to appease the views of foreign jurisdictions could result in a framework that does not best suit the U.S. insurance market; and
- There are no assurances that decisions made today regarding the design of the GCC will secure support for the AM from non-U.S. IAIS members, many of whom continue to be skeptical of the AM.

The design of the GCC should inform the NAIC’s work on the AM, which will continue after adoption and implementation of the GCC. Given that the AM is intended to serve as a framework that jurisdictions around the world could embrace, we recognize that collaboration and negotiations with these markets could result in a final AM that includes some differences from the GCC. However, the scope of such differences is impossible to predict at present and therefore consideration of the extent to which they would require tweaks to how the GCC has been implemented should be deferred until there is more clarity and certainty.

More broadly, it is important to reiterate that while items such as the Covered Agreements and Credit for Reinsurance Models have established relationships between intervention levels, they do not call for, or warrant, establishing a distinct calibration level for the GCC or AM. With respect to assessing comparability of the AM to the alternative approaches, the focus should be the ability of the tool to provide decision-useful insight into risks and protect policyholders as opposed to attempting to quantitatively align results to flawed benchmarks such as best efforts field test ratios or the intervention level assigned to the Market Adjusted Valuation (MAV) approach.
Notes on Charts

- Slides provide a summary of GCC results and analysis related to issues under consideration by GCCWG.
- See Attachment A for Nov 8 working group call.
- Results grouped into two types of business: "P&C and Composite" and "Life and Health".
- "Composite" means insurer that writes both life and p&c.
- Results grouped into two ownership models: Stock and Mutual.
- One fraternal company is grouped with mutual.
- Individual results are presented on anonymized basis: Group A, Group B, etc.
- Anonymized means that "Group A" is not same on every chart.
- Figures are in $'000s.

Guide to Hi-Level Charts

Results Summary
Summary (Participation)

- 25 volunteer groups provided data

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<tr>
<th>Business Type</th>
<th>Stock</th>
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<th>Property</th>
<th>Total</th>
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<td>1</td>
<td>25</td>
</tr>
</tbody>
</table>

High Level Results (Business Type)

- Chart shows GCC ratios by type of business. Note that there is overlap between the groupings. The GCC is calibrated at 200% of Authorized Control Level.
- Narrower and lower range of ratios among P&C/Composite volunteers than Life/Health volunteers.
- Narrower range of ratios among mutuals than stock companies.
- Note: above averages are unweighted (i.e. a straight average of each individual company’s GCC ratio).

Business Type (Breakdown by $ amount)

- Chart shows GCC available capital in $'000s
- Excludes Holding Company and Capital instruments

Business Type (% Breakdown)

- Chart shows % of available capital excluding Holding Company and Capital instruments.

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Analysis Related to Proposed GCC Modifications

Stress & Debt Allowance

- To investigate calculation of limit for debt, Trial GCC included a stress scenario based on 30% decline in available capital. Proposal is to remove this stress and keep current debt allowance.
- Chart shows weighted average GCC ratios by business type pre-stress and post-stress (both with and without impact on debt limit).
- Six groups had instruments go above the debt limit as a result of a stress. Of those one was pre-stress, debt allowance.

Other Debt (Breakdown)

- Subject to limits and criteria, the GCC has an allowance for Senior and Hybrid Debt instruments.
- A sensitivity test related to "Other Debt" was included in the Trial Implementation proposal and is removed.
- Chart shows anonymized results for the 16 volunteer groups with reported capital instruments.
- 'Other Debt' makes up a significant portion of capital instruments for 2 of the 16 groups.

Other Debt (As % AC)

- Chart shows ratios of amount of each instrument type to available capital, relative to available capital.
- In no case are 'Other' instruments material relative to available capital.
Non-Risk (Capital Ratios)

- Chart compares GCC ratios under two different treatments of Non-Risk sensitive foreign entities for the 10 groups with exposure to such entities.
- Current GCC treatment for non-risk foreign based entities is to set calculated capital equal to 100% of available capital.
- An alternative treatment with 50% of AC has been proposed. This leads to a max decrease in capital ratio of 51%.

Non-Risk (Breakdown)

- Chart shows breakdown of insurance entity exposure by volunteer shows that most volunteers are predominantly exposed to US entities. Foreign exposure is predominantly in risk sensitive entities (Risk on chart).
- Ten groups have exposure to foreign Non-risk sensitive entities. The exposure is significant for two. In both cases, the bulk of the exposure is in Barbados. (Note lettering is different from prior slide).

Asset Mgmt (Breakdown)

- Proposal is to replace the current capital treatment for asset managers with a 3-year average revenue-based regulatory capital standard imposed by FINRA.
- Chart above shows breakdown of the portion of available capital for financial entities by type of financial entity for the 19 volunteers with relevant exposure.

Asset Mgmt (Ratios)

- While capital amounts under FINRA standard were not part of GCC reporting, above chart of GCC calculated with and without Asset Management entities should give sense of the materiality.
- Same letters as next slide but only including groups with Asset Mgmt entities.
The Group Solvency Issues (E) Working Group of the Financial Condition (E) Committee met Nov. 30, 2021. The following Working Group members participated: Justin Schrader, Chair (NE); Jamie Walker, Vice Chair (TX); Kim Hudson and Susan Bernard (CA); Kathy Belfi (CT); Charles Santana (DE); Virginia Christy (FL); Kevin Clark (IA); Cindy Andersen, Susan Berry, and Eric Moser (IL); John Turchi (MA); Judy Weaver (MI); Debbie Doggett, Shannon Schmeeger, and John Rehagen (MO); Margot Small (NY); Dale Bruggeman and Tim Biler (OH); Kimberly Rankin and Melissa Greiner (PA); Doug Stolte (VA); and Amy Malm (WI).

1. **Adopted its Summer National Meeting Minutes**

Ms. Walker made a motion, seconded by Ms. Weaver, to adopt the Working Group’s Aug. 4 minutes (see NAIC Proceedings – Summer 2021, Financial Condition (E) Committee, Attachment Three). The motion passed unanimously.

2. **Discussed Comments Received on Proposed Revisions to the Financial Analysis Handbook**

Mr. Schrader stated that the second agenda item for the call is to discuss the comments received during the recent re-exposure of proposed revisions to the Financial Analysis Handbook (Handbook) to incorporate elements of the International Association of Insurance Supervisors’ (IAIS’) Common Framework for the Supervision of Internationally Active Insurance Groups (ComFrame) deemed appropriate for the U.S. system of solvency regulation. After the Working Group received and discussed comments received on the initial exposure of Handbook revisions during its Aug. 4 meeting, the Financial Analysis Drafting Group updated the guidance in response to the comments received. The updates were summarized in a comment matrix provided along with an updated draft of Handbook guidance that was exposed for a 30-day public comment period ending Oct. 9. As a result of the exposure, comment letters were received from the American Council of Life Insurers (ACLI) and the American Property Casualty Insurance Association (APCIA).

Robert Neill (ACLI) provided an overview of the ACLI comments, which included concerns related to language referencing the IAIS’ insurance capital standard (ICS) in the updated draft, as well as references to various IAIS materials in the updated draft. He stated that while language related to both items was improved in the updated draft, the ACLI continues to be concerned about language indicating that the ICS “may assist supervisors in ongoing risk assessment,” given the many flaws and limitations that have been identified and discussed regarding the appropriateness of the reference ICS formula for use in the U.S.

Mr. Schrader stated that while he understands the concerns, he feels it is important to provide some background information on the ICS and cross-references to IAIS source material in the Handbook to assist analysts that may need to gain an understanding of international standards in these areas, even if they are not being fully implemented in the U.S. Ms. Weaver stated her agreement and emphasized the importance of using the Handbook as an educational tool for staff.

Bruce Jenson (NAIC) stated that language indicating that the reference that ICS could be used for risk assessment purposes was intended for removal from the updated draft, as analysts are being encouraged to utilize group capital calculation (GCC) and Own Risk and Solvency Assessment (ORSA) information for the purposes of group capital risk assessment. As such, the language highlighted by the ACLI represents a drafting oversight. After some additional discussion, the Working Group agreed to remove all language indicating that reference ICS reporting could be used for risk assessment purposes.

Tom Finnell (APCIA) provided an overview of the APCIA comments, many of which recognized and thanked the drafting group for addressing its prior comments. He stated that there appears to be one area where the drafting group missed removing a direct reference to ComFrame, which was the intent of the updated draft. Mr. Schrader stated that he agrees that this was a drafting oversight, and he encouraged NAIC staff to remove the direct reference to ComFrame from the Handbook guidance.

Mr. Finnell stated that the guidance around the possibility of requesting group wide ORSA or Corporate Governance Annual Disclosures has the potential to exceed regulatory authority, and the APCIA letter suggested the addition of language used in another area of the Handbook to caution state insurance regulators in this area. Ms. Belfi stated that she is not in favor of adding
this language, as she feels state insurance regulator authority over internationally active insurance groups (IAIGs) is clear in this area. Mr. Rehagen stated his agreement, and he indicated that the suggested language could discourage analysts from gathering the information necessary to conduct an adequate assessment in these areas.

Mr. Finnell stated that while the Working Group’s agreement to remove language related to using the ICS in risk assessment is appreciated, the APCIA letter recommends additional language to make the overall U.S. position on the ICS clearer in the Handbook. Mr. Schrader stated that he is not in favor of adding disclaimer-type language on the reference ICS to the Handbook, as the ICS continues to be a work in progress. However, he stated that he would be in favor of adding language into the Handbook stating that state insurance regulators support the development of an aggregation method as an outcome-equivalent approach for the implementation of the ICS. Mr. Rehagen and Ms. Walker both stated their support for this language, and NAIC staff were asked to include it in the updated draft.

Mr. Finnell stated that the last item he would like to highlight from the comment letter is the importance of adequate confidentiality protections around any information-sharing tools and portals being used by state insurance regulators to share company information with international regulators. Mr. Schrader agreed that this is an important topic, and state insurance regulators should continue to exercise caution in this area.

3. Received an Update on Other Drafting Efforts

Mr. Schrader stated that two other volunteer drafting groups have been meeting to develop proposed revisions to the NAIC’s Financial Condition Examiners Handbook and ORSA Guidance Manual to incorporate ComFrame elements, as deemed appropriate, for the U.S. system of insurance regulation.

Bailey Henning (NAIC) provided an update on the status of the ComFrame Examination Drafting Group, which has held two meetings so far and has a goal to complete its initial drafting efforts in the first quarter of 2022. Elisabetta Russo (NAIC) provided an update on the status of the ComFrame ORSA Drafting Group, which has met three times and conducted a survey of IAIG Lead States to gather information on the format of ORSA Summary Reports being received from IAIGs. The drafting group also plans to complete its initial drafting efforts in the first quarter of 2022.

4. Received an Update on IAIS Activities

Mr. Schrader stated that the IAIS recently adopted a revised Application Paper on Supervisory Colleges, which was updated to reflect developments in IAIS supervisory material, including revisions to Insurance Core Principle (ICP) 3 – Information Sharing and Confidentiality Requirements and ICP 25 – Supervisory Cooperation and Coordination. He encouraged state insurance regulators and interested parties to review the updated paper to gain an understanding of recommended practices in facilitating effective supervisory college sessions.

Having no further business, the Group Solvency Issues (E) Working Group adjourned.

GSIWG Minutes
The Mutual Recognition of Jurisdictions (E) Working Group of the Financial Condition (E) Committee met Nov. 18, 2021. The following Working Group members participated: Robert Wake, Chair (ME); Monica Macaluso, Vice Chair (CA); Kathy Belfi (CT); Virginia Christy (FL); Scott Sanders (GA); Tom Travis (LA); Shelley Woods (MO); Lindsay Crawford (NE); John Tirado (NJ); Michael Campanelli (NY); and Amy Garcia (TX).

1. Adopted the Yearly Due Diligence Reviews of the Qualified Jurisdictions and Reciprocal Jurisdictions

Mr. Wake stated that the Process for Evaluating Qualified and Reciprocal Jurisdictions (QJ/RJ Process) provides a process for re-evaluating both qualified jurisdictions and reciprocal jurisdictions after their initial review and noted that this information is detailed in a memorandum from NAIC staff dated Nov. 8, 2021 (Attachment Four-A). Mr. Wake stated that prior to the 2019 revisions to the QJ/RJ Process, all qualified jurisdictions were to be reviewed fully every five years. He noted that the document was updated in 2019 with the process to be ongoing and continuous, where NAIC staff provide an annual update to the Working Group that verifies that there have not been any changes to the laws, regulations, or administrative processes of the jurisdictions that would potentially affect their status.

Jake Stultz (NAIC) stated that to conduct the review, NAIC staff searched for any publicly available information that would potentially affect the jurisdictions’ status as a qualified jurisdiction or as a reciprocal jurisdiction. He stated that much of the same documentation was used in the initial review and the 2019 full re-review of the jurisdictions. He stated that NAIC staff searched for any publicly available information about any changes to existing insurance and reinsurance laws and regulations in the jurisdictions. NAIC staff verified whether a new Financial Sector Assessment Program (FSAP) Report prepared by the International Monetary Fund (IMF), or any other externally produced documentation, was available, including the Technical Note on Insurance Sector Supervision, and if there was any other publicly available information regarding the laws, regulations, administrative practices, and procedures applicable to the reinsurance supervisory system. He stated that this search also included any documents from ratings agencies and any other public information that was deemed to be relevant.

Mr. Stultz stated that NAIC staff did not engage directly with the qualified jurisdictions or reciprocal jurisdictions and relied solely on publicly available information. He noted that NAIC staff consulted with the Federal Insurance Office (FIO) and United States Trade Representative (USTR).

Mr. Stultz stated that NAIC staff concluded that the reinsurance supervisory systems of the seven qualified jurisdictions (i.e., Bermuda, France, Germany, Ireland, Japan, Switzerland, and the United Kingdom [UK]) continue to achieve a level of effectiveness in financial solvency regulation that is acceptable for purposes of reinsurance collateral reduction, that their demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with their respective reinsurance supervisory systems, and that their laws and practices satisfy the criteria required of qualified jurisdictions as set forth in the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786). NAIC staff made similar findings with respect to the three reciprocal jurisdictions that are not subject to an in-force covered agreement (i.e., Bermuda, Japan, and Switzerland). He stated that NAIC staff recommend that these jurisdictions continue to qualify for inclusion on the NAIC List of Qualified Jurisdictions and the NAIC List of Reciprocal Jurisdictions.

Mr. Travis made a motion, seconded by Ms. Crawford, to confirm the status of Bermuda, France, Germany, Ireland, Japan, Switzerland, and the UK as qualified jurisdictions and Bermuda, Japan, and Switzerland as reciprocal jurisdictions. The motion passed unanimously.

2. Adopted the GCC Process

Mr. Wake stated that during 2020, the NAIC adopted revisions to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation With Reporting Forms and Instructions (#450), which implemented group capital calculation (GCC) filing requirements for insurance groups at the level of the ultimate controlling person and incorporate the requirements for a group-wide capital calculation as addressed under the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance”
(UK Covered Agreement) and the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement).

Mr. Wake stated that Section 4L(2) of Model #440 provides two ways a non-U.S. jurisdiction may meet the standards for its insurance groups to be exempted from the GCC. The first is if the jurisdiction has been determined to be a reciprocal jurisdiction for purposes of credit for reinsurance, and the second is if the jurisdiction has otherwise been determined to recognize and accept the GCC by procedures specified in regulation. He noted that the Working Group was charged with creating a process to determine whether other jurisdictions “recognize and accept” the NAIC GCC.

Mr. Wake stated that the Working Group originally exposed a draft of the Process for Evaluating Jurisdictions That Recognize and Accept the Group Capital Calculation (GCC Process) for a public comment period on July 21 and received a public comment letter from a U.S. coalition of companies (Attachment Four-B) and an informal comment from a non-U.S. insurance supervisor. The Working Group then met Sept. 22 in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, regarding international regulatory matters. Mr. Wake said the Working Group released a revised draft of the GCC Process for a 21-day public comment period on Sept. 22 (Attachment Four-C) and noted that one comment letter was received (Attachment Four-D). Mr. Wake stated that after exposing the Sept. 22 draft, NAIC staff held discussions with representatives of the FIO, and because of the discussions, NAIC staff revised the GCC Process in a draft dated Nov. 8 that was included with the meeting materials.

Dan Schelp (NAIC) stated that the revisions contained in both the Nov. 8 and Sept. 22 drafts are primarily stylistic in nature and non-substantive. He noted that most of the revisions found in the Sept. 22 draft were based on the U.S. coalition of companies comment letter. He noted that the Sept. 22 draft added a section for the review of evaluation materials, which is consistent with the QJ/RJ Process. He added that a revision to paragraph 12 addressed the informal comment received from a non-U.S. supervisor regarding the use of memorandum of understanding (MOU); specifically, it will not be necessary for a non-U.S. jurisdiction to enter into multiple MOUs with jurisdictions where its company does business in multiple states. He stated that the jurisdiction will only be required to enter into one MOU with a single state that has agreed to serve as a single point of contact for multiple lead states in this process. He noted that this concept is comparable to that used under the processes for certified reinsurers and qualified jurisdictions.

Mr. Schelp stated that the Nov. 8 draft addressed issues discussed with the FIO. He stated that the revisions in paragraph 3 are an acknowledgment that unlike the reinsurance collateral provisions, states are not required to comply with the group capital provisions of the covered agreements and that revisions to paragraph 9 and paragraph 10 are an acknowledgement that both the FIO and the USTR have an interest in the evaluation of reciprocal jurisdictions, and that the Working Group will consult with the FIO and the USTR in these circumstances.

Mr. Schelp stated that the comment letter from Swiss Re suggested that the GCC Process, QJ/RJ Process, and possibly the new ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers (ReFAWG Process) should all become Part B accreditation standards. Mr. Schelp stated that he had contacted NAIC staff support for the the Financial Regulation Standards and Accreditation (F) Committee and added that making these processes accreditation standards would be unusual, but it is something that can be discussed.

Mr. Schelp stated that it is the recommendation of NAIC staff that the Working Group adopt the Nov. 8 draft of the GCC Process. He noted that once it has been approved by the Working Group, it would then go to the Financial Condition (E) Committee and NAIC Executive (EX) Committee and Plenary for final adoption at the Fall National meeting.

Ms. Macaluso made a motion, seconded by Mr. Travis, to adopt the Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation, dated Nov. 8 (Attachment Four-E). The motion passed unanimously.

3. Provided an Update on the Republic of Korea Application to Become a Qualified Jurisdiction

Mr. Wake stated that on May 27, the Working Group approved a recommendation for the Republic of Korea to become a qualified jurisdiction. He noted that this recommendation was exposed publicly by the Reinsurance (E) Task Force on June 3. As a result of the exposure, the Task Force was notified about an ongoing issue with data localization requirements in the Republic of Korea, which must be remediated before the process can move forward. Mr. Wake stated that the Task Force referred this issue back to the Working Group at the Summer National Meeting.
Mr. Wake stated that NAIC staff and a small group of state insurance regulators have held meetings with both the Republic of Korea Financial Services Commission (FSC) and Financial Supervisory Service (FSS), as well as with U.S. insurance trade groups, to better understand the issues and to help move this process forward. He noted that no action had yet been taken and that further updates will be provided to the Working Group when more is known.

Having no further business, the Mutual Recognition of Jurisdictions (E) Working Group adjourned.
TO: Robert Wake, Chair of the Mutual Recognition of Jurisdictions (E) Working Group

FROM: NAIC Staff

RE: Yearly Due Diligence Review of Qualified Jurisdictions & Reciprocal Jurisdictions

DATE: November 8, 2021

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**Executive Summary & Recommendation**

The Mutual Recognition of Jurisdictions (E) Working Group will perform a yearly review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions. The Working Group will also perform a yearly review with respect to non-Covered Agreement Reciprocal Jurisdictions. NAIC staff has performed a due diligence review of these jurisdictions, and has the following recommendations to the Working Group:

1. The following Qualified Jurisdictions shall retain their status on the *NAIC List of Qualified Jurisdictions*:

   - Bermuda, Bermuda Monetary Authority (BMA)
   - France, Autorité de Contrôle Prudentiel et de Résolution (ACPR)
   - Germany, Federal Financial Supervisory Authority (BaFin)
   - Ireland, Central Bank of Ireland (Central Bank)
   - Japan, Financial Services Agency (FSA)
   - Switzerland, Financial Market Supervisory Authority (FINMA)
   - United Kingdom, Prudential Regulation Authority of the Bank of England (PRA)

2. The following non-Covered Agreement Reciprocal Jurisdictions shall retain their status on the *NAIC List of Reciprocal Jurisdictions*:

   - Bermuda, Bermuda Monetary Authority (BMA)
   - Japan, Financial Services Agency (FSA)
   - Switzerland, Financial Market Supervisory Authority (FINMA)

**Process for Evaluation after Initial Approval**

The afore-described jurisdictions were originally evaluated and placed on the *NAIC List of Qualified Jurisdictions* effective January 1, 2015, and were later re-evaluated effective January 1, 2020. Four of them are entitled to Reciprocal Jurisdiction status by virtue of in-force Covered Agreements. The other three Reciprocal Jurisdictions were evaluated and placed on the *NAIC List of Reciprocal Jurisdictions* effective January 1, 2020. Part III, Section 12 of the *Process for Evaluating Qualified and Reciprocal Jurisdictions*
("Process"), which was amended by the NAIC on August 17, 2021, provides a process for evaluating both Qualified and Reciprocal Jurisdictions after their initial approval:

The process for determining whether a non-U.S. jurisdiction is a Qualified Jurisdiction is ongoing and subject to periodic review. The Mutual Recognition of Jurisdictions (E) Working Group will perform a yearly review of Qualified Jurisdictions to determine whether there have been any significant changes over the prior year that might affect their status as Qualified Jurisdictions. This yearly review shall follow such abbreviated process as may be determined by the Mutual Recognition of Jurisdictions (E) Working Group to be appropriate. It shall include a review of the jurisdiction’s status as a Reciprocal Jurisdiction if the jurisdiction has been recognized by the NAIC as a Reciprocal Jurisdiction through the process established in paragraph 13 [i.e., Qualified Jurisdictions that are not subject to an in-force covered agreement and are not accredited U.S. jurisdictions].

The yearly review shall follow such abbreviated process as may be determined by the Working Group to be appropriate. For this review, NAIC staff searched for any publicly available information that would potentially impact the jurisdictions’ status as a Qualified Jurisdiction or as a Reciprocal Jurisdiction. This evaluation relied on much of the same documentation as was used in the initial review of the jurisdictions, as detailed in Part III, Section 2 of the Process. NAIC staff searched for any publicly available information about any changes to existing insurance and reinsurance laws and regulations in the jurisdictions. Next, NAIC staff verified whether a new Financial Sector Assessment Program (FSAP) Report prepared by the International Monetary Fund (IMF), or any other externally produced documentation was available, including the Technical Note on Insurance Sector Supervision, and any other publicly available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system. This search also included any documents from ratings agencies and any other public information that was deemed to be relevant.

During this process, NAIC staff did not engage directly with the Qualified Jurisdictions or Reciprocal Jurisdictions and relied solely on publicly available information. Additionally, NAIC staff included any information received (if any had been received) directly from regulators, interested parties or impacted insurance companies that could potentially impact the status of the Qualified Jurisdictions or Reciprocal Jurisdictions. NAIC staff also consulted with the Federal Insurance Office and United States Trade Representative.

**NAIC Staff Findings**

Upon review of the available information, NAIC staff has reached the conclusion that the reinsurance supervisory systems of the 7 Qualified Jurisdictions continue to achieve a level of effectiveness in financial solvency regulation that is acceptable for purposes of reinsurance collateral reduction, that their demonstrated practices and procedures with respect to reinsurance supervision continue to be consistent with their respective reinsurance supervisory systems, and that their laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models. NAIC staff made similar findings with respect to the 3 Reciprocal Jurisdictions that are not subject to an in-force Covered Agreement.

Therefore, it is the recommendation of NAIC staff that these jurisdictions continue to qualify for inclusion on the **NAIC List of Qualified Jurisdictions** and the **NAIC List of Reciprocal Jurisdictions**.
August 20, 2021

Re: Comments on the Draft Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation

Dear Mr. Wake:

The undersigned U.S. based insurance groups appreciate the opportunity to comment on the Draft Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation (Draft Process). We support the Draft Process and believe it provides a fair, transparent, and efficient process for evaluating jurisdictions that is consistent with the Model Insurance Holding Company System Regulatory Act and Regulation.

We offer the following suggested changes that we believe will clarify the Draft Process:

1. The Draft Process does not include a section on “review of the evaluation materials”, which is included in the NAIC’s Process for Evaluating Qualified and Reciprocal Jurisdictions. We believe a streamlined section providing for the use of consultants as appropriate and making them subject to confidentiality should be included in the Draft Process.

2. In Section 5 (“Other Jurisdictions that Recognize and Accept”), we believe all of the criteria in subparagraphs (a) through (d) must be met in order for a non-U.S. jurisdiction to be deemed to “recognize and accept” the GCC. To clarify the intent, we recommend the following edit to the Section 5 lead paragraph:

“5. Other Jurisdictions that Recognize and Accept. In addition, because most of the requirements for Reciprocal Jurisdiction status are not relevant to group capital and group supervision, Section 4L(2)(d) of Model #440 provides an alternative pathway for the exemption. The ultimate controlling person of an insurance holding company system whose non-U.S. group-wide supervisor is not in a Reciprocal Jurisdiction is exempted from filing the GCC as long as the jurisdiction of its group-wide supervisor “recognizes and accepts” the GCC, as specified by the commissioner in regulation. Section 21D of Model #450 provides that a non-U.S. jurisdiction is considered to “recognize and accept” the GCC if it satisfies all of the following criteria: ”.

3. Section 8.(d) includes the following:

“Once the Working Group has finally adopted the Summary of Findings and Determination in open session after opportunity for public comment, it will submit the summary of its findings and its recommendation to the Financial Condition (E) Committee at an open meeting. Upon approval by the Committee, the summary and recommendation will be submitted to the Executive (EX) Committee and Plenary, as well as to the Federal Insurance Office (FIO),
United States Trade Representative (USTR) and other relevant federal authorities for consultation purposes.”

We recommend that the highlighted text be revised to state, “for informational purposes,” as the NAIC will have executed its work and made a determination by this point of the evaluation.

4. Section 10: The last sentence before the sub-parts seems to be incomplete. We suggest adding the highlighted text as follows: “The process outlined in this Paragraph will also apply to a jurisdiction that is a Reciprocal Jurisdiction by virtue of a covered agreement, if the Mutual Recognition of Jurisdictions (E) Working Group has determined that a case-by-case review of the jurisdiction is warranted.”

5. Section 13

   o The Draft Process should clarify how the steps under Sections 8, 9, and 10 apply in the case of assessing whether a Recognize and Accepts jurisdiction requires subgroup reporting.

   o Also, it appears that the List will indicate whether a Recognize and Accepts jurisdiction requires subgroup reporting with a "yes" / "no" type approach, but it would be helpful if the process was explicit on how this information will be presented.

6. Similar to the second comment above on Section 13, Section C of the Appendix should clarify how a determination on subgroup reciprocity will be presented on the List (e.g., a “yes” / “no” type approach).

7. Section 14(c): We request that the Working Group amend this section to clarify that it will also give due consideration to any notice provided by the U.S.-based insurance group’s lead state commissioner. We suggest this section be amended as follows: “The Mutual Recognition of Jurisdictions (E) Working Group will also give due consideration to any notice from a U.S.-based insurance group or its lead state commissioner that the group has been required to perform a group capital calculation, at either the group-wide or subgroup level, in a jurisdiction on the “Recognize and Accept” List.”

Thank you for the opportunity to provide these comments. We would be happy to discuss these recommendations.

Sincerely,

Berkshire Hathaway Group of insurance companies
Liberty Mutual Insurance Group
MetLife, Inc.
Odyssey Reinsurance Company
Prudential Financial, Inc.
Reinsurance Group of America, Incorporated
The Travelers Companies, Inc.
Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation

Mutual Recognition of Jurisdictions (E) Working Group
Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation

1. **Group Capital Calculation.** On December 9, 2020, the NAIC adopted revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). These revisions implement the Group Capital Calculation (GCC) filing requirements for insurance groups at the level of the ultimate controlling person for the purposes of evaluating solvency at the group level. The revisions specifically provide that the requirement to file the NAIC’s GCC applies to U.S.-based groups, while a group headquartered outside the U.S. is exempt from the GCC (subject to limited exceptions) if its group-wide supervisor “recognizes and accepts” the GCC for U.S. groups doing business in that jurisdiction. Likewise, a U.S. group subject to a group capital calculation specified by the Federal Reserve Board is exempt from the GCC. This process codifies the concepts of mutual recognition and one group/one group-wide supervisor.

2. **NAIC Listing Process.** Section 4L(2) of Model #440 provides two ways a non-U.S. jurisdiction may meet the standards for its insurance groups to be exempt from the GCC:

   (a) If the jurisdiction has been determined to be a Reciprocal Jurisdiction for purposes of credit for reinsurance, which includes a requirement that the jurisdiction “recognizes the U.S. state regulatory approach to group supervision and group capital”; or

   (b) If the jurisdiction has otherwise been determined to recognize and accept the GCC by procedures specified in regulation.

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

3. **Covered Agreements.** The GCC and the “recognize and accept” process are intended to comply with the requirements under the “Bilateral Agreement Between the United States of

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

2 Model #440. § 4L(2)(c).
America and the European Union on Prudential Measures Regarding Insurance and Reinsurance”, which was signed on September 22, 2017. On December 18, 2018, a similar Covered Agreement was signed with the United Kingdom (UK) (collectively “Covered Agreements”). The Covered Agreements require the elimination of reinsurance collateral requirements for certain reinsurers licensed and domiciled in participating jurisdictions, and limit the worldwide application of prudential group insurance measures on insurance groups based in participating jurisdictions. Specifically, the Covered Agreements provide that U.S. insurers and reinsurers can operate in the EU and UK without subjecting the U.S. parent to the host jurisdiction’s group-level governance, solvency and capital, and reporting requirements, and also provide the same protections for EU and UK insurers and reinsurers operating in the U.S. However, the Covered Agreements only exempt U.S., EU and UK insurance groups from each other’s worldwide group capital requirements if the home supervisor performs worldwide group capital assessments on its own insurance groups and has the authority to impose preventive and corrective measures.

4. Reciprocal Jurisdictions. In response to the Covered Agreements, the NAIC also amended the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) to provide that jurisdictions that are subject to in-force covered agreements are considered to be “Reciprocal Jurisdictions,” and large, financially strong reinsurers that are based in those jurisdictions are not required to post reinsurance collateral. In addition, a “Qualified Jurisdiction” under Section 2E of Model #785 may become a Reciprocal Jurisdiction if, among other requirements, it “recognizes the U.S. state regulatory approach to group supervision and group capital.” By the terms of the Covered Agreements, insurance groups based in EU Member States and the UK are entitled to exemption from the extraterritorial application of the U.S. GCC, and Section 4L(2)(c) of Model #440 recognizes that other Reciprocal Jurisdictions, which have made the same commitment, are entitled to the same treatment.

5. Other Jurisdictions that Recognize and Accept. In addition, because most of the requirements for Reciprocal Jurisdiction status are not relevant to group capital and group supervision, Section 4L(2)(d) of Model #440 provides an alternative pathway for the exemption. The ultimate controlling person of an insurance holding company system whose non-U.S. group-wide supervisor is not in a Reciprocal Jurisdiction is exempted from filing the GCC as long as the jurisdiction of its group-wide supervisor “recognizes and accepts” the GCC, as specified by the commissioner in regulation. Section 21D of Model #450 provides that a non-U.S. jurisdiction is considered to “recognize and accept” the GCC if it satisfies all of the following criteria:

(a) The non-U.S. jurisdiction recognizes the U.S. state regulatory approach to group supervision and group capital, by providing confirmation by a competent regulatory authority, in such jurisdiction, that insurers and insurance groups whose lead state is
accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction;

(b) Where no U.S. insurance groups operate in the non-U.S. jurisdiction, that non-U.S. jurisdiction indicates formally in writing to the lead state with a copy to the International Association of Insurance Supervisors that the group capital calculation is an acceptable international capital standard. This will serve as the documentation otherwise required in Section 21D(1)(a);

(c) The non-U.S. jurisdiction provides confirmation by a competent regulatory authority in such jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC. The commissioner shall determine, in consultation with the NAIC Committee Process, if the requirements of the information sharing agreements are in force;

(d) Notwithstanding these exemptions, Section 4L(2)(e) of Model #440 provides that a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system from a Reciprocal Jurisdiction or “Recognize and Accept” Jurisdiction where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. Section 21E(1) of Model #450 then provides that to assist with a determination under Section 4L(2)(e) of Model #440, the list will also identify whether a jurisdiction that is exempted under either Sections 4L(2)(c) or 4L(2)(d) requires a group capital filing for any U.S.-based insurance group’s operations in that non-U.S. jurisdiction.

6. Mutual Recognition of Jurisdictions (E) Working Group. On March 8, 2021, the Financial Condition (E) Committee repositioned the Qualified Jurisdiction (E) Working Group to report directly to the Committee and revised the name of the group to the Mutual Recognition of Jurisdictions (E) Working Group. The Working Group received the additional charge of developing a process for evaluating jurisdictions that meet the NAIC requirements for recognizing and accepting the GCC (“Process for Evaluating Jurisdictions that Recognize and
Accept the Group Capital Calculation,” or “Recognize and Accept” Process). A separate process exists for evaluating Qualified and Reciprocal Jurisdictions (“Process for Evaluating Qualified and Reciprocal Jurisdictions”), and it is intended that the “Recognize and Accept” Process will closely mirror this process. The Committee charged this Working Group with developing and implementing the “Recognize and Accept” Process due to this Working Group’s experience and expertise in evaluating the insurance regulatory systems of non-U.S. jurisdictions and their recognition of U.S. group-wide supervision.

7. List of Jurisdictions that Recognize and Accept the GCC. The Mutual Recognition of Jurisdictions (E) Working Group will evaluate non-U.S. jurisdictions in accordance with this “Recognize and Accept” Process. A list of “Recognize and Accept” Jurisdictions is published through the NAIC committee process (“NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation”; “Recognize and Accept’ List”; or “List”). The creation of the List does not constitute a delegation of regulatory authority to the NAIC. Although a state must consider this List under Section 21E(3) of Model #450 in its determination of whether a non-U.S. insurance group is exempt from filing an annual GCC, the List is not binding and the ultimate authority to designate a “Recognize and Accept” Jurisdiction resides solely in each state.

(a) The List will include all Reciprocal Jurisdictions that recognize the U.S. state regulatory approach to group supervision and group capital. [See discussion in paragraph 9.]

(b) The evaluation of non-U.S. jurisdictions that are non-Reciprocal Jurisdictions as “Recognize and Accept” Jurisdictions will be conducted in accordance with the provisions of Section 4L(2) of Model #440 and Section 21 of Model #450, and any other relevant guidance developed by the NAIC. [See discussion in paragraphs 10 and 11.]

(c) As specified in Section 21E(1) of Model #450, the List will also identify which “Recognize and Accept” Jurisdictions require a group capital filing for a U.S.-based insurance group’s operations in that jurisdiction. [See discussion of Subgroup Capital Calculation in paragraph 13.]

(d) Upon final inclusion of a jurisdiction on the List, any confidential documents reviewed by the Mutual Recognition of Jurisdictions (E) Working Group in its evaluation of the jurisdiction will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential. The NAIC will maintain the List on its public website and in other appropriate NAIC publications.
If a non-US group’s lead state exempts the group from the GCC, and the group-wide supervisor is based in a jurisdiction that is not on the “Recognize and Accept” List, the state must thoroughly document the justification for the exemption.

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

(a) Initiation of Evaluation. Formal notification of the Mutual Recognition of Jurisdictions (E) Working Group’s intent to initiate the evaluation process will be sent by the NAIC to the supervisory authority in the jurisdiction selected. The process of evaluation and all related documentation are private and confidential matters between the NAIC and the applicant jurisdiction, unless otherwise provided in this document. Upon receipt of confirmation by a competent regulatory authority of the non-U.S. jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group:

i. Will direct NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise to review the materials received from the jurisdiction. Upon completing its review of the evaluation materials, the internal reviewer(s) will report initial findings to the Mutual Recognition of Jurisdictions (E) Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation. Copies of the initial findings may also be made available to the Federal Insurance Office (FIO) and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.

ii. Will issue public notice on the NAIC website inviting public comments with respect to consideration of the jurisdiction as a “Recognize and Accept” Jurisdiction.

iii. Will consider public comments from state regulators, U.S. insurance groups, and any other interested parties.

iv. May review other public materials deemed relevant to making a determination.

v. Will invite each non-U.S. jurisdiction, or its designee, to provide any additional information it deems relevant to making a determination.

vi. Relevant U.S. state and federal authorities will be notified of the Mutual
Recognition of Jurisdictions (E) Working Group’s decision to evaluate a jurisdiction.

(b) Preliminary Evaluation Report. NAIC staff will prepare a Preliminary Evaluation Report for review by the Mutual Recognition of Jurisdictions (E) Working Group. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a “Recognize and Accept” Jurisdiction. Upon review by the Working Group, the results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review. At that time, a copy of the Preliminary Evaluation Report will also be shared with the Group Capital Calculation (E) Working Group in regulator-to-regulator session. The Group Capital Calculation (E) Working Group will also be kept advised of any new developments in the evaluation of this jurisdiction.

(c) Final Evaluation Report. Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. The Mutual Recognition of Jurisdictions (E) Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session.

(d) Summary of Findings and Determination. Upon approval of the Final Evaluation Report, the Mutual Recognition of Jurisdictions (E) Working Group will issue a public statement and a summary of its findings with respect to its determination. At this time, the Working Group will release the Summary of Findings and Determination for public comment. Once the Working Group has finally adopted the Summary of Findings and Determination in open session after opportunity for public comment, it will submit the summary of its findings and its recommendation to the Financial Condition (E) Committee at an open meeting. Upon approval by the Committee, the summary and recommendation will be submitted to the Executive (EX) Committee and Plenary, as well as to the Federal Insurance Office (FIO), United States Trade Representative (USTR) and other relevant federal authorities for consultation/informational purposes. Upon approval as a “Recognize and Accept” Jurisdiction by the Executive (EX) Committee and Plenary, the jurisdiction will be added to the NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation.

9. Evaluation of Reciprocal Jurisdictions. Under Section 4L(2)(c) of Model #440, Reciprocal Jurisdictions that recognize the U.S. state regulatory approach to group supervision and group capital are exempt from the GCC. Because a “recognize and accept” evaluation by the Mutual Recognition of Jurisdictions (E) Working Group is already part of the Reciprocal Jurisdiction
review process, all Reciprocal Jurisdictions designated by the NAIC through that review process are also automatically designated as “Recognize and Accept” Jurisdictions. Likewise, in accordance with the terms of the EU and UK Covered Agreements, all EU States and the UK are automatically designated “Recognize and Accept” Jurisdictions. If there is a material change to the terms of either Covered Agreement, or the United States enters into a new covered agreement with one or more non-U.S. jurisdictions, the Mutual Recognition of Jurisdictions (E) Working Group will rely upon its review and evaluation of the applicable covered agreement, in consultation with FIO and USTR, to determine whether automatic “Recognize and Accept” status is appropriate, or whether it is necessary to conduct a case-by-case review of the jurisdiction or jurisdictions in accordance with Paragraph 10 below.


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

(a) The Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination the representations in the written confirmation are true and accurate.

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

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

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

(a) The Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm that, to the best of its determination, the representations in the written confirmation are true and accurate.

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

(c) NAIC staff will work with the Mutual Recognition of Jurisdictions (E) Working Group and the applicant jurisdiction to prepare an acceptable confirmation letter for this purpose.

12. Memorandum of Understanding.
Section 21D(2) of Model #450 requires a non-Reciprocal Jurisdiction that “recognizes and accepts” the GCC to provide confirmation by a competent regulatory authority that information regarding insurers, and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner of any U.S.-based insurance group doing business in that jurisdiction. Acceptable MOUs include, but are not limited to, the International Association of Insurance Supervisors Multilateral Memorandum of Understanding (“IAIS MMoU”) or other multilateral memoranda of understanding coordinated by the NAIC. The Mutual Recognition of Jurisdictions (E) Working Group will review such memoranda of understanding and include
an opinion in the Summary of Findings and Determination as to whether the jurisdiction has met this condition to be included on the “Recognize and Accept” List.

(a) The lead state will act as a conduit for information between the “Recognize and Accept” Jurisdiction and other states that have an insurer from that jurisdiction, and will share information with these states consistent with the terms governing the further sharing of information included in the applicable MOU, and pursuant to the NAIC Master Information Sharing and Confidentiality Agreement. The jurisdiction must also confirm in writing that it is willing to permit this lead state to act as the contact for purposes of obtaining information concerning all insurers within the group.

(b) If a jurisdiction has not been approved by the IAIS as a signatory to the MMoU, it must either (1) enter into an MOU with the lead state, or (2) enter into an MOU with a state that has agreed to serve as a single point of contact for multiple lead states, similar to the procedure for sharing information under the Process for Evaluating Qualified and Reciprocal Jurisdictions. The MOU will provide for appropriate confidentiality safeguards with respect to the information shared among the jurisdictions.

(c) The same requirements and procedures will apply to a Reciprocal Jurisdiction that is subject to a case-by-case “recognize and accept” review, unless the necessary information-sharing procedures are already specified in the applicable covered agreement.

13. Prudential Oversight and Solvency Monitoring. Section 4L(2)(e) of Model #440 directs a lead state commissioner to require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system based in a “Recognize and Accept” Jurisdiction if, after any necessary consultation with other supervisors or officials, the commissioner deems such a “subgroup” calculation to be appropriate for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. Section 21E(1) of Model #450 provides that to assist with such a determination, the “Recognize and Accept” List will also identify whether a listed jurisdiction requires a subgroup group capital filing for any U.S.-based insurance group’s operations, and a discussion and findings on this review will be included in the Preliminary Evaluation Report, Final Evaluation Report and Summary of Findings and Determination. If the Working Group has evidence indicating that a jurisdiction requires a subgroup group capital filing for any U.S.-based insurance group’s operations in that jurisdiction, it will attempt to obtain written
confirmation of the existence and scope of any such requirement from a competent regulatory authority in any such jurisdiction, but it is recognized that such a confirmation is not an essential element of the Working Group’s determination. The NAIC will identify such jurisdictions on the “Recognize and Accept” List, and may include an explanatory note in cases where a simple “Yes” or “No” response does not adequately describe the jurisdiction’s requirements. States may rely on this List when making determinations under Section 4L(2)(e) of Model #440.

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

(a) Upon determination by a lead state commissioner that a non-U.S. jurisdiction no longer meets one or more of the requirements to “recognize and accept” the GCC, the lead state commissioner may provide a recommendation to the Working Group that the jurisdiction be removed from the “Recognize and Accept” List. Upon review and after consultation with the “Recognize and Accept” Jurisdiction, the Working Group may remove the jurisdiction from the List, which must then be confirmed by the Financial Condition (E) Committee and the NAIC Executive (EX) Committee and Plenary.

(b) Upon determination by a lead state commissioner that a non-U.S. jurisdiction requires a group capital filing for any U.S. based insurance group’s operations in that non-U.S. jurisdiction, the lead state commissioner may provide a recommendation to the Working Group that the non-U.S. jurisdiction be identified as such on the “Recognize and Accept” List. Upon receipt of any such notice, the Mutual Recognition of Jurisdictions (E) Working Group will also consider whether it is necessary to re-evaluate the jurisdiction’s “Recognize and Accept” status.

(c) The Mutual Recognition of Jurisdictions (E) Working Group will also give due consideration to any notice from a U.S.-based insurance group that it has been required to perform a group capital calculation, at either the group-wide or subgroup level, in a jurisdiction on the “Recognize and Accept” List.

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

**Appendix: Letter Templates**

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

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

As the competent regulatory authority for [non-U.S. Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories the following:

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

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

- [Non-U.S. Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

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

As the competent regulatory authority and lead insurance regulatory supervisor for [non-U.S. Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories, with a copy to the International Association of Insurance Supervisors (IAIS), the following:

- [Non-U.S. Jurisdiction] recognizes the Group Capital Calculation as defined under Section 4L(2) of the NAIC Insurance Holding Company System Regulatory Act (#440) as an acceptable international capital standard.

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

- [Non-U.S. Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

**C. Jurisdictions with Subgroup Capital Requirements.** Paragraph 13 of the *Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation* provides that the Mutual Recognition of Jurisdictions (E) Working Group will attempt to obtain written confirmation from a competent regulatory authority in any jurisdiction where the Working Group has evidence indicating that the jurisdiction requires a subgroup group capital filing for any U.S. based insurance group’s operations in that jurisdiction. The NAIC will identify such jurisdictions on the “Recognize and Accept” List, and will provide an explanation and discussion on such determination in its Summary of Findings and Determination. States may rely on this List when making determinations under Section 4L(2)(e) of Model #440.
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October 13, 2021

Re: NAIC Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation Exposure Draft

Thank you for the opportunity to comment on the NAIC’s Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation. Swiss Re believes the process as outlined accurately reflects the requirements contained in the Insurance Holding Company System Models and pertinent provisions in the Credit for Reinsurance Models defining Qualified and Reciprocal Jurisdictions.

The certified reinsurer experience has demonstrated that day-to-day practices do not always align with written processes. Differences among the states in interpretation and implementation of the processes surrounding the evaluation of jurisdictions and reinsurers can frustrate both the international cooperation and financial solvency regulation goals of the NAIC and the states.

Therefore, we recommend that the Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation, the Process for Evaluating Qualified and Reciprocal Jurisdictions, and the checklists for certified and reciprocal jurisdiction reinsurers be added to the NAIC Accreditation Program. Specifically, adherence to these policies should be evaluated by the NAIC accreditation review team as part of the Part B standards – Regulatory Practices and Procedures. Because the purpose of Part B of the accreditation program is to identify base-line regulatory practices and procedures required to supplement and support enforcement of states’ financial solvency laws in order for the states to attain substantial compliance with the core standards established in Part A, and Part A contains both the holding company and credit for reinsurance models, the accreditation program is the ideal mechanism to guide regulatory best practices in this area.
Swiss Re

If you have any questions, please contact me.

Yours sincerely,

Matthew Wulf
Head State Regulatory Affairs Americas
Swiss Re
Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation

Mutual Recognition of Jurisdictions (E) Working Group
Process for Evaluating Jurisdictions that Recognize and Accept
the Group Capital Calculation

1. **Group Capital Calculation.** On December 9, 2020, the NAIC adopted revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). These revisions implement the Group Capital Calculation (GCC) filing requirements for insurance groups at the level of the ultimate controlling person for the purposes of evaluating solvency at the group level. The revisions specifically provide that the requirement to file the NAIC’s GCC applies to U.S.-based groups, while a group headquartered outside the U.S. is exempt from the GCC (subject to limited exceptions)\(^1\) if its group-wide supervisor “recognizes and accepts” the GCC for U.S. groups doing business in that jurisdiction. Likewise, a U.S. group subject to a group capital calculation specified by the Federal Reserve Board is exempt from the GCC. This process codifies the concepts of mutual recognition and one group/one group-wide supervisor.

2. **NAIC Listing Process.** Section 4L(2) of Model #440 provides two ways a non-U.S. jurisdiction may meet the standards for its insurance groups to be exempt from the GCC:

   (a) If the jurisdiction has been determined to be a Reciprocal Jurisdiction for purposes of credit for reinsurance, which includes a requirement that the jurisdiction “recognizes the U.S. state regulatory approach to group supervision and group capital”;\(^2\) or

   (b) If the jurisdiction has otherwise been determined to recognize and accept the GCC by procedures specified in regulation.

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

3. **Covered Agreements.** The GCC and the “recognize and accept” process are intended to comply with the requirements under the “Bilateral Agreement Between the United States of

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

\(^2\) Model #440. § 4L(2)(c).
“America and the European Union on Prudential Measures Regarding Insurance and Reinsurance,” which was signed on September 22, 2017. On December 18, 2018, a similar Covered Agreement was signed with the United Kingdom (UK) (collectively “Covered Agreements”). The Covered Agreements require, inter alia, the elimination of reinsurance collateral requirements for certain reinsurers licensed and domiciled in participating jurisdictions, and limit the worldwide application of prudential group insurance measures on insurance groups based in participating jurisdictions. Specifically, in relevant part, the Covered Agreements provide that U.S. insurers and reinsurers can operate in the EU and UK without subjecting the U.S. parent to the host jurisdiction’s group-level governance, solvency and capital, and reporting requirements, and also provide the same protections for EU and UK insurers and reinsurers operating in the U.S. However, the Covered Agreements only exempt U.S., EU and UK insurance groups from each other’s worldwide group capital requirements if the home supervisor performs worldwide group capital assessments on its own insurance groups and has the authority to impose preventive and corrective measures.

4. Reciprocal Jurisdictions. In response to the Covered Agreements, the NAIC also amended the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) to provide that jurisdictions that are subject to in-force covered agreements are considered to be “Reciprocal Jurisdictions,” and large, financially strong reinsurers that are based in those jurisdictions are not required to post reinsurance collateral. In addition, a “Qualified Jurisdiction” under Section 2E of Model #785 may become a Reciprocal Jurisdiction if, among other requirements, it “recognizes the U.S. state regulatory approach to group supervision and group capital.” By the terms of the Covered Agreements, insurance groups based in EU Member States and the UK are entitled to exemption from the extraterritorial application of the U.S. GCC, and Section 4L(2)(c) of Model #440 recognizes that other Reciprocal Jurisdictions, which have made the same commitment, are entitled to the same treatment.

5. Other Jurisdictions that Recognize and Accept. In addition, because most of the requirements for Reciprocal Jurisdiction status are not relevant to group capital and group supervision, Section 4L(2)(d) of Model #440 provides an alternative pathway for the exemption. The ultimate controlling person of an insurance holding company system whose non-U.S. group-wide supervisor is not in a Reciprocal Jurisdiction is exempted from filing the GCC as long as the jurisdiction of its group-wide supervisor “recognizes and accepts” the GCC, as specified by the commissioner in regulation. Section 21D of Model #450 provides that a non-U.S. jurisdiction is considered to “recognize and accept” the GCC if it satisfies all of the following criteria:

(a) The non-U.S. jurisdiction recognizes the U.S. state regulatory approach to group supervision and group capital, by providing confirmation by a competent regulatory authority, in such jurisdiction, that insurers and insurance groups whose lead state is
accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction;

(b) Where no U.S. insurance groups operate in the non-U.S. jurisdiction, that non-U.S. jurisdiction indicates formally in writing to the lead state with a copy to the International Association of Insurance Supervisors that the group capital calculation is an acceptable international capital standard. This will serve as the documentation otherwise required in Section 21D(1)(a);

(c) The non-U.S. jurisdiction provides confirmation by a competent regulatory authority in such jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC. The commissioner shall determine, in consultation with the NAIC Committee Process, if the requirements of the information sharing agreements are in force;

(d) Notwithstanding these exemptions, Section 4L(2)(e) of Model #440 provides that a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system from a Reciprocal Jurisdiction or “Recognize and Accept” Jurisdiction where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. Section 21E(1) of Model #450 then provides that to assist with a determination under Section 4L(2)(e) of Model #440, the list will also identify whether a jurisdiction that is exempted under either Sections 4L(2)(c) or 4L(2)(d) requires a group capital filing for any U.S.-based insurance group’s operations in that non-U.S. jurisdiction.

6. Mutual Recognition of Jurisdictions (E) Working Group. On March 8, 2021, the Financial Condition (E) Committee repositioned the Qualified Jurisdiction (E) Working Group to report directly to the Committee and revised the name of the group to the Mutual Recognition of Jurisdictions (E) Working Group. The Working Group received the additional charge of developing a process for evaluating jurisdictions that meet the NAIC requirements for recognizing and accepting the GCC (“Process for Evaluating Jurisdictions that Recognize and
Accept the Group Capital Calculation,” or “Recognize and Accept” Process). A separate process exists for evaluating Qualified and Reciprocal Jurisdictions (“Process for Evaluating Qualified and Reciprocal Jurisdictions”), and it is intended that the “Recognize and Accept” Process will closely mirror this process. The Committee charged this Working Group with developing and implementing the “Recognize and Accept” Process due to this Working Group’s experience and expertise in evaluating the insurance regulatory systems of non-U.S. jurisdictions and their recognition of U.S. group-wide supervision.

7. List of Jurisdictions that Recognize and Accept the GCC. The Mutual Recognition of Jurisdictions (E) Working Group will evaluate non-U.S. jurisdictions in accordance with this “Recognize and Accept” Process. A list of “Recognize and Accept” Jurisdictions is published through the NAIC committee process (“NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation”; “Recognize and Accept’ List”; or “List”). The creation of the List does not constitute a delegation of regulatory authority to the NAIC. Although a state must consider this List under Section 21E(3) of Model #450 in its determination of whether a non-U.S. insurance group is exempt from filing an annual GCC, the List is not binding and the ultimate authority to designate a “Recognize and Accept” Jurisdiction resides solely in each state.

(a) The List will include all Reciprocal Jurisdictions that recognize the U.S. state regulatory approach to group supervision and group capital. [See discussion in paragraph 9.]

(b) The evaluation of non-U.S. jurisdictions that are non-Reciprocal Jurisdictions as “Recognize and Accept” Jurisdictions will be conducted in accordance with the provisions of Section 4L(2) of Model #440 and Section 21 of Model #450, and any other relevant guidance developed by the NAIC. [see discussion in paragraphs 10 and 11.]

(c) As specified in Section 21E(1) of Model #450, the List will also identify which “Recognize and Accept” Jurisdictions require a group capital filing for a U.S.-based insurance group’s operations in that jurisdiction. [See discussion of Subgroup Capital Calculation in paragraph 13.]

(d) Upon final inclusion of a jurisdiction on the List, any confidential documents reviewed by the Mutual Recognition of Jurisdictions (E) Working Group in its evaluation of the jurisdiction will be made available to individual U.S. state insurance regulators upon request and confirmation that the information contained therein will remain confidential. The NAIC will maintain the List on its public website and in other appropriate NAIC publications.
(e) If a non-US group’s lead state exempts the group from the GCC, and the group-wide supervisor is based in a jurisdiction that is not on the “Recognize and Accept” List, the state must thoroughly document the justification for the exemption.

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

(a) Initiation of Evaluation. Formal notification of the Mutual Recognition of Jurisdictions (E) Working Group’s intent to initiate the evaluation process will be sent by the NAIC to the supervisory authority in the jurisdiction selected. The process of evaluation and all related documentation are private and confidential matters between the NAIC and the applicant jurisdiction, unless otherwise provided in this document. Upon receipt of confirmation by a competent regulatory authority of the non-U.S. jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group:

i. Will direct NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise to review the materials received from the jurisdiction. Upon completing its review of the evaluation materials, the internal reviewer(s) will report initial findings to the Mutual Recognition of Jurisdictions (E) Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation. Copies of the initial findings may also be made available to the Federal Insurance Office (FIO) and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.

ii. Will issue public notice on the NAIC website inviting public comments with respect to consideration of the jurisdiction as a “Recognize and Accept” Jurisdiction.

iii. Will consider public comments from state regulators, U.S. insurance groups, and any other interested parties.

iv. May review other public materials deemed relevant to making a determination.

v. Will invite each non-U.S. jurisdiction, or its designee, to provide any additional information it deems relevant to making a determination.

vi. Relevant U.S. state and federal authorities will be notified of the Mutual
Recognition of Jurisdictions (E) Working Group’s decision to evaluate a jurisdiction.

(b) **Preliminary Evaluation Report.** NAIC staff will prepare a Preliminary Evaluation Report for review by the Mutual Recognition of Jurisdictions (E) Working Group. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a “Recognize and Accept” Jurisdiction. Upon review by the Working Group, the results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review. At that time, a copy of the Preliminary Evaluation Report will also be shared with the Group Capital Calculation (E) Working Group in regulator-to-regulator session. The Group Capital Calculation (E) Working Group will also be kept advised of any new developments in the evaluation of this jurisdiction.

(c) **Final Evaluation Report.** Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. The Mutual Recognition of Jurisdictions (E) Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session.

(d) **Summary of Findings and Determination.** Upon approval of the Final Evaluation Report, the Mutual Recognition of Jurisdictions (E) Working Group will issue a public statement and a summary of its findings with respect to its determination. At this time, the Working Group will release the Summary of Findings and Determination for public comment. Once the Working Group has finally adopted the Summary of Findings and Determination in open session after opportunity for public comment, it will submit the summary of its findings and its recommendation to the Financial Condition (E) Committee at an open meeting. Upon approval by the Committee, the summary and recommendation will be submitted to the Executive (EX) Committee and Plenary, as well as to the Federal Insurance Office (FIO), United States Trade Representative (USTR) and other relevant federal authorities for informational purposes. Upon approval as a “Recognize and Accept” Jurisdiction by the Executive (EX) Committee and Plenary, the jurisdiction will be added to the NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation.

9. **Evaluation of Reciprocal Jurisdictions.** Under Section 4L(2)(c) of Model #440, Reciprocal Jurisdictions that recognize the U.S. state regulatory approach to group supervision and group capital are exempt from the GCC. Because a “recognize and accept” evaluation by the Mutual Recognition of Jurisdictions (E) Working Group is already part of the Reciprocal Jurisdiction review process, all Reciprocal Jurisdictions designated by the NAIC through that review
process are also automatically designated as “Recognize and Accept” Jurisdictions. Likewise, in accordance with the terms of the EU and UK Covered Agreements, all EU Member States and the UK are automatically designated “Recognize and Accept” Jurisdictions. If there is a material change to the terms of either Covered Agreement, or the United States enters into a new covered agreement with one or more non-U.S. jurisdictions, the Mutual Recognition of Jurisdictions (E) Working Group will rely upon its review and evaluation of the applicable covered agreement, in consultation with FIO and USTR, to determine whether automatic “Recognize and Accept” status is appropriate, or whether it is necessary to conduct a case-by-case review of the jurisdiction or jurisdictions in accordance with Paragraph 10 below. If there is a material change to the terms of the U.S.-EU or U.S.-UK Covered Agreement, or if the United States enters into a new covered agreement with one or more non-U.S. jurisdictions, the Mutual Recognition of Jurisdictions (E) Working Group will consider, and will consult with FIO and USTR regarding, whether and how the applicability of the procedures in this document may apply.


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

(a) The Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination the representations in the written confirmation are true and accurate.

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

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

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

(a) The Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm that, to the best of its determination, the representations in the written confirmation are true and accurate.

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

(c) NAIC staff will work with the Mutual Recognition of Jurisdictions (E) Working Group and the applicant jurisdiction to prepare an acceptable confirmation letter for this purpose.

12. Memorandum of Understanding. Section 21D(2) of Model #450 requires a non-Reciprocal Jurisdiction that “recognizes and accepts” the GCC to provide confirmation by a competent regulatory authority that information regarding insurers, and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner of any U.S.-based insurance group doing business in that jurisdiction, in accordance with a memorandum of understanding or similar document between the commissioner and the jurisdiction.
Acceptable MOUs include, but are not limited to, the International Association of Insurance Supervisors Multilateral Memorandum of Understanding (“IAIS MMoU”) or other multilateral memoranda of understanding coordinated by the NAIC. The Mutual Recognition of Jurisdictions (E) Working Group will review such memoranda of understanding and include an opinion in the Summary of Findings and Determination as to whether the jurisdiction has met this condition to be included on the “Recognize and Accept” List.

(a) The lead state will act as a conduit for information between the “Recognize and Accept” Jurisdiction and other states that have an insurer from that jurisdiction, and will share information with these states consistent with the terms governing the further sharing of information included in the applicable MOU, and pursuant to the NAIC Master Information Sharing and Confidentiality Agreement. The jurisdiction must also confirm in writing that it is willing to permit this lead state to act as the contact for purposes of sharing information concerning all insurers within the group.

(b) If a jurisdiction has not been approved by the IAIS as a signatory to the MMoU, it must either (1) enter into an MOU with the lead state, or (2) enter into an MOU with a state that has agreed to serve as a single point of contact for multiple lead states, similar to the procedure for sharing information under the Process for Evaluating Qualified and Reciprocal Jurisdictions. The MOU must also provide for appropriate confidentiality safeguards with respect to the information shared among the jurisdictions.

(c) The same requirements and procedures will apply to a Reciprocal Jurisdiction that is subject to a case-by-case “recognize and accept” review, unless the necessary information-sharing procedures are already specified in the applicable covered agreement.

13. **Prudential Oversight and Solvency Monitoring.** Section 4L(2)(e) of Model #440 directs a lead state commissioner to require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system based in a “Recognize and Accept” Jurisdiction if, after any necessary consultation with other supervisors or officials, the commissioner deems such a “subgroup” calculation to be appropriate for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. Section 21E(1) of Model #450 provides that to assist with such a determination, the “Recognize and Accept” List will also identify whether a listed jurisdiction requires a group capital filing for any U.S. based insurance group’s operations in that jurisdiction. As part of Paragraph 8, Procedure for Evaluation of Non-U.S. Jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm whether or not any “Recognize and Accept” Jurisdiction requires a subgroup group capital filing for a U.S.-based insurance group’s operations, and a discussion and findings on this review will be included in the Preliminary Evaluation Report, Final
Evaluation Report and Summary of Findings and Determination. If the Working Group has evidence indicating that a jurisdiction requires a subgroup group capital filing for any U.S.-based insurance group’s operations in that jurisdiction, it will attempt to obtain written confirmation of the existence and scope of any such requirement from a competent regulatory authority in that jurisdiction, but it is recognized that such a confirmation is not an essential element of the Working Group’s determination. The NAIC will identify such jurisdictions on the “Recognize and Accept” List, and may include an explanatory note in cases where a simple “Yes” or “No” response does not adequately describe the jurisdiction’s requirements. States may rely on this List when making determinations under Section 4L(2)(e) of Model #440.

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

(a) Upon determination by a lead state commissioner that a non-U.S. jurisdiction no longer meets one or more of the requirements to “recognize and accept” the GCC, the lead state commissioner may provide a recommendation to the Working Group that the jurisdiction be removed from the “Recognize and Accept” List. Upon review and after consultation with the “Recognize and Accept” Jurisdiction, the Working Group may remove the jurisdiction from the List, which must then be confirmed by the Financial Condition (E) Committee and the NAIC Executive (EX) Committee and Plenary.

(b) Upon determination by a lead state commissioner that a non-U.S. jurisdiction requires a group capital filing for any U.S. based insurance group’s operations in a non-U.S. jurisdiction, the lead state commissioner may provide a recommendation to the Working Group that the non-U.S. jurisdiction be identified as such on the “Recognize and Accept” List. Upon receipt of any such notice, the Mutual Recognition of Jurisdictions (E) Working Group will also consider whether it is necessary to re-evaluate the jurisdiction’s “Recognize and Accept” status.

(c) The Mutual Recognition of Jurisdictions (E) Working Group will also give due consideration to any notice from a U.S.-based insurance group that it has been required to perform a group capital calculation, at either the group-wide or subgroup level, in a jurisdiction on the “Recognize and Accept” List.
(d) If a jurisdiction referred for re-evaluation under this Paragraph is a Reciprocal Jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group shall conduct a concurrent review of the jurisdiction’s continuing status as a Reciprocal Jurisdiction, or, in the case of a jurisdiction entitled to that status by virtue of a covered agreement, shall refer the matter to the Reinsurance (E) Task Force for further discussion and communication with appropriate federal and/or international authorities, in accordance with the Process for Evaluating Qualified and Reciprocal Jurisdictions.

Appendix: Letter Templates

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

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

As the competent regulatory authority for [non-U.S. Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories the following:

- [Non-U.S. Jurisdiction] recognizes the U.S. state regulatory approach to group supervision and group capital, and confirms that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction;
• Information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to a lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and [non-U.S. Jurisdiction], including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.

• [Non-U.S. Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

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

As the competent regulatory authority and lead insurance regulatory supervisor for [non-U.S. Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories, with a copy to the International Association of Insurance Supervisors (IAIS), the following:

• [Non-U.S. Jurisdiction] recognizes the Group Capital Calculation as defined under Section 4L(2) of the NAIC Insurance Holding Company System Regulatory Act (#440) as an acceptable international capital standard.

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

• [Non-U.S. Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

C. Jurisdictions with Subgroup Capital Requirements. Paragraph 13 of the Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation provides that the Mutual Recognition of Jurisdictions (E) Working Group will attempt to obtain written confirmation from a competent regulatory authority in any jurisdiction where the Working Group has evidence indicating that the jurisdiction requires a subgroup group capital filing for any U.S. based insurance group’s operations in that jurisdiction. The NAIC will identify such
jurisdictions on the “Recognize and Accept” List, and will provide an explanation and discussion on such determination in its Summary of Findings and Determination. States may rely on this List when making determinations under Section 4L(2)(e) of Model #440.
The NAIC/AICPA (E) Working Group of the Financial Condition (E) Committee met Sept. 13, 2021. The following Working Group members participated: Doug Stolte, Chair (VA); Laura Clements (CA); Rylynn Brown (DE); Kevin Clark (IA); Judy Weaver (MI); Shannon Schmoeger (MO); Lindsay Crawford (NE); Doug Bartlett (NH); Dale Bruggeman (OH); Melissa Greiner and Kimberly Rankin (PA); Johanna Nickelson (SD); and Weimei Ye (UT).

1. **Discussed the Model #205 Premium Threshold**

   Mr. Stolte said the Working Group is responsible for reviewing the $500 million annual premium threshold contained within the *Annual Financial Reporting Model Regulation (#205)* on an annual basis. Bruce Jenson (NAIC) gave an update on the results of the annual review, noting that as of Dec. 31, 2020, 92.6% of all direct written premiums and 94.1% of all gross written premiums would be subject to internal control reporting requirements. Mr. Stolte noted that these results were within the Working Group’s expectations, and no action to adjust the threshold was deemed necessary at this time.

2. **Heard an Update on Recent Auditing Pronouncements**

   Jean Connolly (PricewaterhouseCoopers—PwC) provided an overview of recent auditing pronouncements affecting statutory audit reports. She stated that the AICPA Auditing Standards Board issued *Statement on Auditing Standards (SAS) No. 139—Amendments to AU-C Sections 800, 805, and 810 to Incorporate Auditor Reporting Changes From SAS No. 134*, which incorporates the new auditor reporting language in SAS No. 134—*Auditor Reporting and Amendments; Including Amendments Addressing Disclosures in the Audit of Financial Statements* for statements prepared following special purpose frameworks. The changes are intended to enhance the communicative value and relevance of the auditor’s report and to be more consistent with the standards of the International Auditing and Assurance Standards Board (IAASB) and recent updates to Public Company Accounting Oversight Board (PCAOB) standards. The original effective date was deferred a year for the pandemic and is now effective for periods ending on or after Dec. 15, 2021.

   Ms. Connolly stated that the call materials provided an example of the revised auditor report drafted by the AICPA (Attachment Five-A). The application of SAS No. 139 results in changes to the format and enhanced information added to the auditor report. The opinion section of the report is now required to be presented first, followed by a section outlining the basis for the opinion. This section will not include a statement that the auditor is required to be independent of the entity and meet the auditor’s other ethical responsibilities, in accordance with the relevant ethical requirements relating to the audit.

   In addition, Ms. Connolly stated that the revised report includes enhanced auditor reporting relating to the company’s ability to continue as a going concern, including a description of the respective responsibilities of management when required by the applicable financial reporting framework, and the auditor for going concern considerations. The revised report also includes an expanded description of the auditor’s responsibilities, including the auditor’s responsibilities relating to professional judgment and professional skepticism, and the auditor’s communications with those charged with governance. Ms. Connolly stated that the auditors' responsibilities have not changed under SAS No. 139, but auditors will now be required to communicate those responsibilities in more detail.

   Ms. Connolly stated that the example report included in the materials is a general use report, but some certified public accountant (CPA) firms issue restricted use reports for insurance company statutory financial statements. These reports will look very similar to the example provided, except there will be no opinion on conformity with U.S. generally accepted accounting principles (GAAP), and the financial statements may not be suitable for purposes other than for use by the state insurance regulator.

   In addition to the SAS No. 139 changes, Ms. Connolly noted that other new auditing standards have recently been adopted; i.e., *SAS No. 142—Audit Evidence, SAS No. 143—Auditing Accounting Estimates and Related Disclosures*, and SAS No. 144—*Amendments to AU-C Sections 501, 540, and 620 Related to the Use of Specialists and the Use of Pricing Information Obtained From External Information Sources*. However, they will not be applied until audits as of Dec. 31, 2022, or Dec. 31, 2023.

   Mr. Stolte thanked Ms. Connolly for her overview of the new standards.

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3. **Heard an Update on the Results of 2020 Reserve Data Training**

Mr. Stolte said the next agenda item is to hear an update on the results and takeaways from a joint project between the NAIC and the AICPA on reserve data training for state insurance regulators that was conducted in 2020. Mr. Jenson stated that AICPA firm representatives prepared and presented two different two-hour webinars on testing the completeness and accuracy of underlying loss reserve data to financial regulators in September 2020. More than 300 regulators participated in each session, with the training being very well received and highly rated. Mr. Jenson stated that NAIC staff have since been working to incorporate lessons learned from the training into the development of updated guidance for the NAIC’s *Financial Condition Examiners Handbook* (Handbook).

Bailey Henning (NAIC) stated that proposed revisions to the Handbook include the development of additional procedures for inclusion in the reserving and underwriting repositories, with an emphasis on additional analytical procedures and communication with the examination actuary in determining the testing to be performed in this area. She stated that the proposed revisions will be presented to the Financial Examiners Handbook (E) Technical Group on its next call before being exposed for a public comment period.

Mr. Stolte thanked the AICPA firm representatives for preparing and presenting the training, and he encouraged Working Group members to follow the efforts of the Technical Group on this project.

4. **Discussed Other Matters**

Mr. Stolte stated that earlier this year, the Working Group conducted an e-vote to adopt updates to the NAIC’s *Model Audit Rule Implementation Guide* (Implementation Guide) to encourage audit firms to provide information on the engagement partner in the annual “Communication of Internal Control Related Matters Noted in an Audit” letter. The intent behind collecting information on the engagement partner in this letter is to assist state insurance regulators in monitoring compliance with auditor qualifications and rotation requirements. Mr. Stolte stated that this information will be expected to be included in internal control letters filed in support of the Dec. 31, 2021, annual audit period, so he encouraged states to ensure that their domestic insurers and external auditors are aware of this new expectation. He stated that the updated guidance has been included in the Implementation Guide available on the NAIC website, and it will also be included in the printed version of the NAIC’s *Accounting Practices and Procedures Manual* (AP&P Manual) next year. In addition, he stated that the new guidance has been incorporated into the AICPA’s Insurance Audit Guides and its internal control letter templates.

Having no further business, the NAIC/AICPA (E) Working Group adjourned.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/Fall 2021/Cmte/E/AICPA/9-13-21 AICPAWGmin.docx
AICPA Update – September 2021

Revised Auditors Reports

Statement on Auditing Standards (SAS) No. 139, Amendments to AU-C Sections 800, 805, and 810 to Incorporate Auditor Reporting Changes From SAS No. 134, was issued in March 2020 by the AICPA Auditing Standards Board (ASB). The effective date had been deferred a year for the pandemic and is now effective for periods ending on or after December 15, 2021 (effective for 2021 audits).

SAS No. 139 updates the form and content of auditors’ reports addressed in the AU-C 800 series to be more consistent with the standards of the International Auditing and Assurance Standards Board and recent updates to PCAOB standards.

Below is an illustrative example of an auditor’s report on statutory financial statements intended for general use in accordance with the new GAAS requirements (similar revisions are required for restricted use reports):

Independent Auditor’s Report

[Appropriate Addressee]

Report on the Audit of the Financial Statements

Opinions

We have audited the statutory financial statements of ABC Insurance Company, which comprise the statutory statements of admitted assets, liabilities, and surplus of ABC Insurance Company as of December 31, 20X2 and 20X1, and the related statutory statements of income and changes in surplus, and cash flows for the years then ended, and the related notes to the financial statements.

Unmodified Opinion on Regulatory Basis of Accounting

In our opinion, the accompanying financial statements present fairly, in all material respects, the admitted assets, liabilities, and surplus of ABC Insurance Company as of December 31, 20X2 and 20X1, and the results of its operations and its cash flows thereof for the years then ended in accordance with the basis of accounting described in Note X.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles section of our report, the financial statements do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of ABC Insurance Company as of December 31, 20X2 and 20X1, or the results of its operations or its cash flows thereof for the years then ended.

Basis for Opinions

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor’s
Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of ABC Insurance Company, and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note X of the financial statements, the financial statements are prepared using accounting practices prescribed or permitted by the Insurance Department of the State of [State of domicile], which is a basis of accounting other than accounting principles generally accepted in the United States of America. The effects on the financial statements of the variances between these statutory accounting practices described in Note X and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material and pervasive.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the Insurance Department of the State of [State of domicile]. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about ABC Insurance Company’s ability to continue as a going concern for one year after the date that the financial statements are issued.

Auditor’s Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor’s report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of ABC Insurance Company’s internal control. Accordingly, no such opinion is expressed.
• Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

• Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about ABC Insurance Company’s ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

[Signature of the auditor’s firm]

[Auditor’s city and state]

[Date of the auditor’s report]

As a comparison below is a similar illustrative example of an auditor’s report on statutory financial statements intended for general use in accordance with the GAAS requirements prior to adoption of SAS No. 139:

Independent Auditor’s Report

[Appropriate Addressee]

Report on the Financial Statements

We have audited the accompanying statutory financial statements of ABC Insurance Company, which comprise the statutory statements of admitted assets, liabilities, and surplus of ABC Insurance Company as of December 31, 20X2 and 20X1, and the related statutory statements of income and changes in surplus, and cash flow for the years then ended, and the related notes to the financial statements.

Management’s Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the accounting practices prescribed or permitted by the Insurance Department of the State of [State of domicile]. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor’s Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor’s judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making
those risk assessments, the auditor considers internal control relevant to the entity’s preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity’s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note X to the financial statements, the ABC Insurance Company prepared these financial statements using accounting practices prescribed or permitted by the Insurance Department of the State of [State of domicile], which is a basis of accounting other than accounting principles generally accepted in the United States of America.

The effects on the financial statements of the variances between these statutory accounting practices and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the "Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles" paragraph, the financial statements referred to above do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of ABC Insurance Company as of December 31, 20X2 and 20X1, or the results of its operations or its cash flows thereof for the year then ended.

Opinion on Regulatory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, and surplus of ABC Insurance Company as of December 31, 20X2 and 20X1, and the results of its operations and its cash flows for the years then ended, on the basis of accounting described in Note X.

[Auditor’s signature]

[Auditor’s city and state]

[Date of the auditor’s report]

New Statements on Auditing Standards:

- **SAS No. 144, Amendments to AU-C Sections 501, 540, and 620 Related to the Use of Specialists and the Use of Pricing Information Obtained From External Information Sources**, is effective for audits of financial statements for periods ending on or after June 15, 2023. Early implementation is permitted.

The amendments include revisions to various application paragraphs in AU-C section 620 to enhance the guidance related to using the work of an auditor’s specialist.
• **SAS No. 143, Auditing Accounting Estimates and Related Disclosures**, is effective for audits of financial statements for periods ending on or after Dec. 15, 2023.

SAS No. 143 addresses the auditor’s responsibilities relating to accounting estimates, including fair value accounting estimates, and related disclosures in an audit of financial statements. This standard enables auditors to appropriately address the increasingly complex scenarios that arise from new accounting standards that include estimates.

• **SAS No. 142, Audit Evidence**, is effective for periods ending on or after December 15, 2022.

SAS No. 142 explains what constitutes audit evidence in an audit of financial statements and sets out attributes of information that are considered by the auditor when evaluating information to be used as audit evidence. Taking these attributes into account assists the auditor in maintaining professional skepticism.

The revisions to SAS No. 142 address the evolving nature of transacting business as well as the evolution of audit services. Issues addressed include use of emerging technologies and techniques by both preparers and auditors, the application of professional skepticism, the expanding use of external information sources to provide audit evidence, and more broadly, the relevance and reliability of audit evidence.
The National Treatment and Coordination (E) Working Group of the Financial Condition (E) Committee met Dec. 1, 2021. The following Working Group members participated: Debbie Doggett, Co-Chair (MO); Linda Johnson, Co-Chair (WY); Cindy Hathaway (CO); Alan Sundell (CT); Carolyn Morgan and Alison Sterett (FL); Stewart Guerin and Mike Boutwell (LA); Kari Leonard (MT); Cameron Piatt (OH); Greg Lathrop (OR); Karen Feather and Kimberly Rankin (PA); Amy Garcia (TX); Jay Sueoka (UT); Ron Pastuch (WA); and Amy Malm (WI). Also participating were: Kim Cross (IA); and Kristin Hynes (MI).

1. **Adopted its Sept. 29 Minutes**

Ms. Johnson said the Working Group met Sept. 29 and took the following action; 1) discussed its 2022 proposed charges; 2) adopted proposal 2021-06 (Request for Disclaimer); 3) received a referral from the Financial Analysis (E) Working Group; 4) discussed Form A guidance on shell company acquisitions; and 5) discussed non-domiciliary state notifications of dissolution or mergers. She asked if there were any corrections or edits to the Sept, 29 minutes.

Ms. Malm made a motion, seconded by Mr. Sueoka, to adopt the Working Group’s Sept. 29 minutes (Attachment Six-A).

2. **Exposed Proposal 2021-07 (Application Instructions regarding Company Responses)**

Ms. Sterett said that during an informal meeting of state insurance regulators, she asked if states had procedures in place on a specific time frame, did they wait for a company’s response to a pending application. Most states agreed that 30 days was ample time to wait for a response from the company before they considered the application closed and notified the company. Specific wording was drafted for the application instructions.

Ms. Johnson said that proposal 2021-07 will be exposed for a 45-day public comment period ending Jan. 14, 2022.

3. **Exposed Proposal 2021-08 (Voluntary Dissolution Best Practices)**

Ms. Johnson said that the purpose of the voluntary dissolution in the *Company Licensing Best Practices Handbook* (Best Practices) was due to a recent discussion by state insurance regulators who were not aware that this form and instructions were available. The Best Practices provides guidance for those states that do not have practices in place. She suggested that the Working Group consider exposing the Best Practices now or the Working Group can wait until the electronic application is developed. Mr. Boutwell asked what the status of the electronic application was. Jane Barr (NAIC) said that the project should begin early next year, with the release of the domestic applications beginning third quarter to the end of the year for the corporate amendments. She added that this proposal only inserts instructions for the voluntary dissolution application, because it was never included when the form was created six years ago. Once all the application are in electronic format, the Working Group will consider revising the entire document to include the review of electronic submissions.

Ms. Johnson said that Wyoming does not have many voluntary dissolutions. Mr. Boutwell said that Louisiana may have had three in 30 years and did not have a burning need. Ms. Barr said that this proposal is inserting this application in the Best Practices. She said instructions and forms have been posted on the Uniform Certification of Authority Application (UCAA) website for several years. Ms. Rankin thought it would be beneficial to at least put something in the Best Practices to bring attention to the form for those states that might not know it is available.

Mr. Lathrop said that Oregon built their own procedures because they did not know there were instructions and forms already in existence, although they have all been single state insurers. Ms. Hynes said that she has seen where companies have surrendered their certificate of authority in their domestic states and are just now coming to the foreign states to withdraw. She added that in the previous company licensing regulator forum call several states had voiced the same concern. She said for an application that is not used frequently, the Best Practices would be an appropriate reminder to the states. Ms. Malm said that Wisconsin experienced the same issue this past summer, where the domestic state allowed the company to dissolve, and Wisconsin was waiting for a filing and was not aware the company dissolved.
Hearing no objections, the Working Group agreed to expose proposal 2021-08 for a 45-day public comment period ending Jan. 14, 2022.

4. Discussed Shell Acquisitions

Ms. Doggett said the purpose of this guidance was due primarily to companies being purchased out of receivership or liquidation with the assets/license being separated from the liabilities. She said that most licensing regulators may not be the ones reviewing the Form A, but the licensing staff would be reviewing the transactions after it comes out of receivership. Ms. Garcia said that Texas has received two companies being purchased at a receivership, and both filed a Form A just like any other acquisition. Once the receivership has court approval of the sale, the application process is like any other Form A. Ms. Malm said that Wisconsin has a company being purchased out of rehabilitation that will also follow the Form A process. Ms. Doggett said that the proposal provides instructions for the domestic state but agreed that instruction for the non-domestic state may be beneficial. She added that there are considerations to be made with the separation of assets and liabilities and whether the company code stays with the assets versus the corporate existence. Mr. Boutwell asked if this fell under the purview of company licensing or receiverships/uniform liquidation proceedings or perhaps a joint effort between the two areas. Ms. Doggett agreed. Ms. Cross said the guidance may add more confusion. Ms. Barr clarified that the purpose of the guidance is to provide some consistency between states on the sale of a liquidated company’s assets and ensure that the NAIC company code remain with the assets for historical purposes and license reinstatement purposes with foreign states. She said she also checked the Receiver’s Handbook for Insurance Company Insolvencies (Receiver’s Handbook) and found no additional guidance. Ms. Cross said that Iowa has a statutory process for companies in liquidation versus a company that does run-off of the liabilities and is selling the licenses.

Ms. Doggett asked if it is easier to reinstate a license if the company code remains with the assets. Ms. Barr reminded the Working Group of an acquisition from several years ago that the Working Group oversaw because the assets were sold and the code remained with the liabilities. Before the foreign licenses were reinstated, the company changed its name, and it caused a lot of confusion with the non-domestic states when they did not recognize the company name or company code. This past summer, several of these transactions were taking place, and NAIC staff thought that there should be a process in place to provide consistency and avoid confusion with the states when they receive their filings for these transactions. Ms. Feather said that it is also confusing with a company has been liquidated and then the same company codes are reactivated. She added that this may be the way of the future, when liquidators are trying to find value in any of the assets by selling the licenses. Ms. Cross agreed. She added that Iowa added a statute to their liquidation process that enables the court to essentially cleanse the shells and to sell without the liabilities. She said she believes that many states may have this statute. Mr. Boutwell said that in the 1990s Louisiana, had done this quite often. He added that it is difficult to set a standard when it is determined by the courts. He said Louisiana looks at the application in its entirety, and justification for lifting the suspension depends on circumstances of how it happened, money going in or out, new players involved, lines of business being written, etc. Ms. Doggett said that before moving forward, the Working Group should discuss with the receivership groups to encourage consistency. She said she believes in keeping the NAIC company code with the organizational existence of the company so that the foreign states can reactivate the licenses if approved. Mr. Piatt said that for a company that had an order against it before it went into receivership, the order does not go away when a company comes out of receivership, unless it specially asks to have the order removed. Ohio has a specific process for the removal of an order. Mr. Piatt said that he would like to know how the Receiver’s Handbook (E) Subgroup would handle that. Ms. Feather concurred. She said keeping the NAIC company code is beneficial to the liquidators. Therefore, they should have a process in place, and the licensing side should treat these like any other Form A.

Ms. Doggett asked Ms. Barr to set up a meeting with the Receivership (E) Working Group for further discussion.

5. Discussed Other Matters

Ms. Barr said that the next phase of the primary and redomestication application is to discuss and determine the electronic process. She asked any state that would like to participate on the electronic workflow discussion to contact her, and she will forward the meeting notice for the ad hoc discussion on Dec. 13. She also added that this time last year, a statewide survey was distributed asking for state-specific requirements, and three states did not respond. All state-specific requirements will be added to the electronic application. Any requirement received after the start of the project will have to be added sometime later as an enhancement once the application is in production.

The next Working Group meeting is tentatively set for January 2022.

Having no further business, the National Treatment and Coordination (E) Working Group adjourned.
The National Treatment and Coordination (E) Working Group of the Financial Condition (E) Committee met Sept. 29, 2021. The following Working Group members participated: Debbie Doggett, Co-Chair (MO); Linda Johnson, Co-Chair (WY); Joan Nakano and William Mitchell (CT); Alisa Pritchard (DE); Carolyn Morgan (FL); Stewart Guerin and Mike Boutwell (LA); Kari Leonard (MT); Cameron Piatt (OH); Karen Feather (PA); Amy Garcia (TX); Jay Sueoka (UT); Ron Pastuch (WA); and Amy Malm (WI). Also participating were: Kim Cross (IA); and Kristin Hynes (MI).

1. Discussed its 2022 Draft Charges

Ms. Doggett stated that the draft 2022 charges will be adopted by the Financial Condition (E) Committee. She asked if there were any modifications or changes. Hearing none, the charges will be adopted by the Committee.

2. Adopted Proposal 2021-06 (Request for Disclaimer)

Ms. Johnson said the request for disclaimer proposal (Form 9) was exposed for a 45-day public comment period ending Sept. 24, and no comments were received. The purpose of this proposal is to provide a uniform option for individuals requesting a disclaimer for affiliation or control of the applicant company when a biographical affidavit is required to be filed with the department of insurance (DOI).

Ms. Doggett suggested clarifying language regarding item 3, “material relationship,” by adding a parenthetical, “(including but not limited to any contracts between the person and the subject or any affiliate of the person and the subject).”

Ms. Cross asked about the intent of Form 9 and whether it is just a starting point and in no way limits the state from requesting additional information. Ms. Johnson concurred that this is just a uniform process to initiate the request and in no way precludes the state from requesting additional information.

Mr. Piatt made a motion, seconded by Mr. Pastuch, to adopt proposal 2021-06 (Attachment Six-A1) with suggested wording as a friendly amendment with no additional exposure period. The motion passed unanimously.

Ms. Johnson noted that the proposal’s effective date will coincide with the release of the new electronic applications.

3. Received a Referral from the Financial Analysis (E) Working Group

Ms. Johnson summarized the referral; it is requesting an addition to the Form A database to inform state insurance regulators regarding when private equity firms are acquiring ownership of an insurer and to assist in maintaining a record of private equity-owned insurers. She said the referral includes specific guidance regarding the information that should be obtained.

Ms. Johnson suggested that this referral be sent to the Form A Database Ad Hoc Group as part of the rewrite project. An alternative would be to let the National Treatment and Coordination (E) Working Group discuss this first before referring it to the ad hoc group. Mr. Piatt asked if private equity is a defined term or subject to interpretation. Ms. Doggett concurred that private equity could be subject to interpretation; although, she noted that the referral includes a suggested definition of private equity as “an alternative form of private financing, typically away from public markets, in which funds and/or investors directly invest in companies or engage in buyouts of such companies. Private equity firms can typically be classified as venture capital, mezzanine, private credit, and leveraged buyout (LBO) funds, and they are generally structured as partnerships with several limited partner investors. The companies they invest in may be deemed portfolio companies, which may include insurance companies. The companies may also be held on the firm's balance sheet as a strategic investment.” She added that this definition is what the ad hoc group should focus on. Ms. Johnson asked any DOI that has experts in private equity or investment specialists who would be interested in assisting the ad hoc group with the rewrite to contact Jane Barr (NAIC). Ms. Cross said she and Iowa’s investment specialist would be interested in assisting.

Hearing no objections, the referral will be sent to the Form A Database Ad Hoc Group for incorporation into the new electronic application.
4. Discussed Form A Guidance or an FAQ Document

Ms. Doggett said Form A guidance was discussed during a regulator-only forum call when discussing shell company acquisitions, including companies that have gone into liquidation and are sold separate from the liabilities. Since there was no interest in forming an ad hoc drafting group to develop guidance or a frequently asked questions (FAQ) document, the Working Group can continue discussion. Ms. Doggett said procedures should be developed not only with the Form A process, but also with retaining the NAIC company code, even if the name and organizational structure may change post-acquisition. She said this guidance should also include companies in liquidation and companies that may have their licenses suspended and revoked so acquiring parties know what application forms should be provided to the state for each scenario. She also said the Receivership Financial Analysis (E) Working Group should also be involved with this development or at least provide its input.

5. Discussed Non-Domiciliary State Notification of Dissolution or Mergers

Ms. Hynes summarized her email by stating that over the past few years, there have been situations that arose with the timing of notifications when a company has been dissolved are provided after the fact. A specific example is when a life company dissolved and its liabilities were transferred to a fraternal company, which raised questions about whether notifications were required, if they were sent to Michigan policyholders, and what impact that might have on guaranty fund coverage for policies originally written by a life insurance company. Ms. Hynes said a more recent example includes a situation where a licensed company was going to surrender its certificate of authority and transfer its liabilities to a company not licensed in Michigan. Michigan code is very specific regarding the transfer of liabilities. Ms. Hynes asked if there was a way to have notifications go out in advance of a dissolution to avoid last minute filings to the states where the company is licensed. Mr. Piatt said Ohio has also experienced similar situations. Ohio has a surrender process, but when the company notified the state, it was already dissolved, so it causes difficulties to have a licensed entity that does not exist.

Ms. Johnson asked if states are aware of Forms 16 and 17 on the Uniform Certificate of Authority Application (UCAA) website regarding the statement of voluntary dissolution and withdrawal, respectively. Form 16 is filed in paper with the domiciliary state tracking the state’s license status in non-domestic states to help the domiciliary state determine how outstanding liabilities are handled in foreign states. Ms. Johnson asked if states are utilizing Form 16 or requiring this form. She said with the implementation of the electronic applications for domestic companies, it will be easier to track and provide notifications to the foreign states. Ms. Doggett said because this is a paper filing now, it would be an easy fix to add an additional column to identify which state received a Form 17 filing. She added that it may be an educational notice to the states that may not be aware that these forms are available to the company to use and file. Ms. Johnson asked if a state survey should be sent asking how each state handles dissolutions. Ms. Hynes said the states she has had conversations with are not on this call, so state-wide notification may be beneficial. Mr. Piatt thought maybe it is the companies that should be educated, so they know what they should file and when those filings should be submitted; it becomes an issue when fees are due to the non-domestic state, even if the company dissolved in its domiciliary state without filing in the foreign state first. He added that the domiciliary state also did not notify the foreign states of this dissolution; if the company would have filed Form 16, the domestic state would see that no notifications/filings were filed with the foreign states and there would be outstanding liabilities. Ms. Doggett agreed that it is an educational issue for both the states and industry. Ms. Johnson suggested that a state chart for dissolution requirements be added to the UCAA website. Crystal Brown (NAIC) said there is a state chart regarding Form 17 requirements for withdrawal/surrender of the certificate of authority in the foreign states. She also said she would talk with Ms. Barr about whether a survey or any additions to the existing state chart would be helpful. Ms. Johnson added that this issue can be followed up on during a call in November. Ms. Feather asked if there could be an educational course provided by the NAIC on the process for when an insurance company ends. She said she recently replaced Cressinda Bybee, who retired after 35 years of service, and would like some training on this process. Ms. Brown said the Working Group has developed two online courses, and if they want, NAIC staff can move forward with additional online courses in the future.

The next Working Group meeting is tentatively set for November.

Having no further business, the National Treatment and Coordination (E) Working Group adjourned.

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National Treatment and Coordination (E) Working Group
Company Licensing Proposal Form

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<td>CONTACT PERSON: Jane Barr</td>
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IDENTIFICATION OF SOURCE AND FORM(S)/INSTRUCTIONS TO BE CHANGED

[X ] UCAA Forms  [ ] UCAA Instructions  [ ] Enhancement to the Electronic Application Process
[ ] Company Licensing Best Practices HB

Forms:
[ ] Form 1 – Checklist  [ ] Form 2 – Application  [ ] Form 3 – Lines of Business
[ ] Form 6 – Certificate of Compliance  [ ] Form 7 – Certificate of Deposit  [ ] Form 8 – Questionnaire
[ ] Form 8C- Corporate Amendment Questionnaire  [ ] Form 11 – Biographical Affidavit  [ ] Form 12 – Uniform Consent to Service of Process
[ ] Form 13 – ProForma  [ ] Form 14 – Change of Address/Contact Notification
[ ] Form 15 – Affidavit of Lost C of A  [ ] Form 16 – Voluntary Dissolution  [ ] Form 17 – Statement of Withdrawal

DESCRIPTION OF CHANGE(S)
A uniform template to be used when requesting disclaimer of affiliation or control for UCAA filings where a biographical affidavit is required. NAIC staff suggest identifying this form as Form 9.

REASON OR JUSTIFICATION FOR CHANGE **
State responses from a recent survey indicated the need for a uniform template for disclaimer requests.

Additional Staff Comments:

** This section must be completed on all forms. Revised 01-2019
Request for Disclaimer of Affiliation or Control of An Individual

Applicant Company Name:________________________________________________________

Group Code (If Applicable): ______

Name:
Title/Position:
1. Provide the number of authorized, issued, and outstanding voting securities of the subject.
2. Provide the number and percentage of shares of the subject's voting securities, which are held of record or known to be beneficially owned, and the number of shares concerning which there is a right to acquire, directly or indirectly.
3. Provide all material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person.
4. Provide an explanation stating why the person should not be considered to control the subject.

I hereby certify, under penalty of perjury, that all of the information, including the attachments, submitted in this request for disclaimer is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this request for disclaimer is grounds for license discipline or other administrative action and may subject me or the Applicant Company, or both, to civil or criminal penalties.

I acknowledge that I am familiar with the insurance laws and regulations of said state, accept the Constitution of such state, in which the Applicant Company is licensed or to which the Applicant Company is applying for licensure.

(eSignature)________________________ (Date)________________
County of ____________
State of ____________

The foregoing instrument was acknowledged before me by means of □ physical presence or □ online notarization, this _____ day of ________, 20______ by ________________, and: □ who is personally known to me, or □ who produced the following identification: ________________________.

[SEAL]

Notary Public

__________________________
Printed Notary Name

__________________________
My Commission Expires

UCAA Form 9
The Restructuring Mechanisms (E) Working Group of the Financial Condition (E) Committee met Dec. 6, 2021. The following Working Group members participated: Elizabeth Kelleher Dwyer, Co-Chair (RI); Glen Mulready, Co-Chair (OK); Jared Kosky (CT); Kevin Fry and Shannon Whalen (IL); Judy Weaver (MI); Fred Andersen (MN); John Rehagen (MO); Lindsay Crawford (NE); My Chi To and Bob Kasinow (NY); Melissa Greiner and Kimberly Rankin (PA); Daniel Morris (SC); Amy Garcia (TX); David Provost (VT); Scott A. White and Thomas J. Sanford (VA); Steve Drutz (WA); and Amy Malm and Richard Wicka (WI). Also participating was: Robert Wake (ME).

1. Considered Written Comments Received on the Co-Chair Exposed Draft White Paper

Superintendent Dwyer described the development and release of the co-chair draft white paper as distributed for the meeting. She stated the purpose of the meeting is to listen to a summary of the comments received (Attachment Seven-A).

   a. NWCRA

Gerald Chiddick (National Workers Compensation Reinsurance Association—NWCRA) stated his organization’s comments are primarily focused on the role the association plays in the residual markets and the need for the association to be notified in advance of any proposed transactions. He said ultimately a failure to notify the association could result in unpaid obligations. Mr. Chiddick referenced his comments and noted he is prepared to answer any questions members had on the comments. The comments emphasize the need for a regulator to be certain that the review process has specifically identified what residual market obligations may be affected by the proposed restructuring, which can be done through outreach to the National Workers Compensation Reinsurance Pooling (NWCRP) mechanism. The insurer should be able to provide information on the existence of such obligations, and the regulator can ascertain with the NWCRP that the reported obligations are accurately stated. The regulator can then ascertain that they are included in the transaction and that those are transferred, both legally and administratively, to the transferee.

   b. NOLHGA and NCIGF

Barbara Cox (National Conference of Insurance Guaranty Funds—NCIGF) stated their comments are neither in favor of nor opposed to the restructuring mechanisms in the white paper, but their concern is continuation of guaranty fund coverage. She stated one request they had was that change to the NAIC guaranty fund model be taken up as soon as possible, for which they had developed specific language changes. Superintendent Dwyer indicated she would check with NAIC staff and the process to determine what the next steps would be. Bill O’Sullivan (National Organization of Life and Health Insurance Guaranty Associations—NOLHGA) stated his only additional comment was the process for assuring coverage was different for life and health insurers and that the comment letter has specific discussion on that topic. Both Ms. Cox and Mr. O’Sullivan stated their appreciation for recognizing within the white paper the importance of ensuring that the guaranty fund association/fund protection a policyholder would have had prior to a restructuring transaction is preserved when the transaction is consummated. They noted that they propose specific changes to the draft white paper to help clarify differences between systems and lines of businesses.

   c. Protucket

Robert A. Romano (Locke Lord), representing Protucket Insurance Company, discussed their extensive experience with United Kingdom (UK) Financial Services and Markets Act 2000 (FSMA) Part VII transactions and encouraged the Working Group to act on their recommendations as quickly as possible. The written comments provided a listing of a significant number of items for the NAIC to complete in order to pave the way for these transactions to occur. This includes, but is not limited to, financial standards to apply to such transactions, considering intra-group versus third-party transactions, supplemental tools, reformulation of risk-based capital (RBC), study of distinctions by line of business, guaranty association coverage, application of assumption reinsurance laws, and the addition of accounting for protected cells into the white paper.
d. Joint Parties

Douglas Wheeler (New York Life Insurance Company) summarized the joint comments from New York Life Insurance Company, Western & Southern Financial Group, Northwestern Mutual, and Massachusetts Mutual Life Insurance Company (MassMutual) (joint parties). Those comments highlighted that in a situation that substitutes a new insurer for the client’s chosen insurer, without consent, is a significant event that needs to be approached with great respect and with the best interests of policyholders in mind. The comments also emphasized their belief that national accreditation standards must be developed that substantially incorporate at a minimum the UK Part VII robust regulatory and court review process. Also discussed was the need for the white paper to discuss the potential adverse consequences to policyholders of the long duration of products. Finally, the comments urge the white paper to specifically state that long-term care insurance (LTCI) should not be eligible for a corporate division or insurance business transfer (IBT).

e. Swiss Re

Matthew Wulf (Swiss Reinsurance Company—Swiss Re) stated Swiss Re’s support for a white paper that can serve as a first step as a basis for continuing discussions about the issues and that the NAIC develop any guidance necessary to meet solvency and consumer protection objectives. He suggested the use of ad hoc groups to help bring the resources needed to complete the NAIC’s work. His comments also identified a number of specific matters related to financial standards, guaranty funds, statutory minimum requirements, and licensure.

f. ACLI

Wayne Mehlman (American Council of Life Insurers—ACLI) summarized the comments of the ACLI. The comments were focused on the principles of the ACLI that they believe are an important guardrail before a corporate division transaction or IBT transaction can be approved by a state insurance regulator. The comments also included a number of suggestions and edits. Commissioner Mulready asked for clarification on the principle that expects solvency from the transferring party. Mr. Mehlman responded the ACLI believes it would otherwise lead to problems. Superintendent Dwyer questioned if what was meant was that no insolvency should be created as a result of the transaction. Mr. Mehlman responded affirmatively.

g. Commissioner White

Commissioner White stated his appreciation for the co-chairs’ draft in identifying all of the important issues. He stated they had some recent experience with a transaction, which was the basis for some of their comments. Mr. Sanford summarized the comments, including that a request for the white paper to include a discussion of anti-notation statues since they will influence different sections in the white paper. Commissioner White summarized some of the provisions on Virginia’s anti-notation statutes and the effect they have on the white paper. He said more than 10 states with such laws are affected by such laws, and he discussed how laws would interact with each other. Mr. Kosky asked if the Virginia law was specific to IBTs. Mr. Sanford indicated their guidance was specific to IBTs now but how the general principles would apply to other restructuring transactions. Commissioner Mulready asked if the Virginia law was specific to reinsurance transactions only. Mr. Sanford responded that it is broader and applies to all notations.

h. Enstar

James Mills (Enstar) noted how two transactions had now been approved specific to IBTs and noted how the National Council of Insurance Legislators (NCOIL) had created a model law for both IBTs and corporate divisions, therefore emphasizing the need for guidance to be developed. The Enstar comments are focused on two key issues: 1) differentiating between active runoff management insurers, active insurers that also hold business in runoff, and companies that have transitioned from active insuring to managing their own runoff; and 2) the importance of state licensing on companies looking to aggregate runoff business into a single company. The request was made to take these issues up in the future.

i. PwC

Luann Petrellis (PricewaterhouseCoopers—PwC) summarized her comments, which emphasize how a recent transaction in Illinois provides a good illustration of how restructuring tools can be successfully implemented. She acknowledged that each transaction is unique but highlighted many of the positive steps taken by Illinois and the involved company, which provide an example of a robust process that can be used to enable the balance of all stakeholders’ needs when considering these transactions.
transactions. The comment letter details those steps taken by Illinois and the company and can be used as best practices for similar transactions.

j. Mr. Wake

Mr. Wake described how he had submitted comments, some of which are in the form of specific edits to the paper, while others are in the form of specific suggestions or questions. He noted he believes the questions suggested more work was left to be done but that presumably the work could proceed and answer the questions simultaneously.

k. Mr. Rehagen

Mr. Rehagen noted some high-level comments, including some expressed concerns with the overall inability of the white paper to be as balanced as possible. He noted in particular the area of guaranty fund coverage, where he hoped the paper would be revised, and in the area of assumption reinsurance, where he is particularly concerned with the sentence that implied allowing the courts to determine the outcome, especially in the area of personal coverages, where those laws are designed to give consumers choices. He noted that generally speaking, the white paper seemed to downplay the significance of these issues, which was something he believes needs to be raised and worked through before states started approving such transactions.

l. California Health Advocates

Bonnie Burns (California Health Advocates) expressed concern with the section dealing with LTCI. She noted that section was small and should be expanded. She said she believes it would require detailed standards. Superintendent Dwyer responded that her laws do not allow an IBT of LTCI. Commissioner Mulready responded that his state is not entertaining any such transactions. Mr. Wake noted that it is something to think about, if only because it takes just one state to make it a reality. Ms. Burns noted that she was told as a regulator years ago that if the law does not prohibit it, it can be done.

Having no further business, the Restructuring Mechanisms (E) Working Group adjourned.

12-6-21 Restructure Meeting Minutes.docx
Restructuring Mechanisms

*An NAIC White Paper*

October 22, 2021

Created by the
Restructuring Mechanisms (E) Working Group
of the
Financial Condition (E) Committee
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Section 1: Overview of IBT and Corporate Division Laws and Mechanics

A. Introduction

Insurance is a business that sells a promise to pay upon the occurrence of a future event. Policyholders may submit claims many years into the future on covered losses incurred during the policy period requiring insurers to record a liability for these incurred but not-reported claims. As such, it is nearly impossible for an insurer to decide to discontinue writing a certain line of business and pay off all its legal obligations to its policyholders- because there are almost always unknown potential future policyholder obligations that have not yet been reported. Policies previously written on a line of business that is no longer being written creates a block of business that may no longer be the focus of the insurer’s business model and left to slowly run off. For some insurance companies, runoff business1 remains embedded with the core business without the ability to segregate the runoff business. There are even runoff specialists that have developed within the insurance industry that specialize in handling these old blocks of business.

Until recently, U.S. insurance companies wanting to restructure their liabilities had been limited to sale, reinsurance/loss portfolio transfers for individual policy novations. Other than individual policy novation, these solutions do not provide finality as the ultimate liability remains with the original insurer. The only way to transfer a block of business with finality is an individual policy novation. However, the current process of novating individual policies is considered by the industry to be inconsistent among the states, cumbersome, time-consuming, and expensive. The industry suggests that in many instances it will be impossible to obtain positive consent to a novation from all policyholders, especially on older books of business where policyholders are difficult to locate.

The NAIC has addressed aspects of this issue in the following two previous white papers. In 1997, the Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee issued a paper titled “Liability-Based Restructuring White Paper.” (See Attachment 1.) The white paper focused on the efforts by property and casualty insurers attempting to wall off “material exposures to asbestos, pollution and health hazard (APH) claims and other long-tail liabilities”2 from current insurer operations. The white paper achieves this focus by inclusion of various section on related topics as well as multiple appendices. In 2009, the Restructuring Mechanisms for Troubled Companies Subgroup of the Financial Condition (E) Committee issued a white paper titled “Alternative Mechanisms for Troubled Companies.” (See Attachment 2.) The white paper focuses on troubled companies although it also addresses the statutory restructuring mechanisms available in the United States (“US”) at that time. This white paper similar to the 1997 white paper, also includes a number of sections on related topics as well as multiple appendices.

1 For purposes of this paper “runoff business” is defined as a block of insurance business that is no longer being actively written by an insurance company and no premiums are being collected, except where required to in accordance with contractual or regulatory obligations, and where the existing or assumed group of insurance policies or contracts are managed through their termination. This definition was developed based on comments received by the Restructuring Mechanism Subgroup from both regulators and industry interested parties; however, this definition has not yet been adopted by the subgroup.

Over the past few years, states have begun enacting statutes which provide opportunities for restructuring of insurance companies with finality. The purpose of this white paper is to update the 1997 and 2009 white papers and provide explanation of these new statutory processes. These processes can be broken down into two categories generally referred to as insurance business transfer (“IBT”) and corporate division (“CD”). Several states, including Arkansas, Oklahoma, Rhode Island, and Vermont, have enacted IBT statues while other states such as Arizona, Connecticut, Illinois, Iowa, Arkansas, Pennsylvania, and Michigan have enacted CD statutes. The stated intent of all these statutes is to enable insurers to take advantage of the statutory process in order to enhance their ongoing operations.

This white paper will discuss and explore these laws within the US and identify the various regulatory and legal issues involving IBT and CD legislation. This white paper is not intended to establish an official position by the NAIC regarding IBTs or CDs. The authors suggest that each state and its various regulatory authorities should make their own determinations on how best to proceed within their respective jurisdictions. In addition, this paper is not intended to address every situation a company may encounter and leaves possible situations to each insurer as well as the review and approval of all applicable regulatory authorities. Because the robust procedures used in the United Kingdom (“UK”) are seen as a means to utilize IBT in the US, the procedures are discussed in Section 2 of this white paper.

A separate workstream was created to develop financial standards appropriate in US to evaluate IBT and CD transactions. Some stakeholders question whether, even with robust standards, adequate consumer protections would exist when IBTs and CDs are utilized. Therefore, this white paper includes a discussion of a UK case which discussed consumer protection issues.

This is a constantly changing area with states adding and amending statutory provisions and considering new and unique transactions on a continuous basis. Therefore, the factual statements in this whitepaper should be considered a “point in time” discussion.

B. Purposes

During the course of the Restructuring Mechanisms (E) Working Group’s (“Working Group”) discussions, stakeholders identified a number of potential purposes for restructuring transactions. Testimony indicated that reinsurers and insurers were looking for new solutions that provide legal and economic finality to runoff insurance risks to improve the efficient allocation of capital and management resources to runoff and on-going insurance operations. Efficiencies that are obtained through restructuring transactions include the segregation and transfer of runoff books of business with the intent to free up capital, better allocate specialized management resources currently being occupied with the oversight of disparate discontinued and on-going businesses and rationalize and facilitate the runoff of discontinued lines of business. Experience outside the US, including in the UK, has shown that prudent allocation of reserves and management of runoff books of business reduces volatility and improves capital efficiency with benefits for reinsureds and policyholders of both runoff and on-going books of business. Furthermore, runoff experts bring focused expertise to managing runoffs compared to on-going enterprises. The focus of an on-going enterprise is the continual generation of increased premium growth. Runoff business can be both a distraction to management’s focus as well as redirect regulatory focus away from the insurer’s on-going business. The isolation of such business from on-going business enhances the visibility of those runoff operations as well as the supervision of runoff operations, by both regulators and the insurer.
Advocates of these restructuring mechanisms argue that efficiencies resulting from the segregation and specialized management of disparate books of business result in transferring insurers releasing resources and allowing these insurers to better focus on improving current operations. Transferring insurers can better focus on core areas, leading ultimately to better service for current and future policyholders and better service for runoff policyholders. In many cases, the runoff business consists of long-tail lines, such as mass tort, asbestos, environmental and general liability risks. These long-tail lines tie up financial and management resources which are out of proportion compared to the size or importance of the runoff book within the insurer.

As described in the 1997 white paper, restructuring of insurers can be initiated for several reasons that provide value to the insurer. These reasons include restructuring for credit rating, solvency, more effective claims management, need to raise capital and a desire to exit a line of business. With respect to capital and earnings volatility, the 1997 white paper explained that restructuring could allow liabilities to be separated thereby creating the ability to dedicate surplus to support restructured operations, eliminating the drag on earnings in its on-going operations and avoiding further commitment of capital for pre-existing liabilities. One restructuring expert indicated there were three primary reasons that an insurer may choose to restructure: (1) regulatory, capital and earnings volatility; (2) finality of economic transfer; and 3) operational efficiencies.

Of note, restructuring mechanisms may also be beneficial for purposes of credit ratings. Credit ratings are often looked at in terms of capital volatility. Credit rating agencies may take a more favorable view of an insurer that has been able to isolate a particular risk which may be more volatile and subject to further reserve development. However, rating agencies also consider the strength of the insurance group when issuing insurance financial strength ratings, which can negate the credit rating benefit that may be found in restructuring. Ratings are critical for insurers that are writing new business in which the rating has value to potential new customers. While insurance groups use different strategies, it is common that some insurers within a particular insurance group are more critical to the ongoing success of the insurance group as a whole. It is therefore not uncommon for rating agencies to recognize this fact and provide separate ratings for individual insurers within an insurance group. While these considerations can lessen the value of restructuring for credit rating in some instances, insurance groups do still choose to restructure for credit rating purposes.

C. Regulatory Concerns with Restructuring Plans

While restructuring may provide value to the insurer, regulators are concerned that restructuring does not create new resources from which claims can be paid. Restructuring should not be utilized to allow insurers to escape these liabilities or separate claims in a manner that could provide less capital than is needed to satisfy the insurer’s obligation. Restructuring plans that place solvency at risk or threaten consumer benefits will be faced with challenges from regulators. However, when regulators are shown that the restructuring plan benefits both the insurer and the insured, then the regulator may be willing to

3 David Scasbrook (Swiss Re America Holding Corporation) as stated during the April 6, 2019 meeting of the Restructuring Mechanisms (E) Working Group.
Section 2: History of Restructuring in the United Kingdom

A. Part VII Transfers and Solvent Schemes of Arrangement in the United Kingdom

Part VII transfers require a “scheme report.” This report is required under the independent expert report under US IBT laws, however, because the word “scheme” is not used.


because has a different has negative context connotations in the US, the word “scheme” is not used American English. Under section 109(2) of FSMA, an independent expert the scheme report may only be made by an independent expert person who:

(a) appearing to the PRA to have the skills necessary to enable him to make a proper report; and

(b) is nominated or approved by the PRA.

The independent expert making the report to be a neutral person, who:

(a) is independent, that is any direct or indirect interest or connection he, or his employer, has or has had in either the transferor or transferee should not be such as to prejudice his status in the eyes of the court; and

(b) has relevant knowledge, both practical and theoretical, and experience of the types of insurance business transacted by the transferor and transferee.

The PRA may only nominate or approve an independent expert appointment after consultation with the FCA. An independent expert report must accompany an application to the court to approve the Part VII transfer plan. The independent expert report must comply with the applicable rules on expert evidence and contain the specific information set forth in the statute.

The purpose of the independent expert report is to inform the court. The independent expert, therefore, likely has a duty to the court. Further, policyholders, reinsurers, regulators, and others affected by the Part VII transfer will be relying on the independent expert report. For these reasons, a detailed report is necessary. The amount of detail that it is appropriate to include will depend on the complexity of the transfer, the materiality of each factor and the circumstances surrounding each factor.

During the Working Group’s discussion of the Part VII transfers, consumer representatives raised the UK court’s decision in *In re Prudential v and Rothesay* which imposed several limitations on Part VII transfers. On August 16, 2019, the High Court of Justice issued an opinion rejecting a Part VII transfer between Prudential Assurance Company Limited and Rothesay Life PLC. This Part VII plan was the subject of a four-day hearing in which each insurer was represented by counsel, the PRA and FCA appeared, and a number of policyholders appeared in person. The Court noted that both the PRA and the FCA each produced reports regarding the plan, and both stated that they did not object. The independent expert filed a detailed report that ultimately did not reject the plan either.

The applicant received approximately 7,300 responses from policyholders in response to the approximately 258,000 policyholder packets that were sent out. Of those, about 1,000 were characterized as an objection. The main objection to the plan was that these consumers specifically selected the transferring insurer as their provider. These consumers argued that they should not have their annuity

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8 As noted by Birny Birnbaum (Center for Economic Justice—CEJ) during the Dec 8, 2019 Meeting of the Restructuring Mechanisms (E) Working Group. Note this was overturned by *The Prudential Assurance Company Limited v. Rothesay Life PLC [2020] EWCA Civ 1626*. 

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transferred against their will to a smaller insurer with a very different history and reputation just to further the commercial and financial purposes of the transferor.

This decision was appealed and ultimately overturned. The UK Court of Appeals\(^9\) found that the lower court incorrectly exercised its authority finding amongst other things, that the judge was wrong to give weight to (i) the different capital management policies of both insurers; and (ii) the objections of a small subset of policyholders.

In so holding, the Court of Appeals stated:

(1) The Court below was wrong to decide that both the independent expert and PRA were not justified in looking at the solvency metrics at a specific date to support their conclusions.

(2) The Court below was wrong to find a material disparity in the parent company structure since the parent companies could never be required to provide support to their subsidiaries’ capital.

(3) The Court below should not have accorded any weight to the fact that the policyholders had chosen Prudential based on its long-established reputation, age, and venerability nor to the fact that they had reasonably assumed that Prudential would be their annuity provider throughout its lengthy term.\(^10\)

Despite this set of complex UK decisions, the Part VII transfer continues to be used in the UK and watched closely by the US regulators and stakeholders.

B. Differences between Part VII and Solvent Schemes of Arrangements

Solvent schemes of arrangement are another method of restructuring that exists within the UK. These are primarily designed as a procedure that can allow all liabilities to be settled for an insurer. In doing so, it can achieve many of the objectives set out in this white paper. However, unlike the Part VII transfer, the policies are subject to a court ordered termination instead of transferred. While such an arrangement may provide some of the same features as a Part VII transfer, the solvent scheme does not continue the coverage with a new insurer the way a Part VII transfer does. Other differences may exist in law, but are not deemed to be relevant to this is the most significant for purposes of this specific white paper.

Section 3: Survey of US Restructuring Statutes and Regulations

Various states have enacted corporate restructuring statutes or regulations. Some type of restructuring law generally following the UK structure, began with Rhode Island was the first state to take

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\(^9\) Prudential Assurance Company Ltd and Rothesay Life Plc, Re, England and Wales Court of Appeal (Civil Division)(Dec. 2, 2020).

\(^10\) Id. at Page 6 of Appeal Nos: A2/2019/2407 and 2409 Case No: 1236/5/7/15
this approach, in 2002 adopting a statute in 2002 titled Voluntary Restructuring of Solvent Insurers\textsuperscript{11} patterned after Solvent Schemes of Arrangements. This type of Rhode Island refers to this process as Commutation Plan.\textsuperscript{12} It differs from the UK\textsuperscript{13} Solvent Scheme in a number of areas including an enhanced role for the regulator, designating the independent expert as a consultant to the regulator and limiting the process to commercial property and casualty risks. One commutation plan was adjudicated by the Rhode Island court in 2011 and withstood a constitutional challenge. The written decision in that case addressed many of the issues raised with restructuring plans generally.\textsuperscript{14} Commutation Plans continue to be available under RI law.

Although Commutation Plans continue to be available under Rhode Island law, Rhode Island updated its law in ??? to provide an additional option. In 2015 Rhode Island adopted an Insurance Business Transfer Plan\textsuperscript{15} regulation.\textsuperscript{16} These are similar to the Part VII transfers, but a Again, in contrast to the UK, the Rhode Island regulation provides an enhanced role for the regulator, designates the independent expert as a consultant to the regulator and limits the process to commercial property and casualty risks. The RI regulation provides for notice at the time the plan is filed with the regulator and an ability to comment at that time. If the regulator, after a thorough review of the Plan and comments receives continues to believe that it meets the statutory requirement have been met, it will authorize the Plan to be filed with the Court. The Court will require notice to policyholders and hearings to allow all comments and objections to be considered. A Rhode Island domestic insurer has been formed specifically to undertake IBTs, but a plan has not yet been filed with the regulator.

In 2013, Vermont adopted the Legacy Insurance Management Act (“LIMA”\textsuperscript{17}). LIMA is limited to surplus lines risks and reinsurance, involves department approval but not court approval and allows policyholders to opt-out of the plan. As of this date, no transactions have been completed under LIMA.

In 2018, Oklahoma adopted the Insurance Business Transfer Act\textsuperscript{18} modeled after UK’s Part IV regulation with a few significant differences. The differences include no restriction on the type of insurance nor restrictions on the age of the business. Oklahoma law provides for both insurers to nominate a potential independent expert with the Insurance Commissioner appointing one or another if he or she is not satisfied with the nominations. The independent expert report is submitted with the IBT application to the Oklahoma Insurance Department which approves the IBT plan to be submitted to the court upon satisfactory showing that statutory standards are met. The court requires notice and opportunity to be heard prior to court approval of implementation of the plan. As of this writing, Oklahoma has completed two IBTs in October 2020 and September 2021, involving a Rhode Island and Wisconsin insurer respectively, which are described below. Neither of the plans were challenged in the state court proceedings.

In 2021, Arkansas adopted the Insurance Business Transfer Act\textsuperscript{19} which is based on the Oklahoma and Rhode Island statutes. The key differences are: the assuming insurer must be licensed in each line of business in each state where the transferring insurer is licensed unless an exception is be made for an

\textsuperscript{11} R.I. Gen. Laws Chapter 27-14.5
\textsuperscript{12} In re GEI Reinsurance Co., No. PH 10-3777, 2011 WL 7144917, at *5-6 (R.I. Super. Ct. Apr. 25, 2011)
\textsuperscript{13} 230 RICR 20-45-6.
\textsuperscript{15} Insurance Business Transfer Act, OKLA. STAT. tit. 36, §§ 1681 et seq.
\textsuperscript{16} As announced by the Arkansas Department of Insurance July 8, 2021, ACA §§ 23-69-501, et seq. (See Arkansas statute at https://www.arkleg.state.ar.us/BillsDetail?Id=SB203&ddBienniumSession=2021%2F2021R

\textsuperscript{17} 2310 RICR 20-45-6.
extraordinary circumstance; specific factors are provided in the Arkansas IBT law that the Commissioner must consider before approving the IBT including the impact on contract holders and reinsurers in addition to policyholders; additional guidance on what would be a material adverse impact; specific guidance for proposed long-term care IBTs and additional requirements for the expert opinion report.

And we need more about CDs here...

The National Council of Insurance Legislators has promulgated a model IBT law modeled after the Oklahoma IBT statutes, as well as a model CD law. A number of states have adopted CD statutes, whether specific to insurance or based on the state’s general power over corporations. Those states include Arizona, Connecticut, Illinois, Iowa, Michigan, Arkansas, and Pennsylvania. All of these statutes allow for corporate restructures. As discussed in more detail below, Pennsylvania and Illinois have each completed CD transactions.

A. Similarities and Differences between Statutes

Rhode Island’s IBT law permits transfers of property and casualty commercial blocks of business that have been closed for at least 60 months. In contrast, Oklahoma and Arkansas IBT laws permit transfers of both open and closed books of business and are not limited in the line of business that can be transferred. All three states require approval by a court and no material adverse impact on affected policyholders. The approval of the ceding and assuming insurer’s domestic insurance regulator is also required. All states require an expert report that contains an opinion on the likely effects of the transfer on policyholders. The approval of the ceding and assuming insurer’s domestic insurance regulator is also required. All three states require approval by a court and no material adverse impact on affected transfers of both open and closed books of business and are not limited in the line of business that can be transferred. In contrast, Oklahoma and Arkansas IBT laws permit transfers of property and casualty commercial blocks of business that have been closed for at least 60 months. In contrast, Oklahoma and Arkansas IBT laws permit transfers of both open and closed books of business and are not limited in the line of business that can be transferred. All three states require approval by a court and no material adverse impact on affected policyholders. The approval of the ceding and assuming insurer’s domestic insurance regulator is also required. All states require an expert report that contains an opinion on the likely effects of the transfer on policyholders.

As noted above, several states have also enacted CD laws, rules, and regulations. While differences exist between IBTs and CDs, there are also many similarities between the two mechanisms: they require a regulatory review of the effect on policyholders, they have balance sheet considerations, and they are a way to separate runoff books of business from an insurer.

The Illinois’ Domestic Stock Company Division Law requires disclosure of the allocation of assets and liabilities among companies. Although not statutorily required, the Illinois Department of Insurance Director has committed to providing an opportunity to comment at a public hearing. The standard in the Illinois statute is that the plan must be approved by the Director unless at least one of the following characteristics exist:

1. Policyholder/shareholder interests are not protected;
2. Each insurer would not be eligible to receive a license in the state;
3. Insurers are not protected;
4. Insurers are not protected; and
5. Insurers would not be eligible to receive a license in the state.

The introduction to IBTs ought to be followed by a description of CDs that operate at a similar level, and then the comparison between IBTs and CDs, which is probably where the NCOIL Model goes. It can be included in the comparison with existing state law.

Commented [RAW18]: This doesn’t really fit here. The introduction to IBTs ought to be followed by a description of CDs that operates at a similar level, and then the comparison between IBTs and CDs, which is probably where the NCOIL Model goes. It can be included in the comparison with existing state law.

Commented [RAW19]: Some of the material below needs to go above – there should be an introduction to the CD concept at about the same level of detail as the introduction to the IBT concept.

Commented [RAW20]: As written, Director must find all 5 in order to disapprove. Hope that’s not what the law says.

(3) division violates the Uniform Fraudulent Transfer Act;

(4) division is made for the purpose of hindering, delaying, or defrauding other creditors;

(5) any of the companies is insolvent after the division is complete.

The Connecticut CD statute creates something legally distinct from a merger, consolidation, dissolution, or formation. The resulting insurers are deemed legal successors to the dividing insurer, and any of the assets or obligations allocated are done as a result of succession and not by direct or indirect transfer. The plan must include among other things (1) the name of the domestic dividing insurer; (2) the names of the resulting insurers; (3) proposed corporate by-laws for new insurers; (4) manner for allocating liabilities and reasonable description of policies; (5) other liabilities and capital and surplus to be allocated, including the manner by which each reinsurance contract is allocated; and (6) all other terms and conditions. Connecticut requires approval by the board of directors, stockholders, and other owners before being considered by the Department of Insurance. The plan is then discussed with the Department which will determine whether the liabilities and policies are clearly defined and identifiable and whether the assumptions are conservative based upon actuarial findings. Connecticut law does not require an independent expert or a communication strategy as part of the application, but the Department of Insurance has stated that it will require certain notifications related to a hearing (e.g., newspaper or print publications). Connecticut does not require notice of hearing however the insurance commissioner may require a hearing if in the public interest. Similar to Illinois law, the insurance commissioner must approve a plan of division unless he or she finds that (1) the interest of any policyholder or interest holder would not be adequately protected or (2) the division constitutes a fraudulent transfer. The division itself must be effectuated within 90 days of the filing.

The Pennsylvania CD statute was enacted in 1990 and is the subject of discussion in the NAIC 1997 white paper on Liability-Based Restructuring, attached to this paper as an appendix. The statute upon which the transaction discussed in the 1997 white paper is based is not specific to insurance. The law is brief with only four paragraphs—requiring the plan to be submitted in writing, reasonable notice and opportunity for a hearing, investigations and supplemental studies and approval through an order from the Department and subject to judicial review. The associated procedural regulations essentially are those that exist under the states’ equivalent of the NAIC Insurance Holding Company System Regulatory Act (Model 440).

While the Rhode Island, Oklahoma and Arkansas laws have approval processes that are similar to UK Part VII transfers, there are differences between the three statutes. Rhode Island permits transfers of mature (at least 60 months) closed commercial property and casualty books of business or non-life reinsurance but no other lines of business. Oklahoma does not have similar restrictions and specifically allows property and casualty, life, and health lines of business. Oklahoma and Arkansas do not require the book of business to be closed.

While the CD laws enacted to date all require regulatory review of the effect on policyholders, balance sheet considerations and other operational requirements, the most significant differences that exist

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32 15 PA. CONS. STAT. §§ 361 et seq.
in CD laws are not among themselves, but rather in comparison to the IBT statutes. This is because the CD statutes do not require approval by a court or the same level of notification to policyholders. In addition, while CD states reserve the right to hire their own external expert—similar to a Form A (Change in Control), these states may perform their review based upon their own internal experts.

B. Transactions Completed to Date

One of the earliest transactions completed under these types of laws occurred in Pennsylvania in 1995, when the Pennsylvania Insurance Department approved a division of the Cigna Corporation, which is commonly referred to as the “Brandywine transaction,” after the name of one of the resulting insurers. This transaction is discussed in more detail within Appendix 1 of the 1997 Liability-Based Restructuring White Paper, which is Appendix 1 and relates to Cigna, where more information is available. During the Working Group’s discussions in 2019, the Pennsylvania Insurance Department, which is captured in the following paragraph.

The Brandywine transaction was subject to an insurance department review, which included an actuarial review, a review of the financial information by a consultant and participation by other states that had an interest to understand how the plan would be restructured. There were four actuarial firms that opined on the transaction as well as two opinions from investment banks, one contracted by the insurer and another contracted by the Department. Issues regarding guaranty coverage were not addressed, but it did require Pennsylvania policyholders to be covered by the Pennsylvania fund. Confidentiality was applied to any examination document prepared in the process, actuarial reports, and questions and comments, but insurer responses were made available to the public. The transaction was a large commercial transaction and immaterial to the policyholders, therefore reducing some of the concerns that may have otherwise existed.

In 2011, GTE Re completed a commutation plan in Rhode Island. The plan was approved by the Rhode Island court and the insured was ordered dissolved after all insureds had been paid full value for their policies. The GTE Re Plan was objected to, on a theoretical basis, and the Providence County Superior Court issued a decision on a contract/issue.

In 2020, the District Court of Oklahoma County approved Providence Washington Insurance Company’s (“PWIC”), a Rhode Island domestic insurer, to Sentry Insurance a Mutual Company (“Sentry”), a Wisconsin-based insurer, to submit its IBT Plan to the District Court of Oklahoma County for

Commented [RAW24]: Why was it immaterial to policyholders? Do we mean immaterial to consumers? But what about claimants? What ultimately happened to Brandywine. A quick Google search turns up this from 2005:

Allstate Insurance Company, American International Group Inc., Chubb & Son and St. Paul Travelers are challenging the proposed sale of three of its asbestos and environmental run-off subsidiaries by ACE Limited to Randall & Quilter Investment Holdings of Great Britain. The insurers have asked Commissioner Diane Koken and the Pennsylvania Department of Insurance to closely examine the proposed transaction.

On Jan. 6, ACE announced that it planned to sell its ACE American Reinsurance Company, Brandywine Reinsurance Co. (UK) Ltd. and Brandywine Reinsurance Company S.A.-N.V. to Randall & Quilter. It also said it would take $279 million in after tax reserve charges on Brandywine, and another $19 million relating to the ACE Westchester Speciality unit. Century Indemnity Company, an indirect, wholly owned subsidiary of ACE, is also involved. The saks require the approval of the Pennsylvania department and the U.K. Financial Services Authority.

ACE acquired the companies as part of the acquisition of INA from Cigna in 1999. They subsequently were found to have large exposures to asbestos and environmental claims, and have become a liability for the ACE Group.

The protesting insurers fear that the sale to the U.K.-based Randall & Quilter could weaken the security relied on by policyholders and other insurance companies. They question whether, if asbestos and environmental claims continue to require increases in reserves, Randall & Quilter would have the funds needed. If the transaction is not approved, ACE’s affiliates would remain liable for such continuing obligations.

The insurers’ petition further suggests that the sale is an attempt to shift a share of Century’s run-off liabilities onto British firms outside of U.S. regulatory authorities. The insurers said ACE is trying to “place more distance between itself and the legal obligations of its subsidiaries” and to avoid Pennsylvania’s “continuing scrutiny, moral pressure and directives.”
This IBT transfers a block of reinsurance business underwritten by Sentry to National Legacy Insurance Company, an insurer domiciled in Oklahoma and a subsidiary of Randall & Quilter Investment Holdings Ltd (NLIC). The Sentry transfer was approved by the Court in August of 2021.

Illinois completed a transaction under their CD statute in early 2020. The transaction was a transfer of risks with distinct characteristics into a single insurer within a holding company structure. All the transfers originated and ended within the same holding company. The Illinois Department of Insurance has indicated that it will issue a detailed regulation as experience develops with CD plans proposed and completed under the statute.

Section 4: Impact of IBTs and CDs to Personal Lines

A. Guaranty Association Issues

An important issue for corporate restructuring is the availability of guaranty association coverage in the event of the insolvency of the restructured insurer. In order to uphold the stated declaration that prevent restructuring should not result in materially adversely affecting consumers, it is essential to ensure that guaranty association coverage should not be reduced or eliminated by the restructuring. Each state guaranty association is a separate entity governed by the laws of that state, and those statutes will determine association coverage. Although most states pattern their laws after the NAIC model law, there could potentially be different results concerning guaranty association coverage depending on where the insured resides.

The Working Group received input from both the National Organization of Life and Health Insurance Guaranty Associations ("NOLHGA") and the National Conference of Insurance Guaranty Funds ("NCIGF"). NOLHGA described how the concerns for insurance consumers of personal lines business is particularly pronounced.

NOLHGA indicated that for there to be guaranty association coverage in the event of an insurer insolvency, there are three conditions that must be present. Those conditions are:

1. The consumer seeking protection must be an eligible person under the statute; typically, this is achieved by being a resident of a state who has a guaranty association;
2. The product must be a covered policy; and
3. The failed insurer for which protection is being sought must be a member insurer of the guaranty association of the state where the policyholder resides. To be a member insurer, the insurer must be licensed in that state or have been licensed in the state.

In most states, coverage can also be provided for an “orphan” policyholder of the insurer, who was eligible for protection when the original policy was issued but the policyholder has since moved to a state that where the insurer is not a guaranty association member. Those policies are covered under the state in which the insolvent insurer is domiciled. However, this provision is designed to plug the gap in those rare situations. Orphan coverage was not designed to provide coverage to all policyholders regardless of domicile, only to plug the one specific gap in coverage that has been identified. As such, none of the resulting insurer in an IBT or CD would not otherwise meet the requirements for guarantee association coverage, it is unlikely that the “orphan” policyholder clause would help. If there are gaps in coverage, or coverage is uncertain, legislative action is necessary in each affected state in order to protect policyholders and third-party claimants. These issues can be addressed in legislative and regulatory manners including maintaining a certificate of authority in each state, so the insurer is a guaranty association member insurer in each state. However, if an insurer is unwilling or unable to meet such requirements it could impede the ability to complete a restructure.

NCIGF and NOLHGA have both taken the position that where there was guaranty association coverage before the IBT or CD, any regulation or law should ensure that there is coverage after the IBT or CD. An IBT or CD should not reduce, eliminate or in any way impact guaranty association coverage. An CD or IBT should not create, expand, or in any way impact coverage. NCIGF suggested that possible technical gaps may exist in states that have adopted the NAIC Property & Casualty Guaranty Association Model Act.

One interpretation of the NAIC Property and Casualty Insurance Guaranty Association Model Act (Model # 540) which is based on the definitions of “Covered Claim,” “Member Insurer,” “Insolvent Insurer,” and “Assumed Claim Transaction,” an orphan policyholder could not be covered by the state guaranty association. Consequently, there is a concern that no guarantee association coverage would be provided if policies are transferred to a nonmember insurer. Many statutes require that the policy be issued by the now-insolvent insurer and that it must have been licensed either at the time of issue or when the insured event occurred. These limitations, however, are designed to avoid coverage being provided when the policy at issue did not “contribute” to the association, which would not exist in the case of an insolvency that was not a member at the time the policy was issued.

Fulfilling this intent may require guaranty association statutes to be amended in each of the states where the original insurer was a member of a guaranty association before the transaction becomes final. NCIGF indicated that it had created a subcommittee to address this issue and oversee a coordinated, national effort to enact the necessary changes in each state. Further discussion of this subcommittee’s work is discussed in the Recommendations section below. It should be noted that the same membership and timing issues that are raised by IBTs could also be raised in the case of any other policy novation, including the assumption reinsurance transactions discussed below.


B. Assumption Reinsurance

Existing assumption reinsurance statutes exist to provide policyholder disclosures and rights for rejection of a proposed novation of their policy. These statutes are primarily designed for the benefit of individual policyholders with regard to personal lines coverages, whether for automobile, homeowners, life insurance or long-term care insurance, in situations where the solvency of the insurer might be at risk. There are currently ten states that have enacted the NAIC Assumption Reinsurance Model Act.  

The Assumption Reinsurance Model Act was drafted by state insurance regulators and initially adopted by the NAIC on December 5, 1993. The effect of an assumption reinsurance transaction is to relieve the transferring insurer of all related insurance obligations and to make the assuming insurer directly liable to the policyholder for the transferred risks. Under these statutes, individual policyholders receive a notice of transfer and may reject or accept the transfer. If the policyholder does not respond, the policyholder is deemed to have given implied consent, and the novation of the contract will be effective. When a new agreement replaces an existing agreement, a novation has occurred. There is no judicial involvement under the Assumption Reinsurance Model Act.

Some stakeholders have questioned whether the existence of rights under the Assumption Reinsurance Model Act implicitly prohibit an IBT or a CD. The argument is that the existence of the assumption reinsurance statute prohibits other statutory restructuring mechanisms without the policyholder’s express individual consent. Other stakeholders have suggested that these statutes coexist with restructuring mechanisms since the restructuring statutes are not addressing individual novations of policies. The argument is that the restructuring statutes address transfers of books of business not individual novation of policies and, therefore, are completely separate from assumption reinsurance statutes.

This is not an issue that can be resolved in this white paper. The issue has not yet been addressed by any court nor raised in the proceedings on restructurings. Therefore, while it is raised here for informational purposes, resolution of the issue is left unanswered for now and for the courts to determine in the future.

C. Separate Issues in Long-Term Care

Long-tail liabilities are naturally subject to greater reserve uncertainty and may impact the regulator’s willingness to consider the restructuring of certain lines of business. During the Working Group’s discussion, it was noted by a number of regulators that restructuring of certain lines of business, such as long-term care, could be problematic since the specific line of business has presented significant challenges in determining appropriate reserving and capital required to support the business. The Working Group acknowledges that, regardless of whether some state laws would permit it, use of a corporate restructuring mechanism in certain lines, such as long-term care, is likely to be subject to a great deal of opposition. Even where permitted, it could be subject to higher capital requirements for the insurers involved.

15 Assumption Reinsurance Model Act NAIC Model #803 (Adopted by Colorado, Georgia, Kansas, Maine, Missouri, Nebraska, North Carolina, Oregon, Rhode Island, and Vermont)
The nature circumstances of long-term care policyholders will make restructuring challenging especially with a transfer to a completely new insurer in a new holding company system. Long-term care policyholders are individuals who may find it much more challenging to assert their rights in a court proceeding than a corporate entity would. Furthermore, if the block of business has been in runoff for a substantial period of time, the policyholders will be aging and many will be disabled. This fact, along with the traditional inability of insurers to properly estimate future liabilities in this line of business, makes it a line of business that likely is not appropriate for restructuring mechanisms. This conclusion, however, could be refuted if the appropriate plan addresses these issues and provides benefit to the policyholders.

Section 5: Legal Impacts of IBT and CD Laws

A. How Other Jurisdictions Might Analyze IBT or CD Decisions from Other States

As previously discussed by others, a restructuring mechanism in one state will not provide finality unless the decision is recognized by other jurisdictions. The US Constitution includes the Full Faith and Credit Clause as well as the Privileges and Immunities Clause (also referred to as the doctrine of Comity) in Article IV. These clauses create methods of extending the effect of a restructuring mechanism beyond the state that issued the judgment and giving that state’s judgment effect in all other states in which the insurer does business.

Thus, the Privileges and Immunities Clause or the Full Faith and Credit Clause are two methods stemming from the US Constitution that provide for recognition of court orders from other states. We will briefly touch on both concepts but leave these non-core insurance topics to others to discuss in more depth.

The policyholder challenging the decision must first identify the property of which they are being deprived. Assuming the resulting insurer is sufficiently capitalized, a policyholder who has been reallocated to the resulting insurer, but alleges no additional harm, may have difficulty identifying the property interest of which they have been deprived. The determination on full faith and credit will likely rely upon the issues raised and considered in the Court of the domestic state.

The issue is not likely to be ripe until an insolvency occurs with the assuming insurer. At that point, if the assuming insurer is insolvent and the original insurer is still financially sound, will a court give full faith and credit to the approval of the IBT or CD? This is an open question that is unlikely to be resolved until the specific factual scenario presents itself to the courts. The fact that this issue exists makes it even more important that only transactions with the greatest chance for success be subject to corporate restructuring process.

Comity is typically understood to be a courtesy provided between jurisdictions, not necessarily as a right but rather out of deference and good will. As such, comity might not require in this context that a


33 The same analysis does not apply to jurisdictions outside the United States and is not addressed in this white paper.
state honor the decision of another state. This is an analysis to be conducted by the individual jurisdictions.

B. Impact of UK Part VII Transactions in the US

Although there has been limited experience in the US courts in approving commutations and IBTs, some US courts have had opportunities to review these types of issues because US insurers have been involved with UK-based commutations or transfers. Since the 2000 and 2005 revisions to UK laws, solvent schemes and Part VII transfers have been employed much more frequently in the UK. This has led to more frequent reviews by US courts of the underlying UK transactions. Some of the impact in the US is felt in bankruptcy courts, which often are implicated because US policyholders obtain coverage from UK-based insurers on a regular basis, while others involve non-bankruptcy situations, such as when a policyholder wants to submit a claim for payment but no longer has coverage.

There are several interesting cases that provide some guidance on these issues. Narragansett Electric Co. v. American Home Assurance Co. is one such case. In Narragansett Electric Co., the court reviewed claims by a London-based insurer, Equitas, that the plaintiff had sued the wrong insurer on a claim that was alleged to have occurred more than sixty years earlier. Equitas had assumed a block of business from Lloyd’s of London in a Part VII transfer, but argued that it had not assumed the obligations at issue. As the court summarized, “Equitas’s motion to dismiss raises the question whether this [Part VII] transfer of insurance obligations from Lloyd’s to Equitas is effective and enforceable under U.S. law.”

First, the court decided that it was sitting in diversity jurisdiction and that the appropriate substantive law to apply was English. Next, the court discussed a prior District Court case where another Part VII transfer was discussed at length and not recognized as a foreign bankruptcy proceeding. In reaching a conclusion to reject the request for dismissal, the court relied on a letter sent by Equitas to US policyholders notifying them that Equitas was assuming the obligations of the original insurer. The court found that regardless of whether the Part VII had any effect the latter sent to US policyholders raised sufficient basis to let the suit continue. Equitas attempted to argue that the Part VII transfer did not state that it would become effective in the US, rather that it was only effective in certain countries of Europe. Nevertheless, the utility company alleged that it had not relied on the English High Court Order executing the Part VII transfer, but rather relied on the notice letter it received as the evidence of obligation by the new named insurer.

Air & Liquid System Corp. v. Allianz Insurance Co., dealt with a discovery dispute as to whether a policyholder impacted by a Part VII transfer could later have access to the information that went into a

UK’s independent expert’s report.48 Ultimately, the special master in the District Court allowed discovery to proceed with a deposition of the expert. Allianz-Insurance Co. is an example of one way that Part VII transfers can be used to add complication to an insurance coverage dispute, embroiling all involved in later litigation. Allianz-Insurance Co. also shows how the approval of such a transfer, even though well vetted originally, can later come under scrutiny in unintended or unforeseen locations.

Allianz-Insurance Co. concerned involved a dispute over liabilities incurred by General Star, which wrote policies for excess coverage outside the US for only three years, 1998–2000, and then was put into runoff and ceased writing new policies. By 2010, it had substantially wound down its business and decided to transfer its policies to a new insurer via a Part VII transfer. Both General Star (the transferor) and the transferee taking over the policies shared an ultimate parent company—Berkshire Hathaway.49 At issue here was whether the expert who opined on the Part VII transfer had properly included one particular US-based insured, Howden North America (“Howden”), and all three policies it had purchased from General Star. That insurance contract had been for excess coverage, and Howden had informed General Star of 13,500 potential asbestos related claims that were likely to exceed the initial layers of insurance, making it likely that the General Star excess policy would be required to pay out claims. The real issue in Allianz-Insurance Co. seemed to be that the post-Part VII transferee insurer was put into voluntary liquidation days after the Part VII transfer concluded, leading to questions about whether and how the independent expert had valued Howden’s potential asbestos claims.

In re Board of Directors of Hopewell International Insurance Ltd. involved a New York bankruptcy judge analyzed a solvent scheme of arrangement that occurred in Bermuda, and applied Bermuda law, rather than the requested Minnesota law.40 The court determined that, given the location of the petitioner’s assets, Respondents had failed to object to the solvent scheme as proposed when they had been provided notice, and that petitioner had been subjected to a foreign proceeding, it had jurisdiction. As such, the court enjoined the respondent from taking action against petitioner based on the underlying action.41 The court in Hopewell also recognized the Bermuda solvent scheme as one qualifying as a foreign proceeding under US Bankruptcy Code.42

Section 6: Recommendations

A. Financial Standards Developed by Subgroup

As reflected in this whitepaper, these restructuring mechanisms depend considerably upon the specific plan being proposed. Currently, each state with relevant statutes is being presented with plans for

49 Id. at *12. This interrelated nature is not unusual and is referred to as an intra-company-group transaction.
51 Written by the then-Chief United States bankruptcy judge in the Southern District of New York, Tina Brozman, this decision detailed relevant history behind the Bermuda schemes of arrangement, including the different methods available to companies. One arrangement involved a cut-off scheme, developed in 1995, in which companies have no more than five years to submit additional claims prior to a bar date. This scheme greatly reduced the time for a run-off to wind down its business.
52 Citing to 11 U.S.C. § 101(23)(2012). The court applied a standard that “a foreign proceeding is a foreign judicial or administrative process whose end is to liquidate the foreign estate, adjust its debts or effectuate its reorganization.” Id. at 49 (internal quotations omitted).
evaluation with no standard set of criteria under which to judge the financial underpinnings of the plan. The Working Group believes that trust in these mechanisms, and protection of the policyholders who will be impacted by them, demands a standard set of financial principles under which to judge the transaction. Accordingly, the Working Group created a subgroup to specifically address these financial issues.

The Restructuring Mechanism Subgroup ("Subgroup") has been charged with the following initial work related to this White Paper:

Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer along with the adequacy of long-term liquidity needs. Also develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for its consideration. Complete by the 2021 Summer National Meeting. 31

Members of the Subgroup have studied and acknowledge that the UK Part VII procedures, and have concluded that they set forth robust processes and that setting similar requirements should be applied to established for IBTs and CDs.

As of the date of this paper, the charge related to best practices has not been completed. The Subgroup will continue its work with the goal of developing financial best practices. Those practices will be exposed for comment and discussion before referral to other groups.

B. Guaranty Association Issues

As discussed above, when these restructuring mechanisms are applied to personal lines serious issues arise over the continuation of guaranty association coverage. A number of states—Connecticut, California, and Oklahoma—have enacted statutory solutions to these issues. In addition, NCIGF has provided proposed statutory language. The Working Group would suggest that these issues, and the potential solutions, be referred to the Receivership Task Force for consideration to include language in the Guaranty Association Model Act.

Inclusion in the model, of course, only provides a roadmap for a state. The Working Group, therefore, suggests that, once appropriate language has been drafted, a serious effort be undertaken to obtain changes to the statutes in the various states to address this issue. Until that is accomplished, regulators should very carefully consider how plans presented address the guaranty association issues to assure that consumers are not harmed by the transaction.

C. Statutory Minimums

During the Working Group hearing, stakeholders made a number of suggestions as to provisions which should be required to be included in IBT and CD statutes. Those include:

Commented [RAW43]: Is this important?

Commented [RAW45]: This looks like a placeholder. Has the Subgroup concluded that there are no gaps or room for improvement? What about the refinements noted earlier in some US laws?

Commented [RAW46]: This should go first. Reading the two paragraphs together, it sounds like it's saying "So far, what they've concluded is that the best practices should include, but not be limited to, standards similar to the guardrails imposed by UK law for Part VII transfers."

Commented [RAW47]: Any chance we'll know more about best practices before this paper is finalized? It seems like a really important ingredient in an effective white paper.

Commented [RAW48]: How does this differ from best practices? If the intent is a two-tier recommendation, that's awkward. "A good system will do X, but any system had better at least do Y." Furthermore, if there's going to be a two-tier system, the "best" should be more robust and detailed than the "minimum," and we have the opposite here.

31 Charges were adopted by the Financial Condition (E) Committee Oct. 27, 2020 (see NAIC Fall National Meeting Minutes for the Financial Condition (E) Committee-Attachment Two).
(1) Requirement of court approval must be required for all restructuring mechanisms. Currently the IBT statutes (except for Vermont) require court approval, but the CD statutes generally do not.

(2) Requirement of the use of an independent expert to assist the state in both IBT and CD transactions, even though none of the states require this independent expert assistance for a CD.

(3) Requirement of a notice to stakeholders, a public hearing, robust regulatory process, and an opportunity to submit written comments are necessary for all policyholders, reinsurers, and guaranty associations.

None of the restructuring mechanisms are based on an NAIC model. While the Rhode Island, Oklahoma and Arkansas statutes are similar and are based on the Part VII processes in the UK, all CD processes are different and drafted by the legislatures of the respective states which enacted the statutes. Each of these recommendations is designed to address possible impairment of the financial position of the policyholders of the companies involved in the IBT and CD. As some commenters indicated, each of these suggestions would be beneficial in some transactions. Other transactions, however, may not need all of these provisions. For example, an intra holding company transaction may not need full faith and credit.

While independent experts can be of value, the mere fact that someone is employed by an insurance department does not mean that their skill set is not sufficient for certain transactions. Depending upon the transaction, department staff with a deep understanding of the insurer might provide more protection for consumers than a newly hired individual without a history with the insurer. Thus far, none of the transactions have been undertaken without a robust regulatory process; however, there would be concern from other regulators if this quality of regulatory process was not in place.

D. Impact of Licensing Statutes

Insurers formed for the purpose of effectuating restructuring mechanisms may, in the right transactions, provide value to consumers in the efficient management of runoff liabilities. However, these newly formed companies have difficulty getting licensed in the various states either because of “seasoning” issues or because a state may be hesitant to grant a license to a company that is not writing ongoing business so the state may be hesitant to grant a license. There are two possible outcomes, neither of them desirable. Either the restructuring fails to go forward, even though it is in the public interest, or the resulting or transferee company operates without a license, creating gaps in guaranty association coverage and lack of license can provide a lack of regulatory control over the company’s ongoing operations which can lead open the door to actions which that harm consumers. The Working Group, therefore, recommends that the appropriate committee look at licensing standards for runoff companies that states may wish to adopt.
Liability-Based Restructuring
White Paper

Liability-Based Restructuring Working Group of the
NAIC Financial Condition (EX4) Subcommittee
June 1997

Adopted by Liability-Based Restructuring Working Group & EX4 in June 1997
by Executive Committee in September 1997
Adopted by Plenary in December 1997
I. Scope

II. Business Reasons
  A. Rating Considerations
  B. Solvency Issues
  C. Other

III. Advantages and Disadvantages

IV. Financial Solvency Issues
  A. General Solvency Considerations
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     1. Collectibility of reinsurance balances
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V. Legal and Public Policy Issues
  A. Applicable Laws
     1. General Corporation Statutes
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     1. Overview of Guaranty Fund System
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VI. On-going Regulatory Oversight
  A. General
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VII. Conclusions and Recommendations

Appendix 1 – Case Studies
Appendix 2 – Pre-approval Checklist
Appendix 3 – On-going Regulatory Oversight
I. SCOPE

In general, restructurings can be effected through various forms and occur for different reasons: a parent company may divest itself of insurance operations by walling off and trying to sell certain operations, or making material changes to pooling arrangements in a way that, in effect, results in a corporate restructuring. Similarly, an insurance organization may spin-off some of its operations, possibly taking a private company public, may separate commercial and personal lines operations, or may create an off-shore entity to which problematic liabilities and/or assets are transferred due to favorable regulatory and tax environments. The most common specific examples of restructuring during the past several years have been liability-based restructurings (LBRs) of insurance operations into discontinued and on-going operations, primarily because of material exposures to asbestos, pollution and health hazard (APH) claims and other long-tail liabilities. Policyholders, insurers, regulators and guaranty funds have expressed concerns about these transactions. Descriptions of some recent restructurings are summarized in Appendix 1.

Conceptually, an LBR is an extraordinary transaction, or series of transactions, in which one or more affiliated insurance companies wholly or partially, isolate their existing insurance obligations from their on-going insurance operations. The notion of isolation is one of substantive change that creates a legal separation, such that policyholders and other creditors holding the isolated existing insurance obligations have limited or no financial recourse for their direct satisfaction against the on-going insurance operations. The concept of an LBR does not, in the absence of such isolation, include restructurings to achieve capital allocation or business-mix decisions, such as changes in pooling percentages, changes of the primary insurance writer or the separation of on-going insurance operations from other on-going insurance operations.

The purpose of this paper is to identify and discuss regulatory, legal and public policy issues surrounding such LBRs of multistate property/casualty companies and their affiliates. Single-state insurers and their affiliates may undertake similar LBRs and many of the issues contained herein may apply; individual states may choose to utilize this paper as a resource in those transactions. While restructurings of life and health companies are known to have occurred, such transactions may present different issues and considerations and therefore are excluded from discussion in this paper.

This paper is not intended to establish a position either for or against LBRs since each case must be evaluated on its own merits by the regulatory authority. Furthermore, this paper is not intended to address every insurance company merger, acquisition, divestiture, withdrawal from one or more lines of business or states, or other corporate transaction which impacts a company’s obligation to its policyholders or its ability to meet those obligations. These are typically addressed under other applicable statutes or regulations.

II. BUSINESS REASONS

A. Rating Considerations

One of the major considerations in recent LBRs has been the insurer’s desire to maintain or obtain favorable financial and other rating designations from the private rating agencies. Ratings play a major role in determining whether an insurer can remain competitive in its target market and may
affect its ability to attract new capital. Insurers that have been subject to earnings drag due to the adverse development of APH or other liabilities may be faced with rating downgrades. By separating problem liabilities from on-going operations, the insurer may improve or maintain its rating. In turn, this may allow the insurer to more effectively take advantage of business opportunities, potentially achieve higher returns on its capital, and become more attractive to the financial markets.

B. Solvency Issues

Through an assessment of its APH or other liability exposures, an insurer may realize that recognition of probable ultimate liabilities in these areas will have a material impact on its financial condition. By separating these liabilities from the on-going operations, the insurer can dedicate surplus to support the restructured operations and eliminate the drag on earnings in its on-going operations and avoid further commitment of capital for pre-existing liabilities.

It should be recognized that an LBR, by itself, does not create resources from which claims can be paid. Accurately establishing adequate reserves to meet probable ultimate liabilities may eliminate the drag on earnings. If the establishment of such reserves materially weakens the insurer’s financial condition, it is unlikely that it will be able to dedicate appropriate surplus to support both the restructured and on-going operations without additional capital. In these circumstances, if additional capital is not forthcoming, the regulatory authority should take appropriate action.

C. Other

Other reasons an insurer may consider restructuring include, but are not limited to, the need to raise capital or a desire to exit a line of business. In some cases, restructuring may be considered as a method to exit the insurance business or to camouflage financial and other problems.

III. ADVANTAGES AND DISADVANTAGES

LBRs may result in a more effective use of existing capital, a more competitive on-going insurance operation, more effective claims management, better management of ultimate liabilities related to problematic lines of business, and improvement of the availability and affordability of insurance coverage. In addition, an LBR may result in the attraction of additional capital and the enhancement of shareholder value.

On the other hand, underfunded LBRs may reduce the likelihood certain policyholder claims will be paid by the insurer. In addition, LBRs may be difficult to structure equitably due to the uncertainty associated with estimating APH liabilities, may pose questions related to policyholder participation and guaranty fund coverage in the event a restructured entity fails, and may have a negative impact on the public trust in the property and casualty insurance industry and the effectiveness of insurance regulation.

Each LBR will present certain advantages and disadvantages. An advantage to future policyholders (availability and affordability) may arise from a disadvantage to existing and prior policyholders (reduced likelihood of having their claims paid). The regulatory process requires that these advantages and disadvantages be assessed in light of applicable law and the impact upon policyholders. A pre-approval checklist is attached at Appendix 2.
IV. FINANCIAL SOLVENCY ISSUES

A. General Solvency Considerations

Regardless of the nature of an LBR, a key responsibility of the regulatory authority in assessing whether to approve the transaction will be to analyze financial solvency issues. The regulatory authority must determine whether the resulting structure will have sufficient assets, both as to quality and duration, to meet policyholder and other creditor obligations. To make this determination, the regulatory authority will need to assess reserve adequacy, collectibility of reinsurance balances, and the value and liquidity of assets. Before formulating a conclusion based on these assessments, the regulatory authority should also consider the adequacy of capital and surplus levels and whether financial support is available from the parent company or other affiliates.

The restructuring insurer should provide the regulatory authority a detailed analysis of business and operational aspects of the LBR, including a detailed business plan, historical, current and pro-forma financial statements, and a description of the transaction’s tax consequences. The financial information provided should include a balance sheet of the insurer as if the restructuring plan were approved, and schedules detailing assets and liabilities to be reallocated as a part of the restructuring plan. Any special charges or write-downs that will be made as a result of the LBR should also be specifically identified. The detailed business plan should also include a discussion of how the LBR will impact obligations to policyholders and other creditors. In addition, a statement should be provided describing the consequences if the LBR is not approved.

The regulatory authority should consider the engagement of experts to provide opinions about the impact on obligations to policyholders and other creditors, solvency, and the financial condition of the companies affected by the LBR, both immediately before and after restructurings.

B. Reserve Adequacy

Determining a reasonable estimate for liabilities will be a key part of the regulatory review process. Long-tail liabilities, especially those related to APH exposure, are most difficult to estimate. Although it is acknowledged that there is a high degree of uncertainty related to estimation of APH reserves, some regulatory authorities have concluded that sufficient information and actuarial methodologies exist to assess and estimate these exposures. The regulatory authority should consider taking the following actions to thoroughly review the adequacy of reserve estimates:

First, the regulatory authority should engage a qualified actuarial firm to: a) review methodologies used by the insurer to estimate reserves; b) review the insurer’s economic approach to funding the run-off liabilities, including reserve discounting, if any; c) determine whether the claims unit is adequately staffed with qualified professionals and that its approach to settling claims is consistent with industry “best practices”; d) opine on the adequacy of reserves on a gross and net of reinsurance basis, by accident year and line of business; and e) review the funding of the discount and the adequacy of reserves net of the discount, if reserve discounting will be permitted. Second, if liabilities include material exposures to APH liabilities, consideration should be given to performing a “ground-up” review of reserves to estimate known and incurred but not reported (IBNR) reserves. This review should include the evaluation of all known liabilities on a case-by-case, policy-by-policy basis, including IBNR reserves.
Third, the regulatory authority should consider requiring the development of a cash flow model stress test to evaluate the adequacy of assets, including reinsurance, to fund the liabilities. The ultimate liabilities, payment patterns and cash flow assumptions should be included in thereview. The stress test should consider varying loss payment patterns and investment yields.

C. Reinsurance

1. Collectibility of Reinsurance Balances

The success of an LBR may depend, in large part, on the LBR’s effect upon existing reinsurance agreements and the collectibility of reinsurance balances stemming from those agreements. Depending on the materiality of these balances, the regulatory authority should consider requiring an independent analysis of reinsurance recoverables including: a) a review of the process used to monitor, collect, and settle outstanding reinsurance recoverables; b) an analysis of existing and projected reinsurance balances, including the expected timing of cash flows; c) an analysis of the quality and financial condition of the reinsurers and prospects for recovery; d) a detailed description of write-offs or required reserves based on the independent analysis taken as a whole; e) disclosure of material disputes related to reinsurance balances and the potential impact of resolving those disputes; and f) a discussion of the impact of the LBR on the collectibility of the reinsurance balances.

The regulatory authority may also consider requiring a legal analysis of the effect a liquidation or rehabilitation proceeding involving the restructured entity would have on the timing and amounts of reinsurance recoverables and the legal rights of reinsurers to claim offsets against such recoveries.

2. Reinsurance Coverage

LBRs may include reinsurance stop loss or excess of loss coverage as an integral part of the transaction. These treaties are often complex and may require the regulatory authority to retain qualified experts to ensure that coverage is adequate, and that the treaty will perform as anticipated. The treaty may be analyzed to determine how it will operate, how the reinsurance premium will be calculated and how it will be paid, and whether the quality and financial condition of the reinsurer(s) is adequate. The regulatory authority should determine whether the amount of coverage provided by the treaty, in combination with other resources, is sufficient to meet the obligations of the restructured entity.

In addition to a stop loss or excess of loss treaty, the LBR may involve new or amended quota-share or pooling agreements within the group. The regulatory authority should review the agreements and supporting documentation to understand the movement of business and to determine the financial impact of the changes on the run-off and on-going companies. The regulatory authority should also consider reviewing existing reinsurance programs to determine that provisions are consistent with other information provided and that adequate coverage exists for on-going operations.
D. Liquidity and Value of Assets

Although proper estimation of liabilities is critical to the success of an LBR, equally as important is the assessment of whether existing assets and future cash flow are sufficient to fund the liabilities.

Much of the work related to determining whether there is a proper matching can be achieved through an appropriate stress testing process. The asset assumptions used in the stress test should be evaluated by the regulatory authority, especially if assets have high volatility, liquidity uncertainties, material valuation issues or lack diversification.

Consideration should be given to obtaining current appraisals for any material real estate or mortgage holdings; and obtaining independent investment expertise to value limited partnerships, certain privately traded investments, highly volatile collateralized mortgage obligations, structured securities, and any other asset for which the regulatory authority has concerns about the carrying value.

The regulatory authority should also consider reviewing assumptions as to investment yield and determine how the reallocation of assets might impact historical yields. This review will be the key determination of allowable discount rates and the spreads to be required between investment yield and reserve discount.

Should the asset analysis indicate there are problems related to asset matching, the regulatory authority may consider requiring: a) reallocation of problem assets to other parts of the organizational structure that are financially capable of absorbing the additional risk; b) parental guarantee of investment yields; c) collateralized parental guarantee of asset valuation; and d) disposition of assets prior to transaction approval.

E. Capital and Surplus Adequacy

One of the most difficult aspects of reviewing an LBR is determining what level of capital and surplus is adequate. In general, standard provisions of the NAIC’s Risk-Based Capital (RBC) For Insurers Model Act (the Model Act) should apply.

Unlike an ongoing insurance company, run-off entities do not compete for new or renewal business. There may be other differences in the risk profile of run-off entities that could indicate the need for reassessment of the applicability of the Model Act in individual circumstances. The reserve, underwriting, and investment factors generating the majority of required RBC were developed to measure risks retained by a run-off entity. The Model Act makes specific provision for exempting a property and casualty insurer from actions to be taken at the Mandatory Control Level if that insurer is writing no business and is running-off its existing business. Under such circumstances the insurer may be allowed to continue its run-off operations with the regulatory authority’s oversight.

Other factors to consider in determining the adequacy of capital and surplus levels include...
volatility and uncertainty related to reserve estimates, the quality of assets, and the degree of parental and affiliated support.

F. Support From Parents and Other Affiliates

As discussed in previous sections, support from parents or affiliates may play an integral part in the LBR and may be a significant factor in whether the transaction is approved. The regulatory authority should consider analyzing the change in organizational structure resulting from the LBR, placing special emphasis on the extent to which the resulting corporate structures have common ownership, overlapping management, substantial reinsurance arrangements, and on-going business ties. If the financial and marketing futures of the corporate structures are materially tied together, it may be less likely that any part of the organization will be abandoned.

If one of the resulting insurer structures is perceived to be weaker than another, the parent may show its intention of continued support through issuance of “cut-through” provisions for the benefit of policyholders of the “weaker” entity. These provisions give policyholders the legal right to file a claim against the entity issuing the cut-through should the insurer liable under the insurance contract (policy) be unable to meet its obligations. (Note: Some states have enacted laws prohibiting cut-through transactions.)

Stop loss and excess of loss reinsurance transactions have been discussed earlier in this report. The importance of these transactions, especially if with affiliated entities, should not be minimized. These transactions are often used to provide a cushion for the uncertainties related to asset and liability assumptions and can often be structured to strengthen the transaction. The regulatory authority should determine whether parental or affiliated support is available should the collectibility of reinsurance balances deteriorate.

The parent or affiliates should be encouraged to provide financial and managerial support to all entities. This support lends credibility to the LBR and provides an additional layer of security to policyholders.

V. LEGAL AND PUBLIC POLICY ISSUES

A. Applicable Laws

LBRs may implicate, directly or indirectly, a number of laws in the state of domicile including both general corporate statutes and insurance code provisions. A thorough review of all potentially applicable laws is necessary to fully understand the requirements and potential ramifications of an LBR. To the extent changes to an insurer’s corporate structure affect relationships with policyholders in other states, the laws of those jurisdictions may apply. Following is an overview of the principal laws that may need to be considered by the regulatory authority with regard to an LBR.

1. General Corporation Statutes

Corporate organization is governed by each state’s corporation law. Many states have
enacted the Revised Model Business Corporation Act (RMBCA)\(^1\) or a similar law. In most states, the corporation law applies to insurers, unless stated otherwise. The state insurance codes supplement the corporate law with additional or different requirements for insurers.\(^2\)

The general corporation law addresses the existence and internal governance of the corporation. Corporation laws set forth minimum requirements and procedures to be adhered to in connection with extraordinary transactions affecting corporate existence and structure such as reorganizations, mergers, exchanges, divisions,\(^3\) disposal of assets and dissolutions. Such extraordinary transactions may require the approval of shareholders in addition to that of the board of directors.

### a. Mergers and Consolidations

State law governs consolidation and mergers of insurers. The procedures and requirements regarding changes to the corporate structure of an insurer are usually the same as those for other corporate entities. Insurers may be subject to more regulatory scrutiny than general business corporations. A merger occurs when one corporation absorbs the other and the identity of the absorbed corporation disappears. In consolidation, the separate corporate entities disappear and a new corporate entity emerges.

Statutes governing consolidations or mergers, for the most part, require that notice be given to all stockholders or members. Mergers or consolidations of stock insurers do not require the approval of policyholders but do require approval by the regulatory authority. Mergers or consolidations of mutual insurers must be approved by both the policyholders and the regulatory authority.

### b. Divisions

Division statutes have recently been enacted by two jurisdictions. These statutes permit the division of a single corporation into two or more resulting corporations. In a division, assets and liabilities are allocated among the resulting corporations. An LBR that includes a division may also include other transactions such as changes to a pooling agreement that may require regulatory review in other jurisdictions.


#### a. Insurance Holding Company Act\(^4\)

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\(^1\) As of 1996, 22 states have enacted the current version of the RMBCA or substantially similar laws.

\(^2\) Neb.Rev.Stat. § 44-301 (Reissue 1993) states in pertinent part: "...[T]he Nebraska Business Corporation Act except as otherwise provided... shall apply to all domestic incorporated insurance companies so far as the Act is applicable or pertinent to and not in conflict with other provisions of the law relating to such companies."


\(^4\) The Insurance Holding Company System Regulatory Act (Holding Company Act) adopted by the NAIC is enacted in some form in 48 states.
Certain aspects of an LBR may be subject to the Holding Company Act even though the act does not explicitly address LBRs. An LBR may be subject to review by the regulatory authority under the Holding Company Act if the insurer is a member of an insurance holding company system. For example, if an LBR results in a change of control of a domestic insurer, the transaction must be pre-approved by the regulatory authority in accordance with certain stated criteria. In addition, the Holding Company Act governs transactions between the domestic insurer and other members of the insurance holding company system even if there is no change in control. Some of these transactions trigger advance notification to the regulatory authority depending upon the nature and extent of the transaction. All of these transactions must be on terms that are fair and reasonable. An LBR will probably be subject to these requirements of the Holding Company Act if intercompany agreements such as management agreements, reinsurance agreements or tax allocation agreements are affected.

Finally, the Holding Company Act also governs dividends or distributions by a domestic insurer. For example, if an extraordinary dividend or distribution is part of an LBR, the prior approval of the regulatory authority may be required.

b. Examination Law

All states have examination statutes that provide the authority and responsibility to conduct examinations of insurers to determine their financial condition and compliance with insurance laws and regulations. This authority includes targeted examinations triggered by a wide array of events such as deteriorating financial condition, risk-based capital results, financial analysis results, financial ratios and LBRs. Generally, a periodic examination of insurers is contemplated; however, the regulatory authority may also conduct an examination as often as deemed appropriate. The regulatory authority has the discretion within statutory confines to determine the scheduling, nature and scope of an examination. The regulatory authority is also granted examination powers under the Holding Company Act.

Generally, the regulatory authority may retain attorneys, appraisers, actuaries, certified public accountants, loss-reserve specialists, investment bankers or other professionals and specialists at the cost of the insurer being examined. Given the extraordinary nature and complexity of LBRs, it is essential that the regulatory

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5 Control is presumed to exist with the power to vote 10% or more of the voting securities of an insurer.

6 Regulatory jurisdiction under the NAIC Insurance Holding Company System Regulatory Act is of domestic insurers, but some states assert jurisdiction over non-domestic insurers on the basis of the insurer being “commercially domiciled” in that jurisdiction due to the volume of business. See CAL. INS. CODE § 1215.4 (1993).

7 The NAIC Insurance Holding Company System Regulatory Act at Section 5A. Similar authority as to insurers that are not a part of an insurance holding company system can be found in the Disclosure of Material Transactions Model Act adopted by the NAIC.

8 Id. at Section 5B.

9 The Model Law on Examinations adopted by the NAIC has been enacted in 41 states, see Section 3A.

10 The NAIC Insurance Holding Company System Regulatory Act at Section 6A.

11 The NAIC Model Law on Examination at Section 4D.
authority have the ability to contract for the services of all experts and specialists deemed necessary and to assess such costs to the insurer.

The examination statutes generally provide for the confidentiality of all workpapers, recorded information and documents obtained by, or disclosed to, the regulatory authority in the course of an examination and that these materials may not be made public, subject to some limited exceptions. The examination authority under the Holding Company Act contains a similar provision regarding confidentiality of examination materials. These confidentiality provisions are necessary for the regulatory authority to conduct a thorough examination. The examination statutes provide the regulatory authority an important tool to evaluate LBRs, but the examination law prevents the regulatory authority from disclosing examination documents that might be of interest to policyholders. (See § 5(B)(4)).

c. Other Laws

Other insurance regulatory laws that may need to be considered regarding an LBR relate to the orderly withdrawal from insurance business in the state,13 demutualization, or redomestication14 of the insurer to another state. Issues regarding guaranty fund coverage and assumption reinsurance requirements deserve special consideration and are discussed in separate sections of this paper. Other insurance laws and regulations may need to be considered in connection with an LBR. Therefore, it is important to evaluate all the ramifications of an LBR and the component steps and transactions necessary to achieve the LBR. This may involve regulatory issues not identified in this paper.

B. Due Process

What do the concepts of due process and equal protection mean in the context of the review of an LBR by the regulatory authority? The requirements of due process and equal protection are triggered by action of the state through its authorized governmental agencies. The concept of due process includes both procedural and substantive aspects. Procedural due process concerns the right of interested parties to notice and the opportunity to be heard. Substantive due process requires that government action be based on legislation that is within the scope of legislative authority and reasonably related to the purpose of the legislation. Not every proposed LBR will affect private interests to the extent that the requirements of due process and equal protection will be applicable.

The regulatory authority should consider the persons whose interests are affected by a proposed LBR and who is entitled to notice and the opportunity to be heard. The regulatory authority should consider whether a public hearing concerning the LBR is required or should be held.15 The regulatory authority should consider whether interested parties should be allowed to present evidence, call witnesses and cross-examine the witnesses of other parties. The regulatory authority should consider whether policyholder consent is necessary.

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12 Id. at Section 5F (Six of the 41 states that have enacted the Model Law have not adopted the section on confidentiality).
14 The Redomestication Model Bill adopted by the NAIC is enacted in 37 states.
15 The United States Supreme Court has held that due process of law does not require a hearing in every case of government action. See 16A Am.Jur.2d 1054, citing Boddie v. Connecticut, 401 U.S. 371 (1971).
The regulatory authority should consider the information that should be disclosed and to whom disclosure should be made. The regulatory authority should consider the persons that may be aggrieved by its decision. These questions may well have their answers in general (i.e., non-insurance) administrative and state and federal constitutional law. If not, local law may govern policyholder relationships and rights. Finally, the regulatory authority should consider whether the action to be taken is reasonable under all the attendant circumstances.

C. Assumption Reinsurance

Corporate restructurings may be subject to the assumption reinsurance transactions statutes. The Assumption Reinsurance Model Act was drafted by state insurance regulators and adopted by the NAIC Dec. 5, 1993. The model act establishes notice and disclosure requirements intended to protect consumers’ rights in an assumption reinsurance transaction. Under these statutes, insurers must seek prior approval from the regulatory authority for a transfer of business as well as notify all policyholders affected by the transfer. Policyholders must be informed that they have the right to reject the transfer.

An assumption reinsurance agreement is any contract that both transfers insurance obligations and is intended to effect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer’s insurance obligations and/or risks under the contracts are extinguished. If the laws of the domiciliary states of both the transferring and assuming insurer contain provisions substantially similar to the model act, the assumption reinsurance transaction is subject to prior approval by both states’ regulatory authorities. If no substantially similar requirements exist, the transaction is subject to the prior approval of the regulatory authorities of the states in which affected policyholders reside. Policyholders receive a notice of transfer by mail and may reject or accept the transfer. If the policyholder does not respond, the policyholder will be deemed to have given implied consent and the novation of the contract will be effected.

The effect of an assumption reinsurance transaction is to relieve the transferring insurer of all related insurance obligations and to make the assuming insurer directly liable to the policyholder for the transferred risks. In addition, a domiciliary regulatory authority has the necessary discretion to effect a transfer and novation if an insurer is in hazardous financial condition and the transfer of its insurance contracts would be in the best interests of the policyholders. These statutes may also come into play if an insurer transfers business through bulk reinsurance or a contract of bulk reinsurance. Bulk reinsurance or a contract of bulk reinsurance is an agreement whereby one insurer cedes by an assumption reinsurance agreement a certain percentage of its business to another insurer. The transaction must be filed with and approved by the regulatory authority of the insurer’s state of domicile.

D. Policyholder Consent

When a new agreement replaces an existing agreement, a novation has occurred. Because the

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16 See, e.g., Black’s Law Dictionary 1064 (6th ed. 1990) which defines “novation” as, in part: “A type of substituted contract that has the effect of adding a party, either as obligor or obligee, who was not a party to the original duty. Substitution of a new contract, debt, or
Assumption Reinsurance Model Act specifically states that it is intended to provide for the regulation of assumption reinsurance transactions as novations of contracts,17 general rules of contract law apply to any disputes arising under the assumption reinsurance agreements.

Many courts have found that the type of implied consent required by the Assumption Reinsurance Model Act is legally sufficient. For example, in State Dept. of Public Welfare v. Central Standard Life Ins. Co.,18 the Supreme Court of Wisconsin found implied consent to an assumption agreement where the policyholder retained the original policy, was silent after receiving a certificate of assumption and subsequently paid 15 premiums to the assuming insurer.

Furthermore, in Sawyer v. Sunset Mutual Life Insurance Co.,19 the Supreme Court of California held that when an insured’s beneficiaries sued the insurer that had assumed the insured’s life insurance policy, “the bringing of suit is sufficient evidence of assent on the part of respondents to said agreement and undertaking.”

However, other courts have required express consent by the policyholder to an assumption reinsurance transaction. For example, in Security Benefit Life Ins. Co. v. Federal Deposit Insurance Corp.,20 the U.S. District Court for the District of Kansas found that where a series of assumption reinsurance agreements was executed, the agreements were not enforceable without proof that the policyholder or at least one of its successors in interest consented to the novation. Acquiescence to the transaction did not constitute policyholder consent to the assumption reinsurance transaction.

In Travelers Indemnity Company v. Gillespie,21 the Supreme Court of California stated that even when an insurer obtained reinsurance and assumption agreements pursuant to the state’s withdrawal statute, policyholder consent to the transaction was still required.

In Prucha v. Guarantee Reserve Life Ins. Co.,22 the policyholder wrote to his insurer and said he did not consent to the transfer of his policy to another insurer through an assumption reinsurance agreement, but he paid premiums to the new company. The Court of Appeal of Florida, Third District, found that the policyholder’s payment of premiums did not constitute implied consent to the novation because the policyholder had no opportunity to consent and his premium payments were merely an effort to protect his investment.

E. Rights of Other Interested Parties

What persons have an interest in a proposed LBR in addition to policyholders and insurance regulators in non-domiciliary states? Guaranty funds have an interest in the approval of LBRs because they may be called upon to step in and pay claims if the restructured entity is subsequently

found to be insolvent. Third parties having pending claims against an insured of the restructuring insurer may also be interested persons. Other interested persons, depending upon the circumstances in each case, may include reinsurers, ceding insurers, general creditors, shareholders, if the restructuring insurer is a stock company, and the public.

The regulatory authority should consider the type of notice to be given to interested persons. The regulatory authority should also consider whether certain persons should be afforded the opportunity to intervene in the proceedings concerning an LBR. Finally, the regulatory authority must consider the fiscal impact of giving notice to a large number of interested persons and the participation of those persons in the approval process.

F. Disclosure of Information

In an LBR the regulatory authority should consider the extent to which financial information about the insurer involved must be disclosed to interested persons or the public. Applicable state laws may require the regulatory authority to disclose certain information. However, most of the states have enacted laws that provide for maintaining the confidentiality of sensitive information acquired by the regulatory authority during an examination of an insurer or in the course of certain other regulatory activities. Use of the examination law to evaluate an LBR may prevent the regulatory authority from disclosing materials that the regulatory authority would prefer to release to interested persons or the public.

The regulatory authority should determine whether disclosure requirements or confidentiality provisions are applicable to the review of an LBR. In the absence of explicit statutory guidance, the regulatory authority should balance due process considerations and the public’s right to know with the need to protect sensitive or proprietary information.

G. Guaranty Fund Coverage

An important issue for the regulatory authority with regard to an LBR is the availability of guaranty fund coverage in the event of the insolvency of the restructured insurer. From the viewpoint of the insurance consumer, absent express consent, guaranty fund coverage should not be reduced or eliminated by an LBR.

1. Overview of Guaranty Fund System

Each state has a guaranty fund, created by statute, to provide a safety net for policyholders and third party liability claimants in the event of the insolvency of an insurer writing property and liability lines of insurance. Although the majority of state guaranty fund statutes are based upon the NAIC Post-Assessment Property and Liability Insurance Guaranty Association Model Act, there are variations from state to state that should be taken into account by the regulatory authority when reviewing a proposed LBR. First, the lines of business covered may differ. Also, the amount of coverage provided per claim varies. Although the Model Act and many state statutes provide for payment of covered claims of up to $300,000, some state laws provide more or less coverage. Several states have enacted net worth provisions that exclude from coverage the claims of persons whose net worth
exceeds a certain benchmark, the rationale being that such persons are sophisticated purchasers and can afford to absorb some loss.\textsuperscript{23}

Since each state guaranty fund is a separate entity, each fund makes its own determination with respect to coverage. Therefore, potentially, the guaranty funds in some states may determine that claims arising from the policies of the restructured insurer are covered, while other guaranty funds may reach a different conclusion.

Finally, although the regulatory authority reviewing an LBR should consider the potential availability of guaranty fund coverage as one of many factors in deciding whether to approve the LBR, it is important to note that the existence of guaranty fund coverage can only be conclusively determined if and when the insurer becomes insolvent.

2. The Availability of Guaranty Fund Coverage May Depend Upon the Form of Restructuring

Whether guaranty fund coverage is available to policyholders, claimants, and creditors of an insurer involved in an LBR may depend upon the form of the restructuring. The regulatory authority should determine the effect of an LBR on the availability of guaranty fund coverage in the event the restructured insurer subsequently becomes insolvent. Issues to be considered include:

a. Whether an unlicensed insurer is involved in the LBR;

b. Whether the restructured insurer that could become insolvent is the insurer that issued the policy;

c. Whether the restructured insurer that could become insolvent was the insurer at the time the insured event occurred;

d. Whether the guaranty fund coverage in other states varies from the coverage available in the regulatory authority’s jurisdiction.

3. Conclusion

Guaranty fund coverage and the provisions for triggering the guaranty fund vary by state. Regulators involved in the approval of an LBR should determine the effect of the LBR on the availability of guaranty fund coverage for policyholders in the event the restructured insurer subsequently becomes insolvent. If it is concluded that an LBR places the availability of guaranty fund coverage in serious question, the structure of the proposed transaction or questionable component should be modified before approval.

VI. ON-GOING REGULATORY OVERSIGHT

\textsuperscript{23} It might be questioned whether such exclusions are appropriate if policies are transferred to a restructured entity without the insured’s consent.
A. General

The responsibility of the regulatory authority does not end with the approval of an LBR. Subsequent to the completion of the transaction there will be one or more insurers with obligations to policyholders and other creditors. These insurers will continue to require regulatory oversight. Because of the existence of obligations to policyholders and other creditors, the insurance laws of the state of domicile should continue to apply to the restructured insurer. However, the LBR may also result in the need for additional regulatory oversight. As an LBR can take many forms, the exact nature of the oversight is dependent on the risks created by an individual restructuring. To the extent that these risks can be identified prior to the approval of the LBR, the regulatory authority should consider incorporating any additional regulatory requirements in the order approving the transaction.

This section assumes that the restructured insurer remains domiciled in the United States. If this is not the case, most of this section will not apply, as the regulatory authorities approving the transaction will no longer have jurisdiction over the restructured insurer. This should be considered prior to approving the LBR.

In the end, any LBR will be judged on the reorganized insurer’s ability to meet its obligations to policyholders and other creditors. If approved, the regulatory authority has the responsibility to identify new risks created by the LBR, and institute appropriate regulatory safe-guards to help ensure that all obligations to policyholders and other creditors will be met. An outline of a program for on-going regulatory oversight is attached at Appendix 3.

B. Oversight

One of the primary areas of concern regarding a restructured insurer is the availability of sufficient resources to meet all of its obligations to policyholders and other creditors. Although the restructured insurer would still be subject to the domiciliary state’s examination law, additional oversight may be required to help mitigate additional risks created by the LBR. For instance, if a dedicated pool of assets is created to meet obligations to policyholders the regulatory authority should consider additional oversight measures designed to ensure the assets will be available to pay policyholder claims. See Appendix 3 for examples of conditions and requirements for on-going regulatory oversight of an LBR.

One of the factors that will be analyzed prior to approving an LBR is future corporate affiliations. In cases where there are continuing affiliations, the regulatory authority’s oversight would most likely include monitoring compliance with agreements between the resulting insurers. For example, the regulatory authority should consider on-going evaluations of statutory compliance with any capital maintenance agreement, and review of management or administrative agreements or other inter-company agreements or transactions. In addition, the regulatory authority should review compliance with the requirements set forth in the order approving the LBR.

Where there is common management and/or ownership of on-going and run-off operations of a restructured insurer, the regulatory authority needs to be aware of any potential conflicts of interest between the two entities. This may lead to inappropriate influence by the on-going entity of the run-off entity’s operations. For example, it might be in the interest of the on-going entity for the run-off
entity to settle claims of current on-going entity customers on a preferential basis. This could have the effect of jeopardizing whether the run-off entity will have sufficient assets to settle other policyholders claims. A similar conflict exists if there is a block of policies whose obligations revert to the on-going entity upon the insolvency of the run-off entity. If such conflicts exist the regulatory authority should consider an examination of the claim settlement patterns of the run-off entity as part of its regular examination process.

If an LBR results in one or more insurers that have no on-going operations, the regulatory authority should consider requiring regulatory approval before the run-off entity can begin or resume on-going operations. Prior to approving the reactivation of operations, the regulatory authority should consider the financial and operational resources available to the restructured insurer, and be able to determine that such a reactivation will not place existing policyholders at any additional risk.

The regulatory authority should evaluate residual market obligations before approval of an LBR. Consideration should be given to requiring that these types of obligations be assumed by the on-going entity.

VII. CONCLUSIONS AND RECOMMENDATIONS

The Liability-Based Restructuring Working Group concludes and recommends as follows:

- LBRs present both advantages and disadvantages, and therefore, LBRs should not be prohibited per se, but each should be evaluated on its own merits by the regulatory authority.

- LBRs are extraordinary transactions that vary widely in form, method and circumstances, and therefore, a “one size fits all” stand alone model law approach is not recommended at this time. Insurance regulatory authorities must have adequate statutory authority with sufficient flexibility and discretion to respond to the situation presented. The Working Group believes that existing regulatory authority is generally adequate, but recommends that the Post-Assessment Property and Liability Insurance Guaranty Association Model Act, the Assumption Reinsurance Model Act, and the Insurance Holding Company System Regulatory Act be revisited to consider whether amendments may be appropriate in light of LBRs.\(^{24}\)

- An LBR should be subject to approval or disapproval by the domestic regulatory authority(ies) on the basis of a comprehensive and thorough review. The regulatory authority should have the ability to engage all experts necessary to assist in the review at the expense of the LBR applicant.

- The LBR applicant has the burden of justifying the LBR to the regulatory authority. There regulatory authority should not approve a proposed LBR if the transaction is likely to jeopardize the financial stability of the insurers, prejudice the interests of policyholders or be unfair or unreasonable to policyholders. An LBR is not an acceptable alternative to appropriate regulatory action, such as the rehabilitation or

\(^{24}\) More specifically: the working group recommends that: (1) the NAIC review its Post-Assessment Property and Liability Insurance Guaranty Association Model Act to consider whether the definitions of “covered claim” and “insolvent insurer” should be amended to make it clear that coverage continues when there has been a division; (2) that the Assumption Reinsurance Model Act be reviewed to consider whether to clarify that a division transaction is subject to all the requirements of that Act; and (3) that the Insurance Holding Company System Regulatory Act be reviewed to consider whether any of the filing requirements should be amended in order to more fully address LBR transactions.
liquidation of insurers in hazardous financial condition, unless the hazardous financial condition is corrected in association with the LBR.

- If the effect of the LBR is intended to extinguish an insurer’s obligation to its policyholders, consent of the policyholders should be required. Such transactions result in a novation or have the same effect on policyholders as a novation and therefore should satisfy the procedural and legal requirements of a novation. States should consider adopting the Assumption Reinsurance Model Act or other legislation that will safeguard the interests of policyholders.25

- Public confidence in insurance and the integrity of the regulatory process requires that regulatory authorities strive to respond to LBRs as consistently as possible. Consideration should be given to developing a standardized regulatory review process through filing requirements, guidelines, protocols and best practices. The Pre-approval Checklist, Appendix 2, and On-going Regulation Oversight, Appendix 3, are examples of such regulatory guidelines.

- Interstate cooperation and communication are especially important. LBRs are likely to trigger the regulatory jurisdiction of more than one state and will be of interest to all states where affected policyholders reside. The domiciliary state of the parent or largest insurer involved in the LBR should coordinate activities among the states having jurisdiction over some aspect of the LBR, make basic information available to non-domiciliary states and respond to specific inquiries from non-domiciliary states as necessary.

- Policyholders should have an opportunity for direct participation in the LBR approval process. At a minimum, this should include notice to policyholders of the proposed LBR with an explanation of the LBR and its effect on policyholders, meaningful access to information about the LBR, and a public hearing that affords policyholders an opportunity to be heard. Meaningful access to information necessarily requires that policyholders be given access to information that may be sensitive and proprietary. The competing interests of the policyholders and the insurer in this regard should be balanced with appropriate measures such as protective orders or confidentiality agreements to allow policyholders access to such information while protecting the insurer’s interests, in accordance with applicable public information laws.

- The review of all financial aspects of a proposed LBR culminate in a determination of the adequacy of capital and surplus. It should be demonstrated that each insurer in the group will have adequate capital and surplus to support its own liabilities and plan of operation. The capital facilities at the holding company level also should be reviewed for adequacy should a member of the group require additional capital infusions, guarantees or other support measures.

- A key regulatory consideration in evaluating an LBR is whether there will be an on-going parental or affiliate involvement with the restructured insurer after the completion of the LBR. This involvement may take many forms, including, but not limited to, overlapping management, capital and surplus guarantees, reinsurance agreements, cut-through provisions and investment yield guarantees. The form and extent of the involvement or support will depend on the structure of the LBR and the entities involved.

- Material exposures to asbestos, pollution and health hazard claims (APH) have been the motivating factor in recent noteworthy LBRs. The Working Group recommends that the NAIC request that the

25 Arizona recently enacted Title 20, chapter 4, article 1, section 20-736 which requires policyholder consent or approval by the Director of Insurance of transfer or assignment of an insurer’s direct obligations under insurance contracts covering Arizona residents.
Casualty Actuarial (Technical) Task Force consider documenting and evaluating the analytical techniques in use to estimate such long-tail exposures.

- The major LBRs that have generated concern and raised issues are a fairly recent development. The nature of future LBRs and their frequency remains to be seen. The NAIC should consider monitoring the evolution of these transactions in order to determine whether additional regulatory responses are necessary.
Case Studies

Cigna Corporation Property and Casualty Division

An intercompany reinsurance pooling arrangement existed between a substantial portion of the property and casualty insurance companies of Cigna Corporation. The lead company in the pool was the Insurance Company of North America (INA), a Pennsylvania-domiciled insurer.

For some years the pool’s loss reserves experienced adverse development mainly from its 1986 and prior general liability policies which included APH and other long-tail liabilities. During 1994, A.M. Best downgraded the rating of the companies within the pool to B++. After a mini-restructuring in 1994 that created two separate intercompany reinsurance pooling arrangements, A.M. Best gave the pools two separate ratings, one being A- with developing implications, the other a B+ with negative implications.

To alleviate A.M. Best’s and market concerns over the operations of Cigna, a second restructuring proposal was submitted to the Pennsylvania Insurance Department in October 1995. The restructuring plan called for the use of the Pennsylvania Business Corporation Law’s division statute to divide INA into two companies. The two companies resulting from the division would be controlled by two separate holding companies. Simultaneously with the division, Cigna would amend its two pooling arrangements. The effect would be that the one resulting insurer, CCI (which would then be merged into Century Indemnity), would receive the 1986 and prior liabilities along with certain assets and be placed in run-off. The other resulting insurer, INA, would receive the remaining liabilities and assets, continue to write business and enter into a new intercompany reinsurance pooling arrangement with a substantial portion of the Cigna companies (active companies). As part of the restructuring, a capital infusion of $500 million was contributed by Cigna Corporation to Century Indemnity. In addition, the active companies supported Century Indemnity through an $800 million excess of loss reinsurance agreement and a $50 million dividend retention fund.

The Pennsylvania Insurance Commissioner approved the division and changes to the intercompany reinsurance pooling arrangements. Seven other states, Texas, Ohio, Indiana, Illinois, California, New Jersey and Connecticut, approved changes in the intercompany reinsurance pooling arrangements and a change of control of certain insurers. The reorganization became effective on Dec. 31, 1995.

Restructuring of the Crum and Forster Group

Prior to the 1993 restructuring, the Crum and Forster Group, ultimately owned by Xerox Corporation, included 21 property and casualty insurance companies, five of which directly participated in an inter-affiliate pool. The lead company of the pool was United States Fire, which, along with affiliates Westchester Fire and Constitution Reinsurance, was domiciled in New York. International Insurance Company was the sole Illinois domestic participant in the inter-affiliate pool. International Surplus Lines, an Illinois domestic, ceded 100% of its business to International Insurance Company, so it was an indirect participant in the pool.

Following a preliminary restructuring in 1990 which included exiting from the standard personal lines market and other market-related action to improve on-going operational results, Xerox announced plans to...
exit the financial services business. During the latter part of 1992, in preparation for the LBR, the group greatly strengthened loss reserves, after having suffered significant losses from Hurricanes Andrew and Iniki. Although the LBR was intended to enhance the salability of the insurance operations, an immediate goal was to realign the business into stand-alone company groups. Each group was to be dedicated to a particular purpose with greater management accountability and better focus.

The initial step of the LBR was to de-pool the group’s operations. Seven separate operating groups were created: (1) Constitution Reinsurance – treaty and facultative reinsurance; (2) Coregis – professional liability, public entity and other property and casualty programs; (3) Crum & Forster Insurance – commercial property and casualty insurance through a select network of independent agents; (4) Industrial Indemnity – workers’ compensation coverage and services; (5) The Resolution Group – reinsurance collection services and management of run-off businesses; (6) Viking – non-standard personal auto; and (7) Westchester Specialty Group – umbrella, excess casualty and specialty property business. To this end, various assumptive and indemnity reinsurance contracts were executed among the affiliates, and a stop loss contract was entered with Ridge Re, an affiliated reinsurer funded by the group’s direct parent, Xerox Financial Services. Additional capital constituting $235 million in cash and $100 million in notes was contributed to the group.

The LBR received approval in the 15 states in which the 21 property and casualty insurance companies were domiciled. The primary states were New York, Illinois, California, and New Jersey. Initial discussions with the states began during the first part of 1993, and approval from all states was received by September 7 of that year. Regulators granted approvals to Form A exemptions, restatement of unassigned funds/quasi-reorganization, various reinsurance agreements, the merger of International Surplus Lines into International Insurance Company, various service agreements, and assumption certificates.

**ITT Corporation**

In 1992, the Connecticut Insurance Department approved a series of transactions through which ITT Corporation restructured its insurance business into discontinued and on-going operations. Effective Sept. 30, 1992, First State Insurance Company (FSIC) redomesticated from Delaware to Connecticut. Ownership of FSIC and its Connecticut domiciled subsidiaries, New England Insurance Company and New England Reinsurance Company, collectively referred to as the First State Companies, was transferred from Hartford Fire Insurance Company (HFIC) to ITT Corporation through an extraordinary dividend. Since Connecticut was domicile to FSIC and its subsidiaries, no other state was required to approve the transaction. All approvals were made pursuant to Connecticut’s holding company act and notification was made to all states requiring notice regarding the discontinuation of writing new and renewal business.

**The Home Insurance Group**

Prior to mid-1995, the Home Insurance Company and five of its seven property/casualty insurance subsidiaries operated under a pooling agreement for the writing of commercial business. Following several years of losses, the Home’s upstream parents, Home Holdings, Inc. and Trygg Hansa AB, entered into an agreement in principle in December 1994 with the Zurich Insurance Group to sell the Home Companies. The agreement virtually put the Home and its subsidiaries into run-off. The issues surrounding the acquisition and related transactions involved adequacy and funding of reserves, including asbestos and environmental, reinsurance, mergers and redomestications, and placement of renewal business. In addition, Home Holdings, Inc. had outstanding public shareholders and public bondholders.
New Hampshire, the domiciliary regulatory authority for the Home Insurance Company, coordinated a multistate review. Provisions of the modified agreement included a guaranteed investment rate of 7.5%, excess of loss reinsurance coverage of up to $1.3 billion, deferral of servicing fees over cost, policyholder access to a Zurich company for new and renewal business, renewal fees paid by Zurich to fund interest on public debt, and the buyout of Home Holdings’ publicly held capital stock. The states of New Hampshire, New York, New Jersey, Illinois, Indiana, California, and Texas participated in approving all or part of the transaction, and all insurance subsidiaries except U.S. International Reinsurance Company were eventually merged into the Home Insurance Company in run-off. New Hampshire has maintained continual regulatory oversight since the transaction was approved in June 1995.
APPENDIX 2

Pre-Approval Checklist

Following is a list of information and data that, if not included in the original filing, should be requested by the regulatory authority and considered in the review of an insurer’s proposed LBR. This list should be used as general guidance and is not intended to be all inclusive. An LBR may be effected through various forms. The regulatory authority may find it necessary to request additional information, dependent upon the complexity of the proposal, the level of regulatory oversight warranted and other circumstances specific to the proposal or the insurer.

1. Narrative
   A general written summary of the proposed LBR, explaining:
   a. Reasons for undertaking the LBR;
   b. All steps necessary to accomplish the LBR, including legal and regulatory requirements and the timetable for completing such requirements;
   c. The effect of the LBR on the insurer’s financial condition;
   d. The effect of the LBR on the insurer’s policyholders;
   e. The consequences if the LBR is not approved.

2. Business Plan
   a. On-going Operations
      i. A listing of the insurer’s major markets/products.
      ii. A description of the insurer’s strategy covering major markets/products and customers and the critical success factors for achieving these strategies.
      iii. A description of the insurer’s competitive positioning for each of its major markets/products and a discussion of growth potential, profit potential and trends for each.
      iv. Identification and a discussion of the significant trends in the insurer’s major markets/products, e.g., demographic changes, alternative markets, distribution methods, etc.
      v. Identification of the largest risk exposures of the insurer, e.g., financial market volatility, environmental exposures, geographic distribution, etc.
      vi. A description of the major business risks of the insurer, e.g., sales practices, data integrity, service delivery, technology, customer satisfaction, etc.
   b. Run-off Operations
      i. A description of all plans regarding any run-off operations.
3. Financial Information
   a. Historical financial statements, including the most recently filed annual and quarterly statutory statements.
   b. Financial statements (in a spreadsheet format) detailing the accounting of the proposed LBR including:
      i. Schedules detailing assets and liabilities to be reallocated as part of the LBR.
      ii. An accounting of any special charges, reevaluations, or write-downs to be made as part of the LBR.
   c. Pro-forma financial statements of the insurer(s) as if the LBR were approved including an explanation of the underlying assumptions.
   d. Financial projections for three years (assuming the LBR is approved) for both the run-off and on-going entities and an explanation of the assumptions upon which the projections are based.
   e. A description of any tax consequences of the LBR.

4. Analysis of Reserves
   Retain qualified independent actuarial experts.
   a. The actuarial expert should perform a “ground-up” actuarial review of case and incurred but not reported reserves for asbestos, pollution, health hazard and other long-tail claims.
   b. The actuarial expert should also opine on:
      i. Methodologies used by the insurer to estimate reserves.
      ii. The adequacy of reserves on a gross and net of reinsurance basis.
      iii. The adequacy of the expertise of the insurer’s claims unit.
      iv. The insurer’s economic approach to funding the run-off liabilities, including cash flow model stress tests.
      v. If reserve discounting is permitted, funding of the discount and the adequacy of reserves net of discount.

5. Analysis of Reinsurance
   a. An analysis of reinsurance recoverables by a qualified expert including:
      i. A review of the process used to monitor, collect and settle outstanding reinsurance recoverables.
      ii. An analysis of existing and projected reinsurance balances including the expected timing of cash flows.
      iii. An analysis of the quality and financial condition of the reinsurers and prospects.
Attachment One

for recovery,
iv. A detailed description of write-offs or required reserves based on the independent analysis taken as a whole.
v. Disclosure of material disputes related to reinsurance balances and the potential impact of resolving those disputes.
vi. A discussion of the impact of the LBR on the collectibility of reinsurance balances.
b. A legal analysis of the effect that a rehabilitation or liquidation proceeding involving the restructured entity would have on the timing and amounts of reinsurance recoverables and on the legal rights of the reinsurers to claim setoffs against such recoveries.
c. If reinsurance stop loss or excess of loss coverage is an integral part of the transaction, a copy of such agreement and a written opinion from a qualified expert as to:
i. The adequacy of coverage;
ii. The ability of the treaty to perform as anticipated and be unaffected by delinquency proceedings;
iii. The practical operation of the treaty;
iv. The timing and method of payment of reinsurance premium;
v. The financial condition of reinsurers;
vi. The sufficiency of coverage and other resources.
d. A discussion of existing or proposed reinsurance programs, whether with affiliates or other reinsurers, to assist the regulatory authority in determining that provisions are consistent with other information provided and that adequate coverage exists for both on-going and run-off operations.
e. Any proposed amended, cancelled, or new pooling agreements, including explanations of significant differences before and after the restructuring, flowcharts to demonstrate the proposed movement of business, and the anticipated financial impact upon the affected companies.

6. Analysis of Liabilities Other Than Reserves
An analysis of material liabilities other than reserves, including a discussion about any reallocations or dispositions as part of the LBR, especially as they relate to reinsurance agreements and inter-company cost and tax-sharing agreements. The analysis should include all non-reserve related accruals and outstanding debt line items found on the Property/Casualty Annual Statement (page 3) for liabilities, including write-ins.

7. Analysis of Assets
An analysis should be performed to determine if existing assets and future cash flows are sufficient to fund liabilities. This analysis should include:
a. Disclosure of assumptions regarding the assets of the insurer(s) involved in the LBR,
especially those assets with high volatility, liquidity uncertainties, material valuation issues, or representing a material percentage of the invested asset portfolio.

b. Current appraisals of any material real estate or mortgage holdings, independent valuation of limited partnerships, certain privately traded investments, highly volatile collateralized mortgage obligations, structured securities, and any other assets of concern.

c. A list of assumptions used by the insurer(s) as to investment yield, and disclosure of the effect that the reallocation of assets will have on historical investment yields.

d. If the asset analysis performed by the insurer indicates a potential asset/liability matching problem, documentation that the insurer plans to take action such as:
   i. Reallocation of problem assets to other parts of the organizational structure that are financially capable of absorbing the additional risk.
   ii. Securing a parental guarantee of investment yield.
   iii. Securing a parental guarantee of asset valuation or a parental agreement to substitute the insurer’s assets.
   iv. Disposing of assets prior to approval of the LBR.

8. Parental Support
   a. The plan should provide for the provision of financial and managerial support by the parent company to all entities.
   b. The plan should provide for a commitment of parental support to run-off operations in the event of:
      i. Inadequacy of reserves;
      ii. Asset deterioration;
      iii. Deterioration in the collectibility of reinsurance recoverables.

9. Organizational Impact
   a. The plan should affirm that the restructured entity was either licensed or an approved surplus lines carrier in all jurisdictions in which it wrote business, and will be licensed in all jurisdictions where it takes on business as a result of the restructuring.
   b. Analysis of the change in organizational structure resulting from the transaction. Areas to emphasize include:
      i. Ownership of the resulting corporate structures;
      ii. relation between management of the resulting entities;
      iii. Substantial reinsurance arrangements between resulting entities;
      iv. Other on-going business ties between the resulting entities.

10. Analysis of Issues Affecting Policyholders
a. Consider whether to require that “cut-through” provisions be put in place for policyholders of the weaker entity.
b. Obtain a legal opinion that policyholders of restructured entities will not lose guaranty fund coverage as a result of the LBR.
c. Hold discussions with affected guaranty funds and National Conference of Insurance Guaranty Funds (NCIGF) regarding any coverage issues.
d. Consider whether to require that a mechanism be put in place to obtain policyholder consent regarding any novations.
APPENDIX 3
ON-GOING REGULATORY OVERSIGHT

The following are examples of conditions and requirements for on-going regulatory oversight of an LBR.

- **Reporting**
  - Require periodic operating reports.
  - Require financial statements and management reports more frequently than required by statute.
  - Require periodic reports on certain losses, including payments.
  - Require financial projections annually.
  - Require reports on actual results compared to plans.

- **Balance Sheet Discipline**
  - Require recurring actuarial reviews of reserves. This requirement could include departmental approval of the actuarial firm selected and the scope of the review.
  - Require periodic independent reviews of reinsurance recoverables.
  - Establish guidelines for future investments of inactive operations.
  - Limit discounting of reserves as allowed by law, so long as investment earnings continue to support the rate of discount.

- **Specific Transactions**
  - Prohibit dividends by inactive operations without prior approval.
  - Prohibit dividends by active operations for a set period of time.
  - Require creation of a dividend “sinking fund,” with contributions from inactive operations requiring regulatory approval and payments to be made from the principal amount. The fund would be maintained in a separate account and could not be terminated without prior written approval from the regulatory authority.
  - Require intercompany balances with the inactive operations be settled within 90 days of each quarter.
  - Require prior approval of affiliated transactions between inactive and active operations.
  - Require prior approval for inactive operations to establish security deposits with any
other jurisdictions except to the extent required by law.

- **Communications**
  - Require notice to all known policyholders and claimants affected by the transaction.
  - Require a written response to any inquiry regarding the LBR.

- **General Monitoring**
  - Require on-site monitoring facilities.
  - Require right to notice of and right to attend all Board of Directors meetings.
Alternative Mechanisms for Troubled Companies

An NAIC White Paper

February 2010

Created by the
NAIC Restructuring Mechanisms for Troubled Companies Subgroup
of the Financial Condition (E) Committee

Drafting Note: This white paper is limited to situations where the legal entity is in a financially troubled condition that could potentially lead to an insolvency in the foreseeable future. It will not consider situations where the insurer is merely inconvenienced by a particular book of business.
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I. INTRODUCTION

A. BACKGROUND/PURPOSE

State insurance regulators have well-developed receivership statutes, practices, and procedures to handle impaired and insolvent insurers. These statutes, practices, and procedures serve, first and foremost, the goal of consumer protection. They are a critical and essential part of the Regulatory Solvency Framework. However, given improvements in regard to the early detection of financially troubled insurers and insureds’ requirements for A-rated coverage, a new landscape has emerged with a growing number of troubled insurers seeking to engage in mechanisms of run-off or restructuring as an alternative to being placed in traditional receivership proceedings. For example, as of mid-year 2008 alone, there were approximately 129 active insurers in voluntary run-off domiciled in the United States with over $36 billion in claims in progress. As a result of a changing landscape and the fact that the NAIC has little formal documentation available to regulators dealing with alternative mechanisms for winding-down troubled companies, the Receivership and Insolvency (E) Task Force during 2007 began drafting charges to undertake a study of alternative mechanisms and relative best practices. These charges were presented to the Financial Condition (E) Committee during the 2007 NAIC Winter National Meeting. The Committee members supported the charges, but felt the topic of active troubled insurers required the expertise and perspective of regulators involved in the active solvency monitoring process, as well as receivership process. Thus, a Restructuring Mechanisms for Troubled Insurers Subgroup was formed directly under the Committee with regulators representing both perspectives. The Subgroup’s 2008 adopted charges were as follows:

- Undertake a study of alternative mechanisms, such as solvent schemes of arrangement, solvent run-offs, and Part VII portfolio transfers (a transfer leaving no recourse to original contractual obligor/insurer) and any other similar mechanisms to gain an understanding of:
  - How these mechanisms are utilized and implemented.
  - The potential effect on claims of domestic companies, including the consideration of preferential treatment within current laws.
  - How alien insurers (including off-shore reinsurers) who have utilized these mechanisms might affect the solvency of domestic companies.
  - Best practices for state insurance departments to consider if utilizing similar mechanisms in the United States and/or interacting with aliens who have implemented these mechanisms.

The study is documented in the form of this NAIC white paper. Additionally, the study was limited to situations where the legal entity was in a financially troubled condition that could have potentially led to insolvency in the foreseeable future. The Subgroup did not consider situations where the insurer was merely inconvenienced by a particular book of business or wished to exit the insurance business for reasons unrelated to solvency.

B. AUTHORITY & APPLICABILITY

The information in this white paper is meant to provide guidance to state insurance regulators and be an advisory resource. It discusses approaches and concepts that are available within and outside the United States in order to assist regulators with assessing possible alternatives for handling troubled insurers. Mechanisms discussed in this white paper may not be available or applicable in all jurisdictions due to differences in statutes, regulations, and implementing tools and resources, as well
as changing market conditions. In fact, statutes and regulations that define the authority and duties of regulators may require, or provide for, specific procedures to be implemented in certain circumstances. In addition, although this white paper was intended to generally apply to all risk-assuming entities that are subject to the authority of the insurance department, the majority of the Subgroup's discussion was focused on property/casualty insurance companies. Due to their unique characteristics, the mechanisms mentioned in this white paper, may not be appropriate in the context of life, health, or other personal lines of insurance for which guaranty association protections are available, or for certain types of specialized risk-assuming entities (e.g., health maintenance organizations, syndicates, risk retention groups, chartered purchasing groups, chartered self-insured groups or pools, captives, insurance exchanges, etc.). Lastly, an appropriate mechanism for a particular troubled insurer will also depend on the specific circumstances of the situation.

C. OTHER CONSIDERATIONS

As state insurance regulators consider the relative advantages and disadvantages of these alternative mechanisms, they should do so in the context of the overall policy objectives behind each alternative. Different policy objectives will inevitably lead to very different results. The current system that utilizes liquidation and provides for guaranty fund protection for certain policyholder claims reflects a legislative policy that places the rights of policyholders and claimants above the interests of other creditors of the insolvent company. While these laws may vary somewhat from state to state, they share several key features. The interests of policyholders and claimants are granted priority over claims brought by other insurers, the government, and general creditors. The laws seek to preserve, to the greatest possible extent, the insurance protection that the policyholder believed he/she was getting when he/she purchased his/her policy from the now-insolvent insurer. The law treats all similarly situated claimants in the same manner, thereby prohibiting preferential treatment for certain favored individuals or entities. Finally, they preserve, in some meaningful form, the right of judicial review. These elements form the foundation of the existing system that exhibits a clear legislative choice to place the interests of consumers above the interests of investors and large institutions that are better equipped to withstand the losses resulting from insurer insolvency.
II. GENERAL ADVANTAGES AND DISADVANTAGES FOR UTILIZING ALTERNATIVE MECHANISMS FOR TROUBLED COMPANIES

A. ADVANTAGES

- Alternative mechanisms can be useful tools for a troubled insurer’s management and regulators, potentially leading to a quicker resolution than a traditional receivership.
- Alternative mechanisms typically allow for continuous claims payments, or at least orderly claims processing and partial claims payments without interruption.
- Alternative mechanisms can cost less than receiverships, thus resulting with maximum dollars paid out to policyholders/claimants.
- Alternative mechanisms may allow greater flexibility to achieve commercially acceptable results, such as freeing up capital.

B. DISADVANTAGES

- The inherent risk for consumer and claimant issues increases, requiring stronger regulatory monitoring and controls for protection. For some alternative mechanisms, there is no guarantee that appropriate fairness will take place.
- Alternative mechanisms for troubled insurers might become a tool for solvent carriers to transfer value away from policyholders.
- As to reinsurance, restructuring might affect the value of the future reinsurance claim or offset rights, arbitration rights, and reinsurance collateral.
- The cost of efficiency or company enticements may come at the expense of policyholders or insureds.
- Difficult decisions arise with a troubled insurer that is not clearly solvent or insolvent, and significant ramifications could follow with certain choices.
- Companies may seek to continue run-off or restructuring activities even after it becomes clear that the company is hopelessly insolvent, resulting in preferential payments made at the expense of outstanding claims.
- Compensation incentives may restrict future claims-paying ability.
- Voluntary restructuring schemes may deny policyholders and consumers the substantive and procedural safeguards otherwise available for their protection in court-supervised receivership proceedings.
- Run-off and restructuring schemes may be used to circumvent state priority and preference rules in order to discount claims at the expense of policyholders and other claimants. They may also be used to circumvent other consumer protection laws, including state receivership and guaranty association laws as well as commutation and assumption transfer laws.
- May allow the company to terminate coverage and extinguish liabilities over the objections of policyholders and other creditors by majority cram-down vote.
- Run-offs and restructuring schemes may result in substantially reduced payments to policyholders. State receivership laws typically require a showing that a rehabilitation plan is fair and equitable, complies with priority rules, and provides no less favorable treatment of claims than would occur in liquidation. Run-offs and alternative mechanisms, such as
those addressed herein, may have the ability to sidestep these equitable standards and permit broad discretion in discounting claim values. In fact, the success of a plan may be dependent on the ability to impose deep discounts on claims, and there may be no rules or mandatory standards in place to protect policyholders or claimants.

- There is a risk that similarly situated creditors will be treated differently or that they will receive payments that are less than they would receive in an insolvency proceeding.
- Alternative mechanisms adopted in any given state may not be enforceable across state lines, leaving the company at risk of further exposure, litigation, and ongoing collection activity that may disrupt efforts to implement a restructuring plan.
- Alternative mechanisms are not appropriate for compromising the claims of consumer policyholders due to lack of sophistication and the existence of extensive consumer protections built into insolvency laws.
- In the absence of strong regulatory involvement, there is a risk that policyholders and creditors will not receive adequate or accurate information on which to base their decisions.
- The interests of management may not be the same as the interests of policyholders and creditors.
III. TYPES OF ALTERNATIVE MECHANISMS FOR TROUBLED COMPANIES

MECHANISMS AVAILABLE TO INSURERS WITHIN THE UNITED STATES AND RELATED TERRITORIES

A. RUN-OFF OF TROUBLED INSURER

1. DESCRIPTION

A troubled company run-off is usually a voluntary course of action where the insurer ceases writing new business on all lines of business, but continues collecting premiums and paying claims as they come due on existing business. Due to state cancellation laws, the insurer may be required to renew business, which can be particularly challenging for insurers running-off personal lines risks. The insurer may seek to run-off business in the traditional sense—paying claims in full in the ordinary course of business—or management of the insurer might seek to end or limit their exposure on insurance business before policy terms expire by utilizing reinsurance, assumption transfers, negotiated settlements, and/or voluntary policy commutations. These transactions should not have a negative impact on policyholders, as close regulatory monitoring is normally maintained throughout the process. The goal is to completely close operations while remaining solvent.

In order to succeed in run-off, assets and income must be maintained at sufficient levels to cover the remaining claims and administrative costs of handling those claims. However, solvent run-offs may have little revenue other than investment income, and run-offs may develop into insolvencies that could require receivership proceedings—for example, if the insurer is unable to collect reinsurance, makes errors in estimating recoverable assets, experiences a decline in asset values and investment income, and/or encounters other cash flow issues at any point in the process.

Although run-off mechanisms can generally be applied to property/casualty, life, health, title, or fraternal insurers, it is of general consensus that personal lines should not be included in any commutation plan incorporated as a component of any run-off plan.

a. STATUTORY BASIS FOR SUPERVISED RUN-OFF PLANS

Run-off of a troubled company may be subject to regulatory supervision under applicable state law. (See, e.g., NAIC Risk-Based Capital (RBC) For Insurers Model Act, Section 6.B(2).) Regulatory supervision of a troubled company run-off may be triggered in order to enhance the regulatory oversight and monitoring of the financial performance, consumer protections, and market conduct related to implementation of the run-off plan. Enhanced regulatory oversight may include increased financial and regulatory reporting requirements, regulatory approval of transactions and claim settlement practices, and on-site regulatory supervision. Supervision of the run-off plan is conducted in order to ensure that policyholders, consumers, and other creditors fare no worse under the run-off plan than in receivership.

For example, the Illinois Insurance Code, based on the NAIC Model Act, provides the Illinois Director of Insurance with a discretionary alternative mechanism for handling troubled property and casualty companies and health organizations whose RBC Reports indicate a mandatory control level event. Section 35A-30(c) of the Illinois Insurance Code, 215 ILCS 5/35A-30(c), provides:
In the case of a mandatory control level event with respect to a property and casualty insurer, the Director shall take the actions necessary to place the insurer in receivership under Article XIII or, in the case of an insurer that is writing no business and that is running-off its existing business, may allow the insurer to continue its run-off under the supervision of the Director. (Emphasis added)

A mandatory control level event is defined under the statute as an RBC Report that indicates that the insurer’s total adjusted capital is less than its mandatory control level RBC. Under this statutory mechanism, if there is a mandatory control level event at a company that has ceased writing new business and the company is engaged in a voluntary run-off, the Director has the discretion to either seek a receivership order or to allow the company to continue its run-off under the Director’s supervision.69 In order to persuade the Director to exercise the supervised run-off option, the company must prepare and present a comprehensive run-off plan, including financial projections, that establishes that the plan is viable, that there is a high probability that the run-off can be conducted without putting policyholders at greater risk, and that all claim obligations will be satisfied.

The specific content of the run-off plan may vary depending upon the nature of the business being run-off and the financial circumstances of the troubled company. (See a sample outline for a run-off plan at VII. Appendix C.) However, the primary goals of the plan should include and achieve consumer protection, satisfaction of all policyholder obligations, and the maintenance of positive surplus and sufficient liquidity. Typically, the components of such a plan would include substantial cost-cutting measures, commutations of reinsurance agreements, collection of outstanding premium, recovery of statutory deposits, policy buy-backs, novations, and claim settlements.70 A key element of such a plan would be a discussion of the benefits to the policyholders of a run-off rather than a receivership, including the impact of any state guaranty fund or guaranty association coverage.

The nature and scope of the Director’s supervision may be delineated in a comprehensive corrective order, which would include and reference such things as the run-off plan, periodic reporting requirements, on-site monitoring, procedures relating to the approval of transactions, claim settlement practices, and other related matters. The corrective order, which may be amended from time to time, would likely be confidential under state law. Because the company is involved in a supervised run-off, it may be appropriate to negotiate certain adjustments (e.g., discount reserves, allow prepaid expenses, remove schedule F penalty) to its statutory financial statements, but, as adjusted, the financial statements should still comply with Generally Accepted Accounting Principles. Any such adjustments should be based upon credible forecasts and other available information.

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69 Section 35A-30(d), 215 ILCS 5/35A-30(d), of the Illinois Insurance Code provides the Director with a similar supervised run-off option with respect to troubled health organizations.

70 In 2005, the Illinois voidable preference statute was amended to provide that in the case of a company involved in a supervised run-off, a transaction involving transfer of cash or other assets by the company (buy-back, settlements, etc.) that was approved by the Director in writing cannot later be found to constitute a voidable transfer, 215 ILCS 5/204 (m)(C). This provision provides policyholders and other parties to buy-back, novation, commutation and other approved transactions with protection from the voidable preference statute in the event that the company ultimately goes into liquidation. In the absence of this protection, policyholders and others may be reluctant to enter into such transactions.
2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

• Voluntary run-offs may enable commercial parties to achieve commercially acceptable results in arm’s-length transactions that reflect customary market practice.
• Timely defense and payment of policyholder claims in full not otherwise always covered by guaranty funds or associations.
• Potentially more favorable environment for the negotiation of disengagement transactions and commutations with reinsurers.
• Continuity of management information systems.
• Some business entities may be willing to acquire insurance companies in run-off and inject additional capital or reduce overhead expense. This consolidation and management expertise could provide some efficiency for regulators in regard to their monitoring processes.
• Typically involve commutations and other solutions reflective of the consent of the contracting parties.
• Strategic decisions can be made quickly and efficiently working with appropriate state regulators.

DISADVANTAGES

• Preferential treatment issues might arise when dealing with business-to-business structures, if both large and small policyholders exist, as deals tend to focus on settling with large carriers first. In addition, more complicated commutations may be structured in the run-off plan to be handled last.
• Preferential payments may arise with respect to creditors whose priority of payment in the event of liquidation would be classified below that of policyholder and consumer claims.
• Policyholders and consumers may be compelled to accept less than the fair value of their claims.
• Potential negative impact of adverse claim development.
• Attempts to commute or settle with policyholders (complete policy buy-backs) can result in reinsurers resisting payment.
• To the extent the estate assets are reduced by paying claims earlier, the estate assets remaining to pay remaining policyholder and guaranty association claims will be reduced, costing the industry more.
• Larger insureds may have better leverage to negotiate better settlements.
• Absent regulatory oversight—there is no guarantee that settlements will be at consistent or even fair levels.
• The absence of court oversight and mandatory rules and standards (such as priority rules and rehabilitation plan standards) increases the likelihood that policyholder claims will be sharply discounted and that bargained-for benefits and protections will be lost.
• Guaranty funds may be disadvantaged in a subsequent receivership if non-guaranteed creditors were paid more than the ultimate distribution from the receivership.
B. NEW YORK REGULATION 141

1. DESCRIPTION

In 1989, at the request of the New York Superintendent of Insurance, the New York Legislature enacted New York Insurance Law § 1321. Section 1321 authorized the Superintendent to permit an impaired or insolvent New York domestic insurer (or an impaired or insolvent United States branch of an alien insurer entered through New York) to commute reinsurance agreements to eliminate the company’s impairment or insolvency.

Until the Legislature enacted NYIL § 1321, commutation agreements with troubled New York domestic insurers were subject to challenge as potential preferences pursuant to the Insurance Law’s voidable transfer provisions. When the Legislature enacted Section 1321, it extended the voidable transfer period from four to 12 months (NYIL § 7425(a)). The Legislature also amended the insurance law to provide that commutation agreements executed pursuant to NYIL § 1321 “shall not be voidable as a preference” (NYIL §7425(d)).

Section 1321 required that any commutation proposed under the new statute be approved by the Superintendent “in accordance with standards prescribed by regulation.” In 1990, the acting New York Superintendent promulgated Regulation 141 (Regulation No. 141, Commutation of Reinsurance Agreements, N.Y. Compo Codes R. & Regs. tit. 11, Section 128 (1989) (11 NYCRR Section 128)). Regulation 141 sets out the “applicable standards that the superintendent will use in determining whether such commutations entered … will be approved.”

Regulation 141 applies to all New York-domiciled insurers (and U.S. branches) “other than a life insurance company” as defined in NYIL § 107(a)(2). However, the regulation excludes impaired or insolvent life insurers and solvent insurers. The Regulation sets out how a troubled insurer may propose and implement a Regulation 141 plan. Among other things, the Regulation’s procedures add the requirement that any company seeking the benefits of Regulation 141 must stipulate that the troubled insurer will consent to an order of rehabilitation or liquidation if its proposed commutation plan does not restore policyholder surplus to the required minimum amounts (or such surplus as the Superintendent deems adequate).

The troubled insurer must provide the New York Department with a draft commutation agreement and a proposed commutation offer that will be extended to “each and every ceding insurer to which the impaired or insolvent insurer has obligations.” The reinsurer must also provide a balance sheet showing both the insurer’s impairment or insolvency as determined by the Superintendent and a pro forma balance sheet reflecting the troubled company’s financial condition subsequent to the plan’s implementations.

The proposed commutation offer must include an offer to pay a percentage of the cedent’s losses. The impaired insurer must advise its cedents that the commutation offer remains subject to the Superintendent’s determination that the total of all accepted commutation offers has restored policyholder surplus either to a statutory minimum or an amount that the Superintendent deems adequate.

Regulation 141 requires that offers to commute assumed reinsurance obligations be made to “each and every ceding insurer to which the impaired insurer or insolvent insurer has obligations.” The Regulation broadly defines the term “obligations” to include paid losses, loss reserves, incurred but not reported (IBNR), all loss adjusting expenses (paid, case, and IBNR), reserves for unearned premiums, and “any
other balances due under the reinsurance agreements.” The terms of all proposed commutation agreements must be the same.

For example, the same discount must be offered to each cedent—e.g., 90% of paid losses, 60% of case reserves, and 30% of IBNR. No cedent may be favored with different discounts. Discounts for different lines of business may be proposed, but these discounts must be “reasonable, actuarially sound, and supported by documents justifying such a variance.” To date, none of the Regulation 141 plans approved by New York Superintendents of Insurance has incorporated different discounts by line of business.

Any proposed Regulation 141 plan submitted to the Superintendent must include an exhibit setting forth the obligations due each cedent to which the troubled company has obligations and the consideration (commutation offer) to be paid each cedent. Within 10 days of the plan’s approval, the troubled company must deliver its proposed commutation agreements to its cedents. No cedent may be compelled to commute its “obligations.” The terms of the proposed commutations and the amount offered “shall not be subject to negotiation.” Each cedent makes its own determination with respect to whether the cedent wishes to accept the proposed commutation or refuse to commute and run the risk that the Regulation 141 plan will not succeed.

The results of an approved plan must be returned to the Superintendent within a period specified by the Superintendent. The plan results must include: copies of all executed commutation agreements; copies of all rejected commutation agreements; “correspondence pertaining to all … offers made to the ceding insurers”; a pro forma balance sheet showing the effect of the accepted/rejected offers; any other components of the plan to restore surplus to policyholders; and copies of any agreements that modify, commute, or assign any retrocession agreements.

If the Superintendent determines that the proposed commutation agreements and any other plan components sufficiently restore policyholder surplus, the commutation agreements take effect. The Superintendent may specify, when he or she approves the Regulation 141 plan, that cedents that agree to commute be paid within so many business days.

If the Superintendent determines that surplus has been restored, the Superintendent may proceed against the troubled company armed with the company’s stipulation consenting to entry of any order of rehabilitation or liquidation.

The primary procedural safeguards for an approved Regulation 141 plan include: the state regulator’s full discretion to accept, reject, or modify any proposed plan; explicit requirements that the same commutation terms be offered to every ceding company whose obligations appear on the troubled company’s books and records; the absence of any “cram down” provisions that would allow the Superintendent to approve the commutation of a cedent’s contracts over a cedent’s objections; time-frames for the submission of a plan and payment of agreed commutation amounts within days after the plan’s results have been approved; and provisions calling for the preservation and production of all communications between the troubled company and its cedents.

In addition, and as previously noted, the commutation agreements executed pursuant to an approved Regulation 141 plan will not take effect “unless … the plan shall eliminate the insurer’s impairment or insolvency” and restore surplus to policyholders to levels required under the insurance law or an amount that the Superintendent deems “is adequate in relation to the insurer’s outstanding liabilities or financial needs.”
Although the troubled company’s directors must consent to an order of rehabilitation or liquidation if the company’s surplus has not been restored to the required minimum, the Superintendent need not consider any plan proposed pursuant to Regulation 141 “in lieu of taking any other action” against the company. This gives the Superintendent full discretion to decide whether to allow the troubled company to propose a plan or to take other action against the company, including supervision, rehabilitation, or liquidation.

Thus far, three professional reinsurers have successfully implemented New York Superintendent-approved commutation plans pursuant to Regulation 141: 1) Rochdale Insurance Company; 2) Paladin Reinsurance Company; and 3) Constellation Reinsurance Company. In addition, the Insurance Company of the State of New York (INSCORP) obtained the Superintendent’s approval for a Regulation 141 plan and submitted its commutation plan results to the Superintendent. However, as a result of the continued adverse development, INSCORP’s policyholder surplus could not be improved to an acceptable level, and INSCORP was placed in rehabilitation.


2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

• No cedent can be outvoted and compelled to accept a commutation offer.
• All communications to and from the ceding insurer must be preserved and provided to the regulator.
• Although the regulation was designed for professional reinsurers, the plan also works if the troubled insurer is engaged in assumed reinsurance and also wrote direct business.
• No court approval is required.
• The plan must show how the proposed commutations will affect its retrocessional program, thus reducing the risk that the commutation plan will bind or negatively affect retrocessionaires.
• The Superintendent has ultimate oversight, flexibility, and control, to the extent that the Superintendent may approve, disapprove, or modify a plan, and the Superintendent may also review all the communications exchanged relating to the offer to ensure that no unfair offsets were arranged or that offers to commute did not otherwise favor or disfavor particular cedents.
• Regulation 141 also allows for other components to be added to the plan to restore policyholder surplus, including surplus notes and capital contributions.

DISADVANTAGES

• As an offer under this regulation is based on the assuming reinsurer’s books at a given date, discrepancies between the ceding and assuming insurers’ books are likely to occur.
• Timing could become problematic if the regulator does not enforce strict deadlines regarding the consideration and execution of offers.
• Regulation 141 does not require an audited balance sheet to confirm the extent of the troubled insurer’s financial condition.
• Many subjective considerations must be used by the troubled insurer to determine in advance what percentage of approval is needed for the plan to work.
C. RHODE ISLAND STATUTE AND REGULATION FOR VOLUNTARY RESTRUCTURING OF SOLVENT INSURERS

1. DESCRIPTION

Rhode Island’s Title 27, Chapter 14.571 provides for voluntary restructuring of solvent insurers. The statute was intended to provide an alternative to a traditional run-off by bringing “solvent schemes of arrangement” (which are discussed further in the next section) to the United States. It allows solvent companies that are in run-off to reach a court-ordered (and department of insurance supervised) agreement with all of its creditors in order to accelerate completion of the run-off, bringing certainty of payment to creditors and reducing administrative costs often associated with lengthy run-offs.

The statute sets forth a structure for court-ordered review, approval and implementation of what the statute refers to as a “commutation plan.” The process may only be utilized by reinsurers and commercial property and casualty insurers domiciled in Rhode Island and in run-off (R.I. Gen. Laws § 27-14.5-1(6)). In addition, the insurer must be solvent and adequately reserved in accordance with all applicable Rhode Island statutes and regulations, as well as in compliance with all other department solvency standards.

A company considering the process must first prepare and submit their proposed commutation plan to the insurance department for review (Insurance Regulation 68(4)(a)(i)). A commutation plan is very broadly defined as a plan for extinguishing the outstanding liabilities of a commercial run-off insurer. After the plan is reviewed by the department and all issues are resolved, the company may apply to the court for an order agreeing to classes of creditors and calling for a meeting of creditors (R.I. Gen. Laws §§ 27-14.5-3 and 27-14.5-4(b)(1)). At this point, the company is required to give notice of the application and proposed commutation plan to all parties pursuant to fairly broad requirements set forth in the statute. (See Insurance Regulation 68(4)(a)(iii)).

All creditors and interested parties (such as Guaranty Funds) are granted full access to the plan and all information related to the plan. Both creditors and interested parties are given an opportunity to file comments or objections to the plan with the court (R.I. Gen. Laws § 27-14.5-4(b)(3)). Ultimately, all creditors must be given an opportunity to vote on the commutation plan, and approval of the plan requires consent of at least i) 50% of each class of creditors, and ii) the holders of 75% in value of the liabilities owed to each class of creditors (R.I. Gen. Laws § 27-14.5-4(b)(4)). However, it is important to note that only the claims of creditors present or voting through proxy at the meeting of the creditors are counted toward determining whether the requisite majorities have been achieved. (See Insurance Regulation 68(4)(c)(i)).

Upon approval of the commutation plan by the creditors, the company must petition the court to enter an order confirming the approval and allowing implementation of the plan (R.I. Gen. Laws § 27-14.5-4(c)(1)). The implementation order must enjoin all litigation in all jurisdictions between the applicant and creditors, as well as release the applicant of all obligations to its creditors upon payment.
of the amounts specified in the plan (R.I. Gen. Laws § 27-14.5-4(c)(2)). The court may only issue an implementation order if it determines that implementation of the commutation plan would not materially adversely affect either the interests of objecting creditors or the interests of assumption policyholders (R.I. Gen. Laws § 27-14.5(c)(1)(ii)). The court does have a responsibility to ensure that all policyholders and creditors have been treated fairly. Once the implementation order is entered, distribution to creditors may begin.

After implementation and upon completion of the commutation plan, the court can issue an order of discharge or dissolution. As a result of this order, the company is either i) dissolved or ii) discharged from the proceeding without any liabilities. At this point, any residual assets are distributed to the company owners (R.I. Gen. Laws § 27-14.5-4(d)).

One of the key aspects of the process is that the court’s implementation order releases the insurer from all obligations to its creditors upon payment of the amounts specified in the commutation plan. This brings about a court-ordered finality to the run-off that would not be possible utilizing traditional run-off options. To this end, the order actually binds the insurer and all of its creditors and owners, whether or not a particular creditor or owner is affected by the plan or has accepted the plan, or whether or not the creditor or owner ultimately receives money under the plan. The order is also binding whether or not creditors had actual notice (R.I. Gen. Laws § 27-14.5-3(b)).

It is also important to note that because the restructuring mechanism provided for by the statute would not be appropriate or practical for companies with a large number of small creditors with very diverse interests, the statute is restricted to use by reinsurers and commercial property and casualty insurers. It includes express limitations on the lines of business that can be included in a commutation plan, and specifically excludes all life insurance, workers’ compensation and personal lines (See R.I. Gen. Laws § 27-14.5-1(21)). However, in cases where a company does have excluded lines, the statute provides for a bifurcated process for disposing of all lines of business within the context of the run-off scheme. Commercial lines would be included in the commutation plan, and, if possible, excluded lines would be transferred to an eligible insurer through court-ordered and department-sanctioned assumption reinsurance (See R.I. Gen. Laws § 27-14.5-1(6) and R.I. Gen. Laws § 27-14.5-4(d)(2)(ii)).

Again, the process is available only to solvent companies—the theory being that the restructuring would permit all liabilities to be paid in full.

The definition of “Commercial Run-off Insurer” under the statute was expanded by amendment in 2007 to include companies newly formed or re-activated under Rhode Island law solely for the purpose of accepting transferred business for restructuring pursuant to the statute (See R.I. Gen. Laws § 27-14.5-1(6)). The purpose of this amendment was to expand the population of insurers that might qualify for the process. The amendment permits an insurer to transfer some or all of its commercial liabilities (a very controversial process) to a newly formed run-off entity for the sole purpose of implementing a commutation plan pursuant to the statute. The original insurer would be allowed to continue writing business with no further obligations under the transferred policies. Any such transfer would require prior approval of the department.

Since the statute’s enactment in 2002, no insurer has availed itself of the statute, and no other U.S. state has adopted a similar law.
2. ADVANTAGES/DISADVANTAGES

ADVANTAGES
• Might provide a better solution for policyholders and investors than traditional run-off options (creditor democracy).
• Provides certainty of payment to creditors of present and future claims.
• Avoidance of a lengthy run-off with the associated ongoing administrative costs, adverse claim development and deteriorating reinsurance collections.
• Provides certainty of payment by reinsurers.
• Accelerated release of capital to shareholders at the conclusion of the process, allowing for more efficient deployment of capital to non-run-off operations.
• Such mechanisms might attract capital to the industry, as the availability of a reasonable exit mechanism for these companies will create an active market for investment in run-off companies.

DISADVANTAGES
• Permits an insurer to terminate coverage and extinguish liabilities over the objections of policyholders and creditors who are in the minority.
• Creditors are bound by the plan whether they had notice or not, and only those present or voting through proxy are counted toward establishing the requisite majority, which may create incentives to manipulate notice (though the department and court could take steps to prevent such manipulation).
• Although the process is limited to solvent insurers and the intent therefore is that full value will be paid to all creditors, there are no guarantees that all policyholders will receive full value, or even present value for their claims (especially those with IBNR claims).
• There is no reference to segregating and preserving reserve assets for excluded lines, or any explanation as to how policies and claims would be administered and paid during the interim period prior to completion of the plan.
• Questions concerning the enforceability of any such plan across state lines may leave companies exposed to further risk, litigation and disruption or termination of a plan—i.e., even if the Rhode Island court did approve the plan, it is possible that policyholder or claimant actions could arise in other states’ courts, (or perhaps federal courts), resulting in enforcement and implementation issues for the company attempting the restructuring.73
• Although the Rhode Island plan is available only to commercial insurers and reinsurers in run-off, the plan is not exclusively limited to “troubled” companies; thus, any commercial run-off insurer could conceivably use this mechanism to cease operations and eliminate ongoing claims payment liability.
• Despite the fact that there is significant statutorily delineated regulatory guidance included in the Rhode Island framework (unlike UK solvent schemes), parties may view Rhode Island’s “commutation plan” statute as simply a domestic version of the UK’s solvent schemes and attribute all of the disadvantages associated with UK-like solvent schemes of arrangements (listed below in D-2) to the Rhode Island system.
• Because the Rhode Island statute allows for the formation or reactivation of a domestic company and the transfer of assets and liabilities to that company, certain parties view this as allowing a “ring-fence” of assets, unfairly shielding assets from creditors.

MECHANISMS AVAILABLE TO INSURERS OUTSIDE THE UNITED STATES AND RELATED TERRITORIES

D. UK-LIKE SOLVENT SCHEMES OF ARRANGEMENTS

1. DESCRIPTION

A scheme of arrangement is essentially a statutory compromise or arrangement between a company and its creditors. The process is allowed under Part 26 of the United Kingdom Companies Act 2006 that requires majority creditor approval representing at least 75% in value of obligations; confirmation by the UK Financial Service Authority (FSA) of no objections; and court sanction. If approved, the process will bind all creditors, but does not necessarily bind reinsurers. The process has evolved over the years and includes a process for insolvent and solvent insurers.

The FSA maintains a very active role in reviewing the schemes with a review document containing approximately 30 questions. In July 2007, the FSA issued a process guide related to decisions made with schemes that included the following:

- Stresses that the scheme must comply with principles for businesses (e.g., treating policyholders fairly and communicating in clear terms).
- Established an FSA schemes review committee.
- Stated that the run-off should be at least five years old.
- Distinguishes between individual retail and small commercial policyholders, large commercial policyholders and other risk carriers.
- Distinguishes between insolvent risk carrier, marginally solvent risk carrier and substantially solvent risk carrier.
- In case of substantially solvent risk carrier, the FSA is likely to object to a scheme unless the risk carrier offers benefits designed to ensure that policyholders are not in a worse position than in a solvent run-off.
- Provides for a role of policyholder advocate.
- The FSA may not object to a scheme, even if it fails to satisfy the criteria stipulated, if the risk carrier can demonstrate that the scheme treats policyholders fairly (e.g., through suitable additional benefits for policyholders and/or safeguards for dissenting procedures).

As of September 2008, there have been approximately 174 solvent schemes of UK non-life business. However, in every instance when policyholders have mounted serious opposition, the UK courts have ruled in the policyholders’ favor. In particular, objecting policyholders have successfully challenged the British Aviation Insurance Co. Ltd. (BAIC), Willis Faber Underwriting Management (WFUM) and Scottish Lion solvent schemes in the UK courts. These are the only solvent schemes involving direct policyholder coverage that have been challenged to date, and all three have resulted in the court rulings favorable to the policyholders. To date, no UK court has agreed to sanction a solvent scheme involving direct coverage (as opposed to reinsurance) in the face of a policyholder legal challenge to the scheme.

Claims being paid can include IBNR, and most schemes have the ability to pay for IBNR based on estimation methodology. Additionally, schemes will allow a creditor’s methodology to be used, if reasonable.
Chapter 15 of the U.S. Bankruptcy Code may be used to assist with a scheme of arrangement in the United States. The effect is to grant a U.S. bankruptcy court authority to enforce the scheme and protect the company’s assets from creditors. However, although no UK solvent scheme has yet been challenged under Chapter 15 of the U.S. Bankruptcy Code, there is a possibility that such challenges may arise, and the U.S. bankruptcy courts could reject solvent schemes.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES
- Some advocates state that solvent scheme mechanisms, in particular, have proven to be very effective in the UK and other jurisdictions to permit closure of companies that have reduced their liabilities to fairly minimal levels and that can reasonably estimate their future liabilities.
- Such mechanisms might attract capital to the industry, as the availability of a reasonable exit mechanism from these companies will create an active market for investment in run-off companies.
- Companies using UK schemes of arrangements have statistically improved their net asset position by approximately 5%.
- Some insurers have made payments to creditors at or near 100%.
- Schemes may allow a creditor’s claim estimation methodology to be used, if reasonable.

DISADVANTAGES
- Schemes may undermine the value of insurance contracts by not honoring contractual obligations.
- Lost coverage may hurt policyholders at the expense of American citizens and the economy.
- Schemes could pose a formidable collective action problem.
- Schemes could undermine the reliability of insurance institutions.
- Schemes may allow for the reduction or cancellation of contractual obligations outside the scope of the current receivership system by not adhering to the statutory priority of distribution rules. Under such a scheme, a troubled company could force certain policyholders to commute (or buy-back) mutually agreed-upon insurance coverage despite their objections.
- The use of terms “debtor” and “creditor” used in the restructuring arena may tactically create a new environment for insurance where risk transfer is not necessarily part of the product purchased.
- Enforceability across state lines.
- Schemes could be used by companies to simply reorganize their corporate structure to move reinsurance operations unencumbered by old claims under a different name.
- In its latest proposal, the Reinsurance (E) Task Force had a provision where an insurer engaging in solvent schemes would not be allowed to take a reduction of collateral.
- Chapter 15 is a relatively new provision of the Bankruptcy Code with relatively little case law to support it, thus leaving the ability for judges’ discretion and leeway in its application.
- Schemes can involve reinsurers, where the reinsurance contract with an insurance company is negatively affected.
- Schemes could provide an opportunity for solvent insurers to avoid insurance and reinsurance obligations and return the risk to insureds of ceding companies who purchased...
Attachment Two

the coverage in good faith.

- Schemes force creditors to trade insurance coverage for payments based on estimations of future claims that are inexact and possibly unfair.
- The individuals chosen to adjudicate claims under a scheme may lack expertise in the necessary legal issues.
- There is no oversight of solicitation by the company of scheme acceptances. Thus, some accepting creditors may have already achieved favorable settlements, while dissenting creditors are left to litigate their claims in an unfavorable forum.
- Schemes do not allow dissenting policyholders to opt out of the scheme.
- Schemes do not ensure continuation of coverage.
- Schemes do not include a safety net of guaranty association protection.
- Schemes do not allow a policyholder to seek judicial review of its claims against the insurer.

E. PART VII PORTFOLIO TRANSFERS

1. DESCRIPTION

Part VII of the Financial Services and Markets Act 2000 (FSMA) allows for a transfer of insurance business under a statutory and court process. The transfer allows a reinsurer to move all or certain of its reinsurance business (assets and liabilities) to another reinsurer without the consent of each and every policyholder but with the sanction of the UK High Court. The main statutory requirements are: 1) policyholder notification; 2) a report by an independent expert; 3) UK High Court approval; and 4) no objection by the FSA or other regulators and interested parties, including policyholders.

The court is involved in the process with the directions hearing, which is when court will grant leave to proceed. The court is also involved in the hearing to sanction the transfer (or final hearing). The relevant legislation and requirements can be found in VII. Appendix D4.

The transferee must be an insurance company established in a European Economic Area (EEA) state. However, the transferor can be authorized in the UK, an EEA branch of a UK firm, a UK branch of an EEA firm, an EEA firm with no UK branch, or a non-EEA that is permitted to carry on business in the UK.

Per the FSA Web site, the following are reasons why reinsurance firms undertake Part VII transfers:
- Rationalization—combine similar business from two or more subsidiaries, putting all into a single regulated entity.
- Efficiency—transfer business between third parties, separating old liabilities in run-off from new business, putting each into separate firms.
- Capital reduction—transfer business to a new firm and extract any surplus shareholders’ funds.
- Exit—transfer business such as employers’ liability that cannot be schemed.

The legal effect of a Part VII transfer is a statutory unilateral novation of the affected contracts of insurance or reinsurance, including any rights attaching to those contracts.

The two primary aspects for the protection of affected parties are as follows: 1) the independent expert’s report, which needs only to consider the effect on policyholders; and 2) the court is required
to be satisfied that the transfer as a whole is fair as between the interests of different classes of persons affected by the transfer.

Per the FSA Web site, the FSA and the court are concerned whether a policyholder, employee, or other interested person or any group of them will be adversely affected by the scheme. This is primarily a matter of actuarial and regulatory judgment involving a comparison of the security and reasonable expectations of policyholders without the scheme with what would be the result if the scheme were implemented. The court will pay close attention to any views expressed by the FSA regarding whether individual policyholders or groups of policyholders may be adversely affected, though this does not necessarily mean that the transfer is to be rejected by the court.

The key question is whether the transfer as a whole is fair as between the interests of the different classes of persons affected. However, it is not the function of the court to produce what, in its view, is the best possible scheme. With regard to different transfers, the court may deem all fair, but it is the company’s directors’ choice to select the transfer to pursue. Under the same principle, the details of the scheme are not a matter for the court, provided that the scheme as a whole is found to be fair. Thus, the court will not amend the scheme, because individual provisions could be improved upon.

Overall, a loss portfolio transfer is a means of transferring outstanding net or gross legal liability from one insurer to another insurer. It has been viewed as a form of retrospective reinsurance. The transfers must be sanctioned by the court, and are subject to review and opinion by an independent expert that is approved by the FSA. Notice of the proposed transfer is usually required to be sent to all policyholders of the parties unless the court decides otherwise. A detailed report must also be provided setting out all the details and the independent expert’s opinion. The FSA and any party who feels adversely affected by the transfer can make representation to the court for consideration.

The FSA is also required to assess a number of aspects (e.g., whether policyholders will be worse off moving from one place to another, or if there is any potential risk posed by the transfer). Rating agency ratings or the effect on ratings could be a component as part of the FSA’s considerations, as well as other regulatory bodies.

There have been over 100 Part 7 transfers, and the majority dealt with internal reorganization within holding groups. Over 50% were performed in the life industry. Very few Part 7 transfers have seen business go from a company to a third party; however, they are becoming increasingly popular. The receiving company’s motives for entering into these arrangements may stem from tax advantages to potential profits based on one’s claims handling experience.
The foregoing tables compare schemes of arrangement and Part 7 transfers with analogous mechanisms available under U.S. law. While it appears that the mechanisms are similar in many respects, in practice they have proven to be quite different. Under UK schemes of arrangement, policyholders have been forced to accept payouts based on estimations of their claims so that equity holders can recapture the capital of the company. Under UK Part 7 transfers, policyholders have been forced to accept the credit of another insurer in order to permit the insurer from whom they bought the policy to exit business and recapture its capital. Current U.S. practice, with the possible exception of the Rhode Island statute, would not enable these results. Policyholders are only required to accept payment based on estimation in the U.S. where the company is insolvent and shareholders will not receive a return of their capital. Also, under current U.S. practice, policy transfers to a new insurer are not made involuntarily except where there is an insolvency of the transferor. While UK regimes certainly have safeguards in the form of voting (in the case of schemes) and court review (in the case of schemes and Part 7 transfers), the ultimate risk is left on the policyholder.

2. ADVANTAGES/DISADVANTAGES

ADVANTAGES

- Permits more efficient management of transferred books of business, allows dedicated capital and focused solutions to be applied to run-off liabilities, and promotes efficient use of capital for ongoing business.
- Options can be explored to strengthen policyholder protections and reach regulator approval, such as altering deductibles, strengthening reserves, obtaining reinsurance, and other arrangements to share the risk.
- Might attract new capital to insurance businesses insofar as it can be invested directly in run-off liabilities, and strengthens ongoing companies by permitting the separation of those
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liabilities.

- Can reduce risk of exposure.
- A recent amended UK rule introduces a simpler alternative where no court sanction is required for pure reinsurance business transfers if all the policyholders affected by the transfer consent to the proposal.
- Substantial regulatory oversight is required.

**DISADVANTAGES**

- Could transfer obligations from the entity the creditor dealt with: to one that is completely unknown; to one with whom the creditor would have never willingly chosen to deal; from a differing country subject to different regulation; and to a less secure debtor.
- A Part VII-like transfer to an alien reinsurer from a U.S. domestic reinsurer may cause the primary insurer to lose its credit for reinsurance.
- Very difficult to quantify trapped capital in these scenarios.
- Problems could arise for a ceding company, if the Part VII transfer goes to a reinsurer with a lower rating, because the rating agency could lower the ceding company’s rating.
- Could present unique accounting and reporting anomalies on both a statutory and GAAP basis.
- The regulator is not required to publicly explain its decision-making process.
IV. OBSERVATIONS AND CONSIDERATIONS BEFORE USING ALTERNATIVE MECHANISMS

A. EXISTING STATUTORY AUTHORITY AND REQUIREMENTS

1. STATE RECEIVERSHIP/GUARANTY FUND LAWS

Delinquency proceedings (receiverships) are instituted against an insurance company by an insurance department for the purpose of conserving, rehabilitating, or liquidating an insurance company. All require a court order, and the domiciliary state court will take jurisdiction over matters involving the resulting receivership estate. The court’s role is to ensure transparency and due process and to be an independent arbiter of any disputes that may arise. The nature, timing, and extent of regulatory action in any given troubled insurer situation depend on the circumstances of the particular situation.

The U.S. Constitution in Article I, Section 10 states that “No state shall … pass any … law impairing the obligation of contracts.” However, during certain delinquency proceedings, states may, on rare exceptions, impair contracts, but only where there is a legitimate public purpose behind the law.

It should be noted that the language in the rehabilitation statutes for most states is very broad and provides that anything that will restructure, revitalize, or reform the insurer can be proposed in a plan.

2. PRIORITY DISTRIBUTION STATUTES/PREFERENTIAL TREATMENT

One of the key consumer protections in the existing state delinquency proceedings are the priority distribution statutes that require payment of policyholder-level claims before the payment of any other claimants, including non-policy claims of the United States government, claims of other insurers and reinsurers, and general creditors. These same priority distribution statutes also require members of the same class or group of creditors to be treated similarly. The priority distribution statutes ensure that the needs of consumers, who might not be sophisticated in insurance matters, are placed ahead of non-policyholder level claimants and that everyone with the same level or type of claim is treated the same.

If assets are not sufficient to cover the remaining claims and administrative costs of an insurer using one of the alternative mechanisms, then all claims paid prior to that point have been given a preference at the expense of the claims to be paid in the future. As a result, the receiver could be statutorily required to attempt to recover these preferential payments.

B. CONSUMER PROTECTIONS AND PUBLIC POLICY CONSIDERATIONS

In order to ensure some baseline of protections for policyholders and consumers, there are certain core principles that regulators should strive to maintain with any alternative mechanism for troubled insurers. The first among these, a requirement that the company honor its contractual obligations to policyholders, is considered the primary and overriding principle. This first principle translates into no impairment of policy benefits and claims without the express, informed, voluntary consent of the policyholder. The others are corollary principles, all supporting that primary goal of honoring contractual obligations to policyholders. Any alternative mechanism for run-off or restructuring of a troubled insurance company’s obligations should strive to establish parameters consistent with these principles.
Core Principles:

1. **Honor Contractual Obligations to Policyholders.** Alternative mechanisms should not be a way for an insurance company to sidestep its contractual obligations to policyholders. There should be no involuntary restructuring of policies or impairment of policy benefits or claims permitted outside of receivership. This would preclude any changes to policies, or reductions to policy claims or benefits, without the express, informed, voluntary consent of individual policyholders. Accordingly, there should be no cram-down approval of a mechanism by majority vote over the objection of policyholders; no involuntary transfer of risk back to policyholders through forced commutation of claims or otherwise; and no cancellation, termination, or non-renewal of coverage, except as permitted under the express terms of the policy. In short, every policyholder should be entitled to continue coverage and to receive all policy benefits for the full term of their policy.

2. **Meaningful Notice and Information Sharing.** This contemplates accurate, consistent, and timely notice and disclosures to all policyholders, creditors, and guaranty associations of meaningful information (including financial information, status plans, and any proposed assumption reinsurance or other significant transactions) at inception and on an established schedule thereafter. Disclosures should also identify creditors (at least below the policy level) in order to permit some meaningful, organized discussion among creditors.

3. **Adherence to Priority Scheme.** Alternative mechanisms should require adherence to statutory liquidation priority schemes. They should not provide a mechanism for circumventing the distribution priority to benefit the company, its shareholders, employees, other stakeholders, or specific groups of policyholders at the expense of other classes of policyholders. Controls on preferences and the outflow of assets are needed, and will require regular ongoing review. The company and/or equity shareholders should not be permitted to retain assets unless all claims having priority, as measured under state liquidation laws, have been satisfied in full.

4. **Coherent, Comprehensive Financial Planning.** Any alternative mechanism should be based on a fully developed and comprehensive financial plan that includes complete and meaningful financial data, and projections based on reasonable and realistic financial assumptions. There should be full disclosure and transparency in financial planning, monitoring, and reporting as a condition to approval of any such plan and throughout implementation. In addition, any such mechanism should provide a global solution addressing all in-force policies and pending policy claims. There should be no ring-fencing or piecemeal disposition of assets and liabilities that may result in unequal treatment of policyholder claims, and give rise to preference and priority concerns. Moreover, the fairness and reasonableness of any mechanism cannot be reasonably assessed on a transaction-by-transaction basis without consideration of the overall impact on other policyholders and creditors.

5. **Procedural Safeguards.** Any alternative mechanism should provide substantive procedural safeguards, including clear standards for disclosure, reporting, and external review; appropriate and timely notice; access to information and the opportunity for informed participation for all stakeholders; court and/or regulatory approval for all significant actions to be taken; and meaningful compliance monitoring and reporting.
V. OBSERVATIONS AND CONSIDERATIONS WHEN USING ALTERNATIVE MECHANISMS

C. EXISTING STATUTORY AUTHORITY AND REQUIREMENTS

1. USE OF PERMITTED PRACTICES

There have been situations where an insurer would be able to maintain operations for 20 years, but to date, since liabilities barely exceed assets based on NAIC accounting practices and procedures, the insurer is nearly or technically insolvent. A carefully thought-out permitted practice could allow a troubled insurer time to dramatically restructure in order to provide better results for consumers in terms of timely claims payments.

2. MODIFICATIONS TO EXISTING STATUTORY AUTHORITY

In some circumstances, state insurance regulators may want to consider modifying laws and regulations to provide for a more favorable environment for certain alternative mechanisms. For example, the Illinois Division of Insurance strongly supported the General Assembly’s adoption of 215 ILCS 5/204 in the Illinois Insurance Code’s provision on Prohibited and Voidable Transfers and Liens to protect transfers made during the Division’s supervision of a solvent run-off. The language reads as follows:

m) The Director as rehabilitator, liquidator, or conservator may not avoid a transfer under this Section to the extent that the transfer was: ***

(C) In the case of a transfer by a company where the Director has determined that an event described in Section 35A-25 [215 ILCS 5/35A-25] or 35A-30 [215 ILCS 5/35A-30] has occurred, specifically approved by the Director in writing pursuant to this subsection, whether or not the company is in receivership under this Article. Upon approval by the Director, such a transfer cannot later be found to constitute a prohibited or voidable transfer based solely upon a deviation from the statutory payment priorities established by law for any subsequent receivership.

D. SURVEILLANCE MONITORING BY STATE INSURANCE REGULATOR

State insurance regulators need to consider whether the state has appropriate expertise on staff or whether the state needs to hire outside consultants of particular functions, such as claims assessment, reserves, reinsurance, etc. Please refer to the Troubled Insurance Company Handbook for a description of competency and skills of personnel assigned to conduct surveillance on troubled insurers.

1. SUPERVISION ORDERS/CONSENT AGREEMENTS/LETTER OF UNDERSTANDING

Regulators may want to consider various methods to articulate the regulator’s expectations with an alternative mechanism, as well as the possible recourse that may occur with the insurer as a result of certain actions or behaviors. Such communication methods can be informal, such as a letter of understanding with the insurer, or formal, such as voluntary consent agreement or a confidential supervision order.
If a supervision order is taken under the commissioner’s administrative provisions, the insurer’s management will generally remain in place subject to restrictions in the supervision order and the direction of the supervisor. The supervision can be voluntary or involuntary and confidential or public. Confidential supervisions are becoming more infrequent, as disclosures of such regulatory actions have become more necessary under federal law for insurers within publicly traded groups. Some states may require court approval, as well.

2. **FINANCIAL REPORTING/ANALYSIS/EXAMINATION**

All active insurers that are not in liquidation proceedings should be filing quarterly financial statements to the NAIC Financial Data Repository to provide regulators, policyholders, creditors, and claimants meaningful information. Enhanced monitoring, such as monthly financial statements and claims/exposure reports, should also be considered.

All states should conduct analysis and examination practices in compliance with Part B of the Financial Regulation Standards and Accreditation Program.

3. **COMMUNICATIONS**

As a result of utilizing various alternative mechanisms, regulators should attempt to coordinate the situation and supervisory plan with other affected insurance departments/jurisdictions, other regulatory agencies, and guaranty associations. Coordination may be useful to avoid actions that may be counterproductive. Interdepartmental and intradepartmental communication is also important to ensure that key departmental officials possess all relevant information to permit decisions to be made on a timely basis.

E. **BENEFITS, RISKS AND CONTROLS: FOR U.S. CLAIMANTS/POLICYHOLDERS WHEN A NON-U.S. INSURER OR REINSURER RESTRUCTURES**

1. **INTRODUCTION**

This section considers the impact upon U.S. policyholders and creditors of the restructuring of non-U.S. insurers and reinsurers. It will not consider the impact upon U.S. policyholders and creditors of the restructured U.S. branch of a non-U.S. insurer, because that will be governed largely by familiar U.S. laws and procedures. However, it should be noted that the extent to which the U.S. branch may realize economic support from its non-U.S. parent and/or affiliates is likely to be governed primarily by the laws of the jurisdiction(s) in which the latter are domiciled.

What this section examines is the possible impact on U.S. policyholders and creditors of the restructuring of a non-U.S. insurer or reinsurer outside the U.S. The restructuring of a non-U.S. insurer or reinsurer may be governed simultaneously by the laws of several jurisdictions. For example, as Solvency II becomes the norm in the European Union, an insurer or reinsurer doing business in many member jurisdictions may be subject to their various laws to varying degrees. However, the jurisdiction in which the parent is domiciled (or the group supervisor, if different) may be particularly influential even over the fate of subsidiaries in other jurisdictions. The continued evolution of group supervision as an integral part of Solvency II is likely to enhance the influence of the parent’s domicile. Less predictable will be the management of the restructuring of insurers doing business simultaneously in EU and non-EU jurisdictions. There remains a wide disparity in the core principles underlying insurance regulatory
systems throughout the world—some attributable to the pace of economic development, others to fundamental cultural differences, and still others to specific national public policies.

This section endeavors to identify the key considerations that should be evaluated from the perspective of U.S. policyholders and creditors when their non-U.S. insurer or reinsurer is restructured. It seeks also to provide a sampling of illustrations of how those considerations might evolve in specific circumstances. Pre-purchase evaluation of how these considerations are addressed in a particular jurisdiction may enable the astute policyholder to avoid purchasing coverage that is apparently reliable but for which there is little effective protection upon restructuring.

2. POTENTIAL ADVANTAGES AND RISKS OF RESTRUCTURING MECHANISMS

In many non-U.S. jurisdictions, mechanisms are available for the restructuring of insurers and reinsurers short of formal rehabilitation or liquidation proceedings. A distinction should be drawn between restructuring in the face of potential insolvency (the focus of this paper) and restructuring as a business strategy not in response to immediate solvency concerns. In the latter case, there is little justification for compromising policyholder interests, and regulatory schemes typically do not permit that result. It is in the face of a potential insolvency that restructuring can present a meaningful dilemma.

On the one hand, restructuring mechanisms can be advantageous when compared to rehabilitation or liquidation proceedings in three key respects:

a. Such mechanisms typically offer at least a realistic prospect of a faster resolution of the underlying financial challenge.

b. Often, these mechanisms are cheaper and therefore consume fewer scarce resources in the implementation of the process itself.

c. Often these mechanisms serve to preserve coverage that might otherwise have to be terminated in the context of formal proceedings.

On the other hand, there can be some serious drawbacks in these alternative schemes. The next subsection considers key factors in more detail. However, the principal concerns that may arise in the context of these alternatives include:

a. Reduced regulatory and judicial oversight resulting in diminished policyholder protection.

b. Greater likelihood that policyholder interests will be compromised for the sake of other constituencies, such as owners, managers, and other creditors.

c. The probability that policyholders will have less influence in the process and a diminished ability to protect themselves from potentially adverse outcomes.

3. KEY CONSIDERATIONS

In the U.S., state insurance regulators are accustomed to the fundamental principle that the interests of policyholders (used here as including insureds), especially consumers, should take precedence over
those of unsecured non-policyholder creditors. This principle is not mandated in non-insurer bankruptcies in the U.S. and may not have the same importance in non-U.S. jurisdictions. It is helpful to identify the likely principal interests of policyholders (including insureds), as they may be affected in insurer restructuring.

In addition, this subsection will identify key considerations for reinsureds and creditors when a non-U.S. reinsurance restructures. The treatment of reinsureds is the primary consideration; however, a proper restructuring plan will keep tax authorities and other creditors informed as well. While the nature of the reinsured/reinsurer (sometimes referred to as cedent/assuming company) relationship invokes many of the same key considerations—because typically reinsureds are sophisticated business entities rather than individual consumers—slight differences may arise.

a. **Right of Payment**

Not surprisingly, the principal interest of policyholders is likely to be assurance that claims (perhaps including those for return of unearned premium) will be paid promptly and in full. With the arguable exception of continuation of coverage, it is likely that policyholders’ other interests (discussed below) are derivative of and ancillary to payment concerns.

The ability to obtain full payment of claims may turn on many factors, only some of which may be attributable to the nature of the proceeding. For example, the debtor’s financial condition will always be a key consideration, regardless of the nature of the proceeding. The nature of the claim will also be an important consideration. For example, policyholders making claims based on IBNR must rely on actuarial estimates, which can vary widely. Such policyholders face a risk that any payment under a restructuring plan would be insufficient to meet future liabilities. This section does not address such considerations, which—however important—are unrelated to the nature of the proceeding or the regulatory or supervisory scheme under which it operates.

b. **Continuation of Coverage**

Under a variety of circumstances, it may be difficult for a policyholder to find acceptable coverage to replace that provided by the restructuring insurer. In the U.S., this interest is typically given more weight in the insurance rather than reinsurance context, and in the case of life accident and health insurance rather than in the context of property and casualty insurance.

c. **Claim Priorities**

As noted, we are accustomed in the U.S. to the supremacy of policyholders over other unsecured creditors. This priority is critically important when available assets may not suffice to discharge fully all liabilities of the insurer. Of course, in insurer insolvencies, typically the category of general creditors includes most notably reinsureds. Thus, the interests of reinsureds and policyholders, treated as congruent in much of this section, may be very divergent in particular circumstances. Policyholder priority may not be observed as strictly, or at all, in other jurisdictions.

d. **Guaranty Association Coverage**

Over the last four decades the U.S. insurance sector has implemented nearly universal guaranty fund mechanisms, providing at least basic protection for the insureds of most failed insurers. There are, of
course, notable exceptions like HMOs, risk retention groups, surplus lines carriers and certain lines (separate account annuities, fiduciary bonds, etc.) in the main; however, this “safety net” serves to soften the impact of insurer failure and effectively provides a standard against which are measured the anticipated results of restructuring. Most non-U.S. jurisdictions have not implemented nearly as comprehensive an insolvency protection scheme. The guaranty association mechanism is typically not available to reinsureds in the U.S. or elsewhere.

e. Right to Vote

Although largely foreign to U.S. insurer restructuring and insolvency proceedings, in other jurisdictions, policyholders may have a right to vote on the restructuring plan. Most often, however, that right exists when the plan does not require that policyholder contracts be fulfilled in their entirety. In such plans, policyholders whose claims consist of incurred but not reported losses may have different rights from policyholders who have unsettled paid claims or outstanding losses.

f. Cram Down

In certain jurisdictions, it is possible for policyholders and reinsureds to be compelled to accept a restructuring plan that requires that they make economic concessions. The plan may require approval upon the votes of creditors, or it may simply require regulatory or court approval. This should be contrasted with U.S. laws, which typically do not permit restructuring plans in which policyholders’ interests are compromised for the benefit of non-policyholder creditors.

g. Voice in Replacement

The restructuring plan may entail coverages being transferred to other insurers or reinsurers with whom policyholders and reinsureds had no relationship. In some cases (including instances in the U.S.), policyholders and reinsureds may have little discretion in the transaction (except potentially non-payment of premium and forfeiture of coverage).

h. Transparency

The ability of creditors, including policyholders or reinsureds, to obtain information about the proceeding, and the financial factors upon which key decisions will be based, varies considerably from jurisdiction to jurisdiction. Access to relevant information, however, is often the essential first step in policyholders’ ability to protect their interest in a restructuring.

i. Accountability

The individual or entity responsible for managing the restructuring may be a private practitioner engaged by the restructuring entity’s management, a group of creditors, or a regulatory authority. Alternatively, the process may be placed in the hands of a public official. The degree to which the individual or entity in charge of the process is accountable to a superior or independent authority can be critically important in ensuring the fairness and efficacy of the process. In those instances in which oversight consists principally of court supervision, the independence of the tribunal is important, as is the degree to which interested parties have access to that tribunal.

j. Regulatory Protection
In some jurisdictions (including the U.S.) statutory or common law (judicial decision) standards govern the manner in which an insurer may be restructured. They range from fundamental constitutional protections against the taking of property without due process to specific thresholds that must be satisfied before a Rehabilitation Plan can be approved. The availability of such protections and of viable enforcement mechanisms (such as an empowered administrative agency) are generally key to the prospect of a meaningful recovery or protection for policyholders and reinsureds.

k. ENFORCEMENT IN THE UNITED STATES

Non-U.S. restructuring plans have been enforced by the U.S. courts under Chapter 15 of the United States Bankruptcy Code. Chapter 15 governs cross-border insolvencies and is a framework whereby representatives in corporate restructuring procedures outside the U.S. can obtain access to U.S. courts. Chapter 15 permits a U.S. bankruptcy court to cooperate with a foreign procedure in which assets and affairs of the debtors are “subject to control or supervision by a foreign court, for the purpose of reorganization or liquidation.” Recent Bankruptcy Act amendments resulting in the current form of this provision were intended in part to bring U.S. law into greater harmony with the provisions adopted by the United Nations Commission on International Trade Law (UNCITRAL) and observed throughout much of the world. Applicability of these rules can be complex and often commences with a determination of which jurisdiction’s proceeding will control. The emerging trend is to defer to the jurisdiction in which lies the Center of Main Interest (COMI). However, it is important to note that the COMI may not necessarily be the domiciliary jurisdiction of the insolvent, and cases applying this principle sometimes reach puzzling results. While further discussion of these issues is beyond the scope of this section, the subject merits careful attention when applicable.

I. STANDING TO APPEAR

The ability to appear before the tribunal or agency conducting or overseeing the proceeding may be an important component of creditor protection. Of course, the fairness and impartiality of such a tribunal or agency are of critical importance. Moreover, the right to appear may be far less important when the individual managing or overseeing the process is charged principally or in material part with protection of policyholders and reinsureds and takes that responsibility seriously.

m. SET-OFFS, CLAIMS ACCELERATION AND ESTIMATION, PREFERENCES, AND VOIDABLE TRANSFERS

Insolvency proceedings can trigger a number of unique technical rules that are common in U.S. jurisdictions but may not receive the same treatment in other regimes. Among these are provisions that govern set-offs of claims and credits, acceleration and estimation of claims, when payments before commencement of a proceeding may be deemed to be reversible preferences, when such payments may constitute fraudulent or voidable transfers, and other such rules.

The issue of claims acceleration and estimation is illustrative of this difference in rules. Reinsurers have repeatedly expressed opposition to any system that could result in the accelerated and involuntary payment of their obligations based on any estimation of policyholder claims. Reinsurers oppose compelled payment of reinsurance recoverables based on IBNR on the basis that they are theoretical losses with theoretical values allocated in a theoretical fashion. Because reinsurance is a contract of indemnity, reinsurers assert that they cannot be required to pay losses, such as IBNR losses, which are unidentified or unknown.
While it is beyond the scope of this section to consider the details of each of these “technical” issues, it is important for the affected party to identify those that may be important in the particular case and determine how they are addressed in the specific proceeding. It should be noted that the application of these rules may not always be immediately evident. For example, if only part of a company’s business is subject to the restructuring plan, reinsurers may be concerned that they will lose existing set-off rights. This concern by reinsurers may affect the ability of reinsureds to receive full payment.

n. Politics

Finally, it should never be forgotten that “all politics are local.” In the U.S., the degree to which political considerations control an outcome is somewhat mitigated by cultural and legal constraints. These constraints, however, may not be as applicable in non-U.S. jurisdictions. Familiarity with the local environment is essential in order to avoid unpleasant surprises. And political considerations may not relate just to governmental entities—they may relate to the industry as well. For example, when the reinsured is also a reinsurer, it may be unwilling to help one of its potential competitors with a restructuring. The presence of existing disputes or investigations may also affect how a reinsured views a restructuring plan.
VI. CONCLUSION

Overall, although alternative mechanisms for troubled insurers can provide cost savings or greater efficiency over the current system, these mechanisms can also pose unique risks for consumers and require specialized surveillance monitoring, practices, and procedures, particularly where the activities may occur outside of court-supervised receivership proceedings. In this context, regulators are encouraged to consider implementing standards and best practices responsive to these risks in order to preserve important consumer protections, increase transparency, and provide appropriate procedural safeguards.

First and foremost, it is the responsibility of regulators to protect insurance consumers. Thus, proponents of alternative mechanisms for troubled insurers should be pressed to prove to the regulator’s satisfaction that the claims of greater efficiency or flexibility will not be used to strip policyholders and claimants of their policy rights so that value can be returned to investors. And regulators should ensure that all alternative mechanisms for troubled insurers place the interests of consumers ahead of other competing interests, coupled with a clear statement of goals and objectives and a meaningful oversight mechanism.
VII. APPENDIX

A. CASE STUDIES

This appendix describes troubled insurance company situations to illustrate some of the alternative concepts and techniques discussed earlier in this paper. The names of the insurers have intentionally been omitted. These case studies are not intended to reveal all problems or situations that may arise during the restructuring of a troubled reinsurance company. Additionally, the proposed actions with respect to the subject company may not be appropriate in all jurisdictions in light of changing market conditions and the possible differences in statutes, regulations, and implementing tools and resources.

1. RESTRUCTURED TROUBLED REINSURANCE COMPANY

Company characteristics, circumstances, and concerns:
- A property/casualty reinsurance company (treaty and individual risk basis).
- Primary reinsured lines included allied lines, commercial multiple peril, accident & health, workers’ compensation, liability, and non-proportional reinsurance.
- Immediate parent and primary reinsurer of a direct property/casualty insurer.
- Non-U.S. ultimate parent.
- Parent refused to provide further financial support to its subsidiary.

BACKGROUND. Restructured Troubled Reinsurance Company (RTRC) was an established property/casualty reinsurer that appeared to be reporting significantly improving financials since two years earlier, accomplished through active re-underwriting and non-renewal of underperforming business. RTRC was a large reinsurer licensed or accredited in 27 states. Growth was moderate over the years, and the company remained adequately capitalized until significant adverse development constrained resources. Almost all property/casualty lines of reinsurance were written by RTRC with primary focus on workers’ compensation, accident & health, liability, and proportional reinsurance. The group restructured through a series of transactions and separated its third-party assumed reinsurance business into an independent corporate structure. RTRC received a surplus note contribution from its ultimate parent that provided for semi-annual interest payments.

CAUSES OF TROUBLE. The Insurance Department had no information immediately on hand that would have raised a question regarding the solvency of RTRC. The financial statements reported much improved underwriting results, as well as ratios that were also continuing to show improvement. Approximately six months after the financial examination, but a few months prior to the restructuring, management met with the Department to discuss the rising amount of reinsurance recoverable related to its “Unicover” business. RTRC conducted a detailed internal review of its prior years’ U.S. casualty business and found that significant reserve strengthening was necessary in its general liability and specialty liability lines, causing a substantial surplus strain and the triggering of the Department’s hazardous financial condition regulation.

PRELIMINARY ACTIONS. The Department had several telephone conferences with RTRC management whereby the Department was informed that a capital contribution from RTRC’s ultimate parent would be forthcoming as a result of the significant adverse development discussed above. Management then contacted the Department for a meeting on the premise that the Chairman was in town and wanted a face-to-face meeting to discuss what was going on at the group. During that meeting, the Department was informed that RTRC and its direct subsidiary would be placed in run-off and neither would irreceiv
a capital infusion as originally discussed. A firm was hired by RTRC’s parent to assist in the development of a strategic plan for a solvent run-off.

**Corrective Actions.** The Department sought to institute more rigorous financial monitoring. RTRC entered into a confidential letter agreement with the Department that required the Department’s approval prior to, among other things, making any material changes to management; moving books and records; making any withdrawals from bank accounts outside the ordinary course of business; incurring any debt; writing or assuming any new business; or making dividend payments or other distributions. It also provided that the Department would receive a monthly report of commutation activity (which, as can be seen below, was the bedrock of the run-off plan); a copy of the final reserve analysis report prepared by an outside firm; and any additional reports the Department reasonably determined were necessary to monitor the financial condition. Finally, the agreement provided that senior management would meet with Department staff weekly, in person or by conference call.

RTRC hired outside actuaries to conduct an external audit. In addition to the reserve strengthening was a non-admission of its deferred tax asset.

A cash flow analysis was commissioned by the Department to conclude whether RTRC could, in fact, have a solvent run-off. RTRC developed a Business Plan/Run-off Plan, which combined commutations with expense cuts (staff and facilities reduction). Quarterly RBC filings were required. Employment levels were reduced commensurate with the Plan, and a retention plan was implemented to help retain talented, necessary staff and management. Surplus note interest payments were disapproved. The Department requested NAIC staff to set up a conference call for regulators to inform states of the situation and provide them time to ask questions or air concerns.

Ultimately, an RBC plan was approved by the Department. Subsequently, a revised Business Plan/Run-off Plan was filed and approved, and the agreement was extended for an additional year.

As commutations continued and improvements began to take hold, the company and its subsidiary were eventually sold. A new plan was developed, as—under new ownership with substantial resources—emphasis was no longer on an aggressive commutation strategy but was now on an aggressive asset management strategy. Monthly calls with management were temporarily put into place to ensure the Department would be aware of any changing circumstance. A less restrictive agreement was implemented as the Department was more comfortable with the possibility of a positive outcome. Ultimately, the subsidiary was again sold—another positive development for RTRC. The frequency of reserve reporting was reduced to an annual basis as long as there was no change in Chief Actuary, and RTRC was released from the agreement.

2. **NEW YORK REGULATION 141 PLAN**

Company characteristics, circumstances, and concerns:
- Professional property and casualty reinsurers and insurers that write such business and also assume reinsurance of property and casualty business.
- All property and casualty lines, but not life business.
- Member of a holding company group or stand-alone entity.
- Other members of the holding company would not or could not provide further financial help.
BACKGROUND. ABC Reinsurance Company (ABC) was a professional reinsurer incorporated in New York in 1977. ABC became capital-impaired and ceased underwriting in 1985. ABC’s management sought approval to commute certain assumed contracts, but the New York Superintendent of Insurance maintained that these commutations would prefer certain creditors over others and that the Superintendent lacked statutory authority to approve such commutations under then-existing New York insurance laws.

CAUSES OF TROUBLE. The parent company refused to add capital. The Department, lacking the authority to authorize the commutations, moved to place ABC in rehabilitation pursuant to New York Insurance Law Article 74. In 1987, the Superintendent moved in Supreme Court, New York County, for an order of liquidation. ABC remained in liquidation until 1992.

During those five years, ABC’s liquidator approved some cedents’ claims, but paid none. In 1990, however, the New York Insurance Department introduced, and the legislature adopted, an amendment of NYIL 1321 to permit an impaired or insolvent New York insurer to commute reinsurance agreements and, with the Superintendent’s approval, eliminate the risk that those agreements could be avoidable as a preference.

In May 1992, the Superintendent, in his role as ABC’s liquidator, petitioned the court to approve a plan of reorganization based on a 100% quota share of ABC’s portfolio of outstanding losses on all business that ABC wrote before its liquidation. XYZ Reinsurance Company of New York (XYZ) proposed the reorganization plan and provided the reinsurance cover.

After a July 1992 hearing, the court approved ABC’s reorganization plan and entered a final order and judgment that terminated the liquidation proceeding. The XYZ quota share contained a $305 million limit and an expansion of the quota share’s limit that expanded based on a formula that included, among other things, paid losses, reinsurance recoveries, and interest income. ABC resumed operations with new directors and officers, but the plan also provided for a manager to administer ABC’s run-off.

When the Superintendent petitioned the court in 1992 to approve the reorganization plan, ABC’s projected liabilities were, as of December 31, 1990, $295.3 million. By 1993, ABC and its quota share reinsurer had paid more than $302.8 million to its ceding insurers. In 2002, ABC substantially increased its asbestos-related IBNR reserves, as did much of the industry. As reported on its 2002 annual statement, ABC’s capital became impaired by more than $12.7 million.

PRELIMINARY ACTIONS. As a result of its 2002 impairment, and pursuant to New York Insurance Law § 1321 and Insurance Regulation 141 (11 NYCRR Part 128) (Regulation 141), ABC submitted to the New York Insurance Department a plan to eliminate capital impairment pursuant to Regulation 141. As required under Regulation 141, ABC’s board and the company’s sole shareholder stipulated that if ABC’s implementation of the Regulation 141 Plan failed to restore ABC’s surplus to policyholders to the minimum required as determined in accordance with Regulation 141, ABC would not oppose a petition to again liquidate the company pursuant to New York Insurance Law Article 74.

Under Regulation 141, no commutation of ABC’s assumed reinsurance could become effective, and no consideration for any such commutation agreement could be paid, until the Superintendent determined that a sufficient number of fully executed commutation agreements had been returned to restore ABC’s surplus to the required minimum (11 NYCRR § 128.5). Regulation 141 also required that ABC provide the Superintendent with copies of all e-mail, correspondence, and other communications between ABC
and its ceding insurers relating to the current Regulation 141 commutation offers, including any such communications rejecting the offer.

The proposed 141 Plan and Regulation 141 also required that ABC offer the same, non-negotiable commutation terms to all of its ceding companies. The 141 Plan further required that an offer to commute reinsurance agreements be made to every ceding insurer for which ABC had paid losses and LAE (Paid Losses) or known case losses and LAE (Case Reserves) on its books as of June 30, 2003.

Under its Regulation 141 Plan, ABC offered to pay 100% of Paid Losses and 60% of Case Reserves to commute obligations under the reinsurance agreements. Cedents were required to respond to this offer within 90 days.

CORRECTIVE ACTIONS. In January 2004, the Superintendent approved the 141 Plan and allowed ABC to extend commutation offers to its cedents. Shortly thereafter, ABC mailed commutation offers pursuant to the Plan to about 580 cedents. In October, ABC delivered to the Superintendent more than 300 executed commutation agreements along with copies of all correspondence with cedents relating to the Plan. The Superintendent subsequently determined that these commutation agreements would, upon his approval, eliminate ABC’s impairment.

With the Superintendent’s approval, ABC paid $22,558,221 to those ceding insurers that accepted its Regulation 141 commutation offers. The post-Plan ABC balance sheet showed a positive surplus of $3,675,366 and the elimination of its 2002 impairment.

The completed Regulation 141 Plan left ABC with many cedents. No cedents were compelled to accept the 141 commutation offers, and the Superintendent’s approval of the Plan was premised on ABC’s sufficient surplus to policyholders to complete its run-off. At the same time, Regulation 141 gave the Superintendent the statutory authority to permit commutation with a troubled company—avoid a protracted receivership—while also respecting every cedent’s right to reject the proposed commutation offers and run the risk that ABC would lack sufficient capital to complete its run-off.

3. COMMERCIAL INSURANCE COMPANY RUN-OFF

Company characteristics, circumstances, and concerns:

- A property/casualty insurance company, writing primarily commercial lines on a national basis.
- Primary lines included commercial multiple peril, accident & health, workers’ compensation, general liability.
- Member of a large multinational property/casualty insurance and reinsurance group with a non-U.S. ultimate parent.
- Parent sought to provide sufficient capital support to its subsidiary.

BACKGROUND. Restructured Troubled Insurance Company (RTIC) was an established property/casualty insurer pursuing a business model outsourcing most of its underwriting and claims functions to managing general agents (MGAs) and third-party administrators (TPAs), respectively. RTIC was licensed and operated in 50 states and wrote directly and through six subsidiary companies. The company had been operating for over 50 years and independent for approximately six years prior to being purchased by its current parent. Following the acquisition, RTIC pursued a modified business strategy for three years before being placed into run-off. RTIC wrote most lines of commercial liability insurance with primary
focus on workers’ compensation, accident & health, and general liability insurance.

**CAUSES OF TROUBLE.** Although the parent company installed new management and sought to reverse the business decline at RTIC following the acquisition, continued underwriting losses and adverse development from past years resulted in a ratings downgrade at the company. In addition, the California Insurance Department had been monitoring RTIC for some time due to the poor underwriting results and concern over the company’s capitalization. The parent determined that the business model for the company was not appropriate for the then-current market and was not likely to result in a return to profitable business for the company. The parent also determined that the profitable lines of business RTIC was writing could be pursued through restructured and separately capitalized subsidiary companies, while the potential for continued adverse development in certain lines written by RTIC—particularly workers’ compensation—would require substantial new capital for RTIC to regain its ratings. Accordingly, the parent determined to place RTIC into run-off.

**PRELIMINARY ACTIONS.** The parent developed a run-off plan that called for the capital and operational restructuring of RTIC. Representatives of the parent, RTIC, and the run-off manager met with the Department to present a detailed plan for RTIC in run-off. The plan included a restructured capital base intended to provide sufficient flexibility and liquidity for the run-off. A principal component of this restructuring was the merger of a subsidiary of the parent already in run-off into RTIC. This contributed company had been in solvent run-off for a number of years and held sufficient excess capital to support RTIC in run-off. The resulting merged entity was to be placed under the management team of the contributed company, a dedicated professional team with 10 years of experience in the operation of run-off companies.

Over the course of a three-month period, the Department and the company representatives met frequently to refine the run-off plan. The Department was receptive to a solvent run-off under the control of the parent, provided that the parent could demonstrate sufficient capitalization within RTIC, the establishment of certain financial standards for RTIC, and enhanced financial and operational reporting by the company. Upon approval by the Department of the run-off plan and the merger, RTIC was formally placed in run-off.

**CORRECTIVE ACTIONS.** The Department, the parent, and RTIC entered into an agreement that required RTIC to maintain a minimum RBC standard of 200%, a net-reserves-to-surplus ratio of no greater than 3-to-1, and a specified minimum surplus amount. The parent guaranteed that RTIC would meet these standards. RTIC also agreed to provide frequent and detailed reporting to the Department on the progress of the run-off.

Based upon the company’s actuarial analysis and a separate review by the Department, RTIC strengthened reserves in certain lines. The run-off plan also included a restructuring of the capital of RTIC which, in addition to the merger, included the contribution of a three-year term note from the parent to insure liquidity and sufficient capital, and the transfer of the stock of certain affiliated companies from RTIC into a trust in favor of RTIC. Certain subsidiaries of RTIC were purchased by the parent to continue writing certain lines outside of the run-off. RTIC reduced staff, and certain operations were subsequently transferred directly to the run-off manager. A retention plan was created to help retain knowledgeable, talented staff and management for the run-off. RTIC met separately with the domestic regulators of its subsidiary insurance companies to inform them of the plan and obtain their approval where necessary. RTIC and the Department also coordinated with NAIC staff to inform all interested states of the situation at an NAIC regulator meeting and to provide
regulators with the opportunity to ask questions or air concerns.

With the Department’s agreement, RTIC began to terminate its MGA and most of its TPA agreements and assumed direct control of most of its claims. The company then began to aggressively settle claims, reduce its overall exposures, and commute certain reinsurance contracts where protection was uncertain or disputed. The investment manager restructured RTIC’s investment portfolio to better address the anticipated cash flow and capital requirements of the run-off.

**PROGRESS OF THE RUN-OFF.** The Department’s cooperation with management and establishment of clear operating guidelines, the capital support at RTIC provided by the parent, and singular focus of management on the satisfaction of RTIC’s obligations and responsible management of the company’s assets have resulted in a stable and successful run-off. Five years into the run-off, RTIC had reduced open claims by approximately 85%, reduced reserves by approximately 40%, and increased surplus by over 70%. The stabilization of RTIC, its successful execution of the run-off plan, and gains in its investment portfolio have resulted in the Department’s agreement to terminate the trust arrangements created for the affiliated company investments, deferral, and subsequent forgiveness of the third installment of the parent note and the return of excess capital from RTIC to the parent. RTIC continues to adhere to the established financial standards, maintaining a comfortable margin over the minimum requirements established by the Department. RTIC management and the Department continue to meet approximately quarterly to review the progress of the run-off.

### 4. RESTRUCTURED TROUBLED LONG-TERM CARE COMPANY

Company characteristics, circumstances, and concerns:
- A stock life, accident and health company.
- Part of a large national life and A&H group.
- Primary line of business is a closed block of predominately long-term care in force.
- Ceased writing new business five years prior to restructuring.
- Received large capital contributions from parent for many years.
- Continuous premium rate increase requests.
- Adverse claim development and reserve strengthening.
- Low RBC ratio.

**BACKGROUND.** Restructured Troubled Long-Term Care Company was a writer of predominately long-term care business, operating in most of the 46 states, D.C., and the U.S. Virgin Islands. It had held a firm niche position in the long-term care market with profitable operations and a conservative balance sheet. The long-term care block of business was written by the Company and its predecessor companies prior to being acquired by the Company in the 1990s.

**CAUSES OF TROUBLE.** Shortly after the acquisition of long-term care blocks in the 1990s, the Company reported a reserve deficiency. The Company phased in a new reserve valuation basis for long-term care policies, requested and implemented premium rate increases, and implemented tighter underwriting standards. The cause of trouble was under-pricing and under-reserving that became evident as the company experienced claim costs and utilization that exceeded expectations. The original pricing assumptions on long-term care assumed a 4% to 5% lapse rate, while the actual lapse rate was only 1% to 2%. Additionally, the Company’s investment return assumptions were much higher than actual returns.
Over the course of more than a dozen years, the Company received capital contributions to offset losses. The Company reported an increasingly larger reserve deficiency each year from 1998 to 2007, several years in excess of $100 million deficient. The Company reported net losses in each year from 1997 to 2007.

PRELIMINARY ACTIONS. In 2003, Company management decided to stop marketing insurance products and to place the Company in run-off. The insurance department began monitoring the Company monthly and meeting with Company management on a quarterly basis as a result of continued poor operating performance, reserve deficiencies, and multi-year rate increase requests. A study was conducted of the Company’s incurred claims experience. As a result, the Company updated the claim cost assumptions underlying the contract reserves and unearned premium reserves for the long-term care policies. The change was made using the “pivot” method, such that the change in claim costs would be accrued into the reserve balance over time. Multiple premium rate increases were sought. Over the course of 15 years, the Company received over $900 million in capital contributions from the parent. The parent company indicated that no future capital contributions would be forthcoming.

The Company also came under scrutiny for market conduct issues, including claims administration and complaint handling practices. The Company underwent a market conduct examination to get a further understanding of the market conduct problems within the Company and, as a result, a settlement agreement was reached, recommendations for corrective measures were made, and an improvement plan was developed. The settlement included a monetary penalty for violations; a contingent penalty for non-compliance with improvements, including systems upgrades and improved claims administration; and restitution and remediation regarding the reevaluation of denied claims.

CORRECTIVE ACTIONS. With the approval of the insurance department, the Company’s parent transferred the stock of the Company to a non-profit independent trust. In connection with the transfer, the parent contributed additional capital to the Company to fund future operating expenses. The capital was in the form of senior notes payable, invested assets, cash, and the forgiveness of unpaid dividends. The trust is intended to operate the Company for the exclusive benefit of the long-term care policyholders, without a profit motive. It is governed by a board of trustees under the oversight of the insurance department, as outlined in the Form A Acquisition Order.

5. LIABILITY OF INSURERS TRANSFERRED TO THIRD PARTY – EUROPE

BACKGROUND. The European market is a provider of insurance and reinsurance to insureds and cedents worldwide.

Events that took place in Europe during the 1990s provide an example of an extreme case of a market coming to the brink of collapse, only to be saved by a series of transactions that were simple in concept but, of necessity, very complex in their implementation. Those transactions amounted to what has become a famous event in the history of insurance. Most recently the final transaction took place, which had the effect of removing the outstanding liabilities of the re/insurers in question.

CAUSES OF TROUBLE. In the early 1990s there was an unexpected, huge increase in long-tail liability claims (typically asbestos, pollution and health hazard) made against certain European market insurers. Many of these insurers faced collapse, as the liabilities swamping the market and the difficulty in estimating the IBNR and calculating an appropriate reinsurance premium were so great. The effect was that several troubled European insurers were without protection and remained exposed to the incoming claims.
CORRECTIVE ACTIONS. The situation was so dire that immense efforts were made to bring about a solution. One solution, in particular, allowed certain troubled European insurers to pay a premium (which varied according to exposure) and have all the liabilities for the exposed years 1992 and earlier to be reinsured by a specially formed company, ABC Reinsurer. Claims handling and all other aspects of the run-off were transferred to XYZ insurer (a wholly owned subsidiary of ABC Reinsurer). XYZ also reinsured ABC Reinsurer under a retrocession agreement. Certain rights of the original troubled insurers as reinsurees of ABC Reinsurer were held on trust for policyholders: In this way, the benefit of all reinsurance recoveries were applied in paying the liabilities due to policyholders. The intervening 10 years to 2006 found XYZ working to plan with a controlled program of inwards and outwards commutations as a means of dealing with the run off of these liabilities. In all practicality the original troubled insurers had finality—i.e. they were no longer financially exposed personally so long as XYZ remained solvent. However, as a matter of law, they did remain personally liable to policyholders for any excess liability over and above that paid by XYZ.

By early 2006, the market in the purchase of portfolios in run-off had taken off. XYZ was the world’s largest business in run-off, so large that the number of likely purchasers was very limited. However, fortunately by the end of 2006, the two-stage deal with a large conglomerate—XOX—was announced, the stages being:

1) XYZ retroceded to XOX’s subsidiary, BOB, its liabilities to ABC Reinsurer arising under the agreement. Cover was limited to approximately $6 billion (U.S.) over and above existing reserves of approximately $9 billion, as of March 2006. The premium was all of XYZ’s assets less approximately $340 million, plus a $145 million contribution from some of the original troubled insurers. Staff and operations were transferred to another XOX subsidiary, RRR.

2) A “Part VII transfer” of all the liabilities of the original troubled European insurers (and the protection of the ABC Reinsurer–XYZ–BOB reinsurance chain) to a third-party company. Provided the transfer was to take place before December 2009, XYZ would be entitled to purchase further reinsurance from BOB of up to $1.3 billion if XYZ’s net undiscounted reserves had not deteriorated by more than $2 billion from their March 31, 2006, position.

Part VII of the UK Financial Services & Markets Act 2000 (FSMA) provides a statutory novation of business (i.e., reinsurees’ obligations to their policyholders) by a transferor re/insurer to the transferee re/insurer, provided that strict procedures are complied with. The novation is effected by court order. The court order has the effect of vesting the transferor’s business in the transferee without the need for consent of the policy holders/reinsurees. The court can and usually does order assets attributable to the underlying business to be transferred—i.e., including the outwards reinsurance contracts. There are strict definitions of business that are subjected to a Part VII transfer. Put broadly, it applies to transfers of business carried on in the UK or elsewhere within the European Economic Area (EEA) with a UK connection as defined and where the transferred business is to be carried on from an establishment of a transferee in an EEA state. There are various conditions and exclusions.

The unusual position of these particular re/insurers, should they wish to avail themselves of Part VII, was recognized at the time Part VII first became law. However, additional changes to the legislation had to be made to facilitate this transaction, and they became law in 2008. In particular, the Part VII provisions in the FSMA were extended to a further cohort of these particular re/insurers.
Under the Part VII transfer procedure, there are two court applications. The first gives directions as to notices to be served and other technical requirements allowing any opposing reinsureds or outwards reinsurers to object to the transfer. In the case of the XYZ Part VII, certain requirements were dispensed with taking into account the high volume of notices that would have to be given to individual names and other relevant parties. An essential part of the procedure is the report provided by an independent expert whose identity is approved by the Financial Services Authority (FSA). Furthermore, the FSA itself provides a report indicating its views that is made available to those interested in the transfer. Time is allowed for any objectors to produce their own case in the context of the independent expert report and the FSA’s report. In the case of the XYZ transfer, the FSA indicated that it would not object to the transfer.

The second and final stage of the process is the application for sanction by the court. The court has discretion whether to sanction the transfer scheme but may not do so unless it considers it appropriate in all the circumstances of the case. Under case law on the statutory provisions, the court is concerned as to whether a policyholder, employee or other interested person will be adversely affected by the transfer scheme. The hearing took place in mid-year 2009, and the judge concluded that the Part VII transfer scheme should go ahead.

During the hearing, the judge was satisfied that other requirements protecting policyholders of the business being transferred had been fulfilled, such as that certificates of solvency for the transferee company were obtained confirming the adequacy of the transferee’s solvency for the purpose. Presentations explaining the import of the transfer had been carried out in the UK and in the jurisdiction of XOX to transferring policyholders, the original troubled insurers, and their representatives. Help lines and a Web site had been set up. Numerous telephone calls, e-mails or letters had been sent in response by the Part VII advisers, with less than 10 people raising substantive issues.

**Enforcement in Other Jurisdictions.** Part VII of the FMSA originates from EU Directives. The sanction order is thereby recognized throughout the EEA. A further step would be needed to ensure enforcement in the United States and other countries where policyholders were located. However, the shape of the scheme is such that enforcement in the United States and other jurisdictions is most probably unnecessary. Policyholders would be entitled to drawdown on trust funds located in the United States, Canada, Australia and South Africa, providing them with security for amounts accruing due to them over time should there be any default payment.

**Progress.** With the sanction of this transfer scheme granted during mid-year 2009, the two-stage transaction provided by the XOX group was completed in time. Because the transfer was affected prior to December 2009, it is believed that the further amount of $1.3 billion (U.S.) reinsurance cover will be available to secure future payment of all policyholder claims.
Attachment Two

B. SAMPLE DOCUMENTS

1. SAMPLE SUPERVISION CONSENT ORDER

In the Matter of:

The Administrative Supervision of

RESTRICTED TROUBLED REINSURANCE CORPORATION, a Connecticut domiciled property and casualty insurance company.

CONSENT ORDER

This Consent Order is entered into by and between Restructured Troubled Reinsurance Corporation (RTRC) and the Insurance Commissioner of the State of Connecticut (the Commissioner) to provide supervision and regulatory oversight of RTRC in the run-off of its insurance and reinsurance obligations in force.

WHEREAS, the Commissioner hereby finds, and RTRC agrees, as follows:

1. The Commissioner has jurisdiction over the subject matter and of RTRC.

2. RTRC is a Connecticut-domiciled property and casualty insurer and reinsurance company having its principal office at XXX Street, Anywhere, XX 00000, and holds a certificate of authority to transact the business of insurance and reinsurance in Connecticut and is licensed or accredited in a number of other states.

3. RTRC is a wholly owned direct subsidiary of Restructured Troubled Corporation (RTC), a Delaware corporation and an indirect subsidiary of Restructured Troubled (Barbados) Ltd., a Barbados corporation which is a wholly owned direct subsidiary of Restructured Troubled Group Ltd. (RTG), a Bermuda corporation.

4. Due to the significant deterioration of RTG’s financial condition in 20XX, on December 3, 20XX, RTRC entered into a “letter of understanding” with the Connecticut Insurance Department (Department) as part of the Department’s continuing financial monitoring of RTRC pursuant to which RTRC agreed that it would not take certain actions without the prior written approval of the Connecticut Insurance Commissioner or her designee, including, among others, disposing of any assets, settling any intercompany balances or paying any dividends.

5. RTRC has submitted to the Department a risk-based capital report, (the RBC Report) pursuant to CONN. AGENCIES REGS. § 38a-72-2. The RBC Report indicates that RTRC was at the “Regulatory Action Level Event” as of December 31, 20XX. On July 30, 20XX, RTRC filed with the Department an updated RBC Report which estimates that RTRC was at the “Authorized Control Level Event” as of June 30, 20XX.

6. RTRC has ceased underwriting activities and has determined that it is in the best interests of its
policyholders and creditors to run-off the existing operations of RTRC in such a manner as would maximize the availability of funds to satisfy the interests of policyholders, creditors, and other constituents.

7. RTRC has retained the services of a firm with expertise and experience in run-off management to review the operations of RTRC and its subsidiaries in run-off, to supplement its internal resources, and to accelerate the successful completion of the run-off, all pursuant to a comprehensive run-off plan (including therein, among other items, a plan to effectuate commutation of existing reinsurance obligations). The run-off management consultant will develop and submit, along with a more extensive run-off engagement agreement retaining their services to manage the run-off, to the RTRC Board of Directors for approval and, if such plan and agreement are approved, to the Commissioner, creditors of RTC, and other constituencies for approval.

8. On April 15, 20XX, the Department commenced a targeted examination of the financial condition of RTRC pursuant to CONN. GEN. STAT. § 38a-14. The examination was called based on RTRC’s submission of a Cash Flow Projection Model to demonstrate that RTRC has sufficient assets and cash flow to pay both claims and operating expenses as those obligations become due.


10. RTRC is in such condition that regulatory control of the insurer is appropriate to help safeguard its financial security and is in the best interests of the policyholders and creditors of the insurer and of the public as RTRC administers the run-off of its existing business.

IT IS THEREFORE ORDERED AND AGREED THAT:

11. RTRC hereby consents to and shall be placed under the administrative supervision of the Commissioner pursuant to CONN. GEN. STAT. § 38a-962b and under the terms herein.

12. RTRC hereby knowingly and voluntarily waives receipt of written notice under CONN. GEN. STAT. § 38a-962b of grounds for the Commissioner to effectuate administrative supervision by the Commissioner.

13. The period of administrative supervision by the Commissioner shall commence upon execution of this Consent Order. The period of supervision pursuant to this Consent Order shall be coterminous with the run-off of RTRC’s existing business, unless the Commissioner takes action pursuant to Paragraph 27 hereof.

14. The determination that RTRC shall be subject to administrative supervision by the Commissioner may be abated and thereby released from administrative supervision by the Commissioner if RTRC complies with the orders of supervision provided herein and, during the period of supervision, RTRC shall have attained sufficient liquidity, surplus, and reserves necessary to exceed and maintain Company Action Level RBC, as defined in CONN. AGENCIES REGS. § 38a-72-1, or the Commissioner in her sole discretion determines the supervision of RTRC is no longer necessary for the protection of policyholders, claimants, creditors, or is no longer in the public interest.

15. During the period of supervision, RTRC shall not undertake, engage in, commit to accept, or renew
any insurance obligations including without limitation, insurance or reinsurance policies or any similar
arrangements or agreements of indemnity or, without the prior written approval of the Commissioner,
make any material change in any insurance or reinsurance agreement which would increase the financial
obligations of RTRC in any material respect. Moreover, RTRC shall not engage inactivities beyond those
that are routine in the day-to-day conduct of its business in run-off and are otherwise consistent with its
comprehensive business run-off plan (Run-off Plan) to be filed with, and found acceptable by, the
Commissioner, without the prior approval of the Commissioner or her designee. The routine day-to-day
conduct of RTRC’s business in run-off includes but is not limited to: (a) paying claims and operating
expenses as such obligations become due and in accordance with the applicable law and the settlement
and commutation of claims and insurance and reinsurance obligations, unless otherwise provided in the
following paragraph or otherwise directed or approved by the Commissioner or her designee; (b)
defending RTRC and persons insured or claiming to be insured by RTRC against claims arising from or
related to insurance policies and reinsurance agreements previously issued, assumed, or ceded by
RTRC; (c) settling or otherwise resolving or attempting to adjust and resolve such claims; (d) engaging,
directing, discharging, and compensating counsel (including reasonable costs incurred) with respect to
such claims or other matters; (e) paying settlements or judgments with respect to such claims; and (f)
investing the assets of RTRC and liquidating such assets in an appropriate manner as required to pay
claims, operating expenses, settlements, commutations, and other charges in the ordinary course of
business and subject to the provisions of this Consent Order.

The routine day-to-day conduct of RTRC’s business in run-off also includes but is not limited to: (a)
submitting information to reinsurers with respect to RTRC’s reinsured losses and loss adjustment
expenses; (b) advising reinsurers of all sums due to RTRC under their respective reinsurance contracts
and treaties with RTRC (including settlement and commutation thereof), provided, however, that RTRC
shall not enter into commutation of liabilities (either inward or outward including obligations of others
to RTRC) or settlements of claims other than for amounts not in excess of $250,000 except as otherwise
provided in the Run-off Plan or otherwise approved by the Commissioner or her designee); and
taking all actions necessary and appropriate to recover all sums due to RTRC from reinsurers and others.

The following activities, to the extent not necessary for the adjusting and payment of losses and expenses
associated with claims adjusting and settlement or commutation of reinsurance agreements are understood
to be outside the day-to-day conduct of RTRC’s business in run-off, and in no event shall RTRC engage
in or undertake the following activities without the prior approval of the Commissioner or her designee:

(a) Dispose of, convey, or encumber any of its assets or its business in force.
(b) Withhold any of its bank accounts.
(c) Lend any of its funds.
(d) Invest any of its funds.
(e) Transfer any of its property.
(f) Incur any debt, obligation, or liability.
(g) Merge or consolidate with another company.
(h) Write new or renewal business.
(i) Enter into any new reinsurance contract or treaty.
(j) Terminate, surrender, forfeit, convert, or lapse any insurance policy, certificate, or
contract, except for nonpayment of premiums due.
(k) Release, pay, or refund premium deposits, unearned premiums, or other reserves
on any insurance policy, certificate, or contract.
(l) Make any material change in management.
(m) Increase salaries and benefits of officers or directors or the preferential payment of bonuses, dividends or other payments deemed preferential.

RTRC shall make a recommendation with the reasons therefore in writing to obtain the prior approval of the Commissioner as to any of the foregoing actions.

16. The Commissioner shall have the final authority to approve or disapprove the initiation, settlement, or withdrawal by RTRC of any action, dispute, arbitration, litigation, or proceeding of any kind involving RTRC that is not in the ordinary course of business or would require payment in excess of $250,000. RTRC shall prepare a written report to the Commissioner with a recommendation for approval or disapproval with the reasons therefore.

17. Without the prior written approval of the Commissioner, RTRC shall not (i) add any individual who is not currently a senior executive officer of RTRC, or one of its affiliates, to the board of directors of RTRC or (ii) move the principal offices or records of RTRC to a location outside of Connecticut.

18. RTRC shall file with the Department a monthly financial statement consisting of a balance sheet and income statement on the 25th day of each month as of the end of the prior month.

19. At least annually, RTRC shall submit an actuarial analysis prepared by a qualified actuary as defined in CONN. AGENCIES REGS. § 38a-53-1 of the loss and loss adjustment expense reserves.

20. RTRC shall submit a report on a quarterly basis containing detailed information on all commutations of reinsurance treaties and related activities which have occurred year-to-date, including specific impact on RTRC’s statutory financial statement.

21. RTRC shall submit to the Department any additional reports that the Department reasonably determines as necessary to ascertain the financial condition of RTRC.

22. RTRC shall submit any and all reports or items required by this Consent Order, and all requests for the Commissioner’s action or approval to:

(name)
Connecticut Insurance Department
P.O. Box 816
Hartford, Connecticut 06142-0816
(860) 297-3823
(860) 566-7410 FAX

23. The Commissioner may retain, at RTRC’s expense, such experts (including, but not limited to, attorneys, actuaries, accountants, and investment advisors) not otherwise a part of the Commissioner’s staff, as the Commissioner reasonably believes is necessary to assist in the supervision of RTRC.

24. RTRC hereby knowingly and voluntarily waives all rights of any kind to challenge or to contest this Consent Order, in any forum now available to it, including the right to any administrative appeal pursuant to CONN. GEN. STAT. § 4-183.
25. This Consent Order of supervision, and proceedings, hearings, notices, correspondence, reports, records and other information in the possession of the Commissioner or the Department relating to the administrative supervision by the Commissioner of RTRC are subject to the confidentiality provisions of CONN. GEN. STAT. § 38a-962c and § 38a-8.

26. RTRC shall continue to comply with all obligations under law, including applicable financial, regulatory, and tax reporting requirements.

27. Nothing in this Consent Order shall preclude the Commissioner from taking further action as the Commissioner in her sole discretion deems appropriate and in the best interest of RTRC’s policyholders and the public, including commencement of further legal proceedings if and as necessary under Chapter 704c of the Connecticut General Statutes.

28. This Consent Order shall supersede in all respects the “letter of understanding” between RTRC and the Department referenced to in Paragraph 4 of this Consent Order, which letter shall have no further force and effect.

29. The Board of Directors of RTRC, at a specially called meeting or by unanimous written consent, has simultaneously, with the entry of this Consent Order, approved and provided resolutions complying with the terms of this Consent Order, which is effective upon entry of this Consent Order.

The foregoing Consent Order for Restructured Troubled Reinsurance Corporation is entered and shall be effective at 3:00 p.m. on this____ day of September 20XX.

(name)
Insurance Commissioner

Agreed and Consented to by RESTRUCTURED TROUBLED REINSURANCE CORPORATION on this___________day of September 20XX.

By: _________________________________
(name)
President

(Corporate Seal)

On this______ day of September 20XX, before me, the subscriber, personally appeared ____________________________, the President of Restructured Troubled Reinsurance Corporation, who I am satisfied is the person who has signed the preceding Consent Order, and he did acknowledge that he signed, sealed with the corporate seal, and delivered the same as such officer aforesaid and that the Consent Order is the voluntary act and deed of such company made by virtue of the authority vested in him by its Board of Directors.

______________________________
(name), (Title)
2. SAMPLE REINSURER LETTER AGREEMENT

November, 20XX

President
Restructured Troubled Reinsurance Company XXX Street
Anywhere, XX 00000

Dear [Name],

The Any State Insurance Department (Department) continues its financial monitoring of Restructured Troubled Reinsurance Corporation (RTRC or Company).

The Company’s parent, Restructured Troubled Group Ltd. (RTG) reported an operating loss of $245 million for the third quarter of 2002 and an operating loss of $252.6 million for the first nine months of 2002. The loss resulted principally from approximately $100.7 million of loss reserve increases recorded by the operating subsidiaries and a $64.5 million loss related to the establishment of a deferred tax valuation reserve. The operating results for the first nine months of 20XX included approximately $33 million of loss development related to the September 11th terrorist attacks recorded in the first quarter of 20XX. On October 18, 20XX, A.M. Best Company lowered the ratings of the operating subsidiaries of RTG from A- to B+. Subsidiary Insurance Company was lowered from A- to B. The downgrade constituted an event of default under RTG’s bank credit facility, under which banks had issued $336 million in letters of credit to support RTG’s underwriting at its Lloyd’s operation. On November 1, 20XX, with the approval of the Department, the Company entered into an Underwriting and Reinsurance Arrangement with Facility Re, Inc., whereby new business is underwritten by Facility Insurance Company, a member of the Facility Group. On November 14, 20XX, A.M. Best again lowered the ratings of the operating subsidiaries of RTG from B+ to B-. Subsidiary Insurance Company was lowered from B to C++. In order to protect the existing quality and integrity of RTRC’s assets, reserves, and management to protect policyholders/reinsureds and the public, it is requested that the Company agree to the following:

1. RTRC shall not take any of the following actions without the prior written approval of the Insurance Commissioner or her designee:
   a. Dispose of, convey, or encumber any of its assets or its business in force.
   b. Withdraw any of its bank accounts except in the ordinary course of business.
   c. Settle any intercompany balances.
   d. Lend any of its funds.
   e. Transfer any of its property.
   f. Make any investments other than cash equivalents.
   g. Incur any debt, obligation, or liability, except liabilities in the ordinary course of business.
   h. Make any material change in management.
Attachment Two

i. Make any material change in the operations of the Company.

j. Move any books and records from its office in Stamford, Connecticut.

k. Pay any dividends, ordinary or extraordinary.

l. Enter into any affiliated reinsurance contracts, affiliated commutation agreements, or settlement agreements.

m. Enter into any unaffiliated insurance or reinsurance contracts that would constitute new or renewal business, or any unaffiliated commutation agreements or settlement agreements in excess of $1 million not in the ordinary course of business.

n. Enter into affiliated transactions of any nature.

2. Senior management shall meet with the Department, in person or by conference call, with such frequency as may be deemed necessary by the Insurance Commissioner or her designee, to provide updates on the status of the parent and any changes in the status of the Company.

3. A monthly financial statement consisting of a balance sheet and income statement shall be filed with the Department on the 25th day of each month as of the prior month end.

4. The above-described terms shall continue in effect until such time as the Insurance Commissioner shall deem they are no longer necessary or issues an order that supersedes this agreement.

5. RTRC acknowledges that nothing contained herein shall in any way limit any power or authority given the Insurance Commissioner under the laws of the State of Connecticut, including the right to initiate any further actions as she deems in her discretion to be necessary for the protection of RTRC’s policyholders/reinsureds and the public.

I have enclosed two originals of this letter to your attention. Please sign and date both originals, retain one for your file, and return one executed original to me.

Sincerely,

__________________________, Chief Examiner
Financial Analysis & Compliance

AGREED TO this ______ day of November, 20XX, by a duly authorized representative of RTRC.
C. SAMPLE OUTLINE FOR RUN-OFF PLANS

The following is a sample outline for a run-off plan.

I. Introductory Overview
   A. Executive Summary: Providing an executive level summary of the history, current business conditions, recent significant transactions, and proposed run-off solution.
      1. Status
      2. Mission
      3. Business (Guiding) Principles
   B. Plan Objectives: Describing the ability of the plan to fully and timely settle all valid policyholder claims in compliance with the liquidation priorities of state distribution scheme.
   C. Advantages
   D. Benefits

II. Corporate History
   A. Summary
   B. Recent Happenings: Description of business plans, significant transactions, prior restructuring plans, and financial performance related thereto.
      1. Mergers & Acquisitions
      2. Employment
      3. Internal Growth
      4. External Factors
      5. Current Position
   C. Business Description: Including a comprehensive description of organizational and corporate structure, lines of insurance, nature of policyholder and other risks, and claim-handling function associated with the run-off.
      1. Lines
      2. Programs
      3. Markets
   D. Reserve Development
      1. Environmental Issues
      2. Underwriting Issues
      3. Adverse Development
      4. Reserves by Line – Summary
E. Financial Condition: Summary of recent financials
   1. Summary
   2. Statutory Surplus
   3. Consolidated Financial Statement(s)
   4. Operating Expenses
      a. Staffing
      b. Insurance
      c. Real Estate
      d. Fixed Costs
      e. Information Technology
   5. Taxes

F. Operations: Description and historical comparison of staffing, real estate, expenses, insurance and information technology, and other pertinent operations associated with run-off.
   1. Claims Handling
   2. Reinsurance
      a. Outstanding Balances
      b. Disputes
      c. Solvency Issues
      d. Uncollectables
      e. Write-offs
      f. Collateral
      g. Lines of Business
      h. Programs
      i. Processes & Systems

III. Run-off Plan: Description of initiatives and priorities, including demonstration of Run-Off Plan serving the best interests of policyholders and other claimants.
   A. Summary
   B. Financial Projections: Including description of surplus-enhancing initiatives and transactions, loss development, liquidity and expense projections.
      1. Key Factors
      2. Assumptions
      3. Revenues
4. Expenses
5. Surplus Projection
6. Liquidity Projection

C. Initiatives
1. Surplus Enhancing
   a. Policy Buybacks
   b. Expense Reductions
      i. Operating Expenses
         a. Staffing
         b. Real Estate
         c. Fixed Costs
         d. Insurance/Benefits
         e. Information Technology
      ii. Allocated Loss Adjustment Expenses
   c. Reinsurance Commutations
2. Liquidity
   a. Asset Portfolio Assessment
   b. Encumbered Assets
   c. Unencumbered Assets
   d. Statutory Deposits

D. Risk Factors: Description and projection of risks associated with Run-Off Plan, including regulatory concerns, preferences, and risks associated with policyholders, and guaranty funds/associations, including identification of critical elements for plan success.
1. Define Uncertainties
   a. Business
   b. Economic
   c. Regulatory
2. Additional Adverse Loss Reserve Development
3. Increased Reinsurance Disputes
4. Unexpected Liabilities
5. Drastic Asset Value Changes
6. Financial Market – Investments
E. Voluntary Run-off vs. Receivership: Analysis and comparison between the alternative mechanisms from best interests of policyholders, claimants, and guaranty funds/associations.

F. Regulatory Reporting: Description of proposed regulatory supervision and reporting requirements—e.g., monthly statutory basis financial statements (balance sheet, statement of income and statement of cash flow), including comparison of actual results to Plan projections; quarterly reports demonstrating reinsurance recoverables and premium receivables past due, in dispute, litigation or arbitration; report demonstrating material credit exposures, related collateral held, and identity of credit impaired transactions; unpaid losses on state-by-state basis; weekly cash flow report; periodic review of loss reserves and amortization of any permitted loss reserve discounting, including appropriate actuarial certification; copies of all internal and external audit reports within five business days of issue; approval of all transactions exceeding pre-determined thresholds; and identification of prohibited transactions.

G. Corporate Governance: Description of proposed governance and internal controls.
D. RELEVANT NAIC MODEL LAWS & REGULATIONS AND STATE STATUTES

This appendix section provides current and relevant NAIC Model Laws and Regulations, as well as specific state statutes that pertain to an insurance department’s authority and responsibilities in dealing with troubled insurers. The sections are not intended to be all-inclusive, but rather a reference source.

1. NAIC MODEL LAWS & REGULATIONS

- Administrative Supervision Model Act
- Insurers Receivership Model Act
- Model Regulation to Define Standards and Commissioners’ Authority for Companies Deemed to be in a Hazardous Financial Condition
- Criminal Sanctions for Failure to Report Impairment Model Bill

2. RULES AND REGULATIONS OF THE STATE OF NEW YORK – TITLE 11 INSURANCE
DEPARTMENT – CHAPTER IV FINANCIAL CONDITION OF INSURER AND REPORTS TO
SUPERINTENDENT – SUBCHAPTER D REINSURANCE – PART 128 COMMUTATION OF
REINSURANCE AGREEMENTS (REGULATION 141)

(Text is current through February 15, 2008.)

Section 128.0. Purpose.
Section 1321 of the Insurance Law authorizes the Superintendent of Insurance to permit an impaired or insolvent domestic insurer or an impaired or insolvent United States branch of an alien insurer entered through this state to commute reinsurance agreements as a means of eliminating such an impairment or insolvency. This Part sets forth applicable standards that the superintendent will use in determining whether such commutations will be approved.

Section 128.1. Applicability.
This Part shall be applicable to any domestic insurer or United States branch of an alien insurer entered through this state, other than a life insurance company as defined in section 107(a)(28) of the Insurance Law.

Section 128.3. General provisions.
(a) Nothing in this Part shall require the superintendent to give prior consideration to a plan which contains the commutation of reinsurance agreements in lieu of taking any other action against an impaired or insolvent insurer in accordance with the Insurance Law, including proceeding against such insurer pursuant to article 74 of the Insurance Law.
(b) All the terms and conditions of any plan which contains the commutation of reinsurance agreements are subject to approval by the superintendent and no such plan will be approved by the superintendent unless the effect of the plan shall eliminate the insurer’s impairment or insolvency and restore the insurer’s surplus to policyholders to the greater of the minimum amount required to be maintained pursuant to the applicable provisions of the Insurance Law or to the amount the superintendent determines is adequate in relation to the insurer’s outstanding liabilities or financial needs. The determination regarding the adequacy of the insurer’s surplus to policyholders shall be made in accordance with the factors set forth in section 1104(c) of the Insurance Law.

Section 128.4. Requirements.
(a) Any plan submitted by an impaired or insolvent insurer which contains the commutation of reinsurance agreements shall provide that:
(1) the offer to commute reinsurance agreements is made to each and every ceding insurer to which the impaired or insolvent insurer has obligations;
(2) the terms of the commutation agreement to be offered to each and every ceding insurer are the same, except that the percentage by which the impaired or insolvent insurer proposes to discount obligations due to each
ceding insurer may vary in regard to the type of business being commuted. Any variance by type of business shall be reasonable, actuarially sound and supported by documentation justifying such a variance; and

(3) the impaired or insolvent insurer agrees to enter into a stipulation with the superintendent consenting to an order of rehabilitation or liquidation in the event that the implementation of the plan by the insurer does not result in restoring the insurer’s surplus to policyholders to the minimum required as determined in accordance with section 128.3(b) of this Part.

(b) Any plan submitted by an impaired or insolvent insurer which contains the commutation of reinsurance agreements shall include:

(1) a balance sheet that reflects the insurer’s impairment or insolvency as determined by the superintendent, a pro forma balance sheet reflecting the financial condition of such insurer subsequent to the effective date of the plan, and a reconciliation between both balance sheets;

(2) an exhibit setting forth the obligations due to each and every ceding insurer as of the proposed effective date of such plan and the consideration to be offered each and every ceding insurer for the commutation of such obligations. The obligations shall be classified in accordance with the categories contained in the definition set forth in section 128.2(c) of this Part; and

(3) details regarding any retrocessionaire’s participation in the plan.

Section 128.5. Procedures.

(a) Any plan which contains the commutation of reinsurance agreements shall be submitted to the superintendent by the impaired or insolvent insurer within a period designated by the superintendent, which shall not be more than 90 days from the determination of the insurer’s impairment or insolvency.

(b) If the superintendent has no objection to any of the plan’s terms and conditions and determines that the impaired or insolvent insurer’s surplus to policyholders will be restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the proposed plan shall be approved and the insurer shall offer the commutation proposals to its ceding insurers. No commutation agreement shall become effective and no consideration for any commutation agreement shall be paid by the impaired or insolvent insurer until the superintendent determines that, as a result of the commutation proposals agreed to and executed by the ceding insurers, along with the effect of any other components of the plan, the impaired or insolvent insurer’s surplus to policyholders is restored to the minimum required.

(c) Within 10 days after the superintendent approves the plan, the impaired or insolvent insurer shall deliver the proposed commutation agreements to each ceding insurer. The terms of any commutation agreement shall not be subject to negotiation between the impaired or insolvent insurer and the ceding insurer.

(d) The impaired or insolvent insurer shall submit to the superintendent, within a designated period as determined by the superintendent, copies of the executed commutation agreements from those ceding insurers agreeing to the proposed terms, copies of rejections of the commutation agreements by those ceding insurers not agreeing to the proposed terms and copies of any other correspondence pertaining to all such offers made to the ceding insurers. This submission shall include a balance sheet that reflects the effect of the executed agreements, together with any other components of the plan, upon the insurer’s impairment or insolvency as determined by the superintendent. The insurer shall also submit copies of executed agreements with any retrocessionaires which either modify, commute or assign any retrocession agreement.

(e) If the superintendent determines that, as a result of the executed commutation agreements submitted by the impaired or insolvent insurer, together with any other components of the plan, the insurer’s surplus to policyholders is restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the executed commutation agreements shall become effective.

(f) If the superintendent determines that, as a result of the executed commutation agreements submitted by the impaired or insolvent insurer, together with any other components of the plan, the insurer’s surplus to policyholders is not restored to the minimum required as determined in accordance with section 128.3(b) of this Part, the superintendent may proceed against the insurer in accordance with the stipulation executed pursuant to section 128.4(a)(3) of this Part.

Section 128.6. Reporting requirements.

Any impaired or insolvent insurer which eliminates such impairment or insolvency using commutations approved by the superintendent in accordance with the provisions of this Part shall exclude all historical data pertaining to such
commutations from the loss development schedules contained in future financial statements filed in accordance with applicable provisions of the Insurance Law. The historical data pertaining to the businesses commuted shall be reported on a supplemental loss development schedule in a form consistent with the schedule contained in statutory financial statements as filed with this department. The supplemental schedule shall show the aggregate experience of such business as of the effective date of commutation agreement.

3. RHODE ISLAND STATUTE AND REGULATION – VOLUNTARY RESTRUCTURING OF SOLVENT INSURERS

§ 27-14.5-2 Jurisdiction, venue, and court orders.
(a) The court considering applications brought under this chapter shall have the same jurisdiction as a court under chapter 14.3 of this title.
(b) Venue for all court proceedings under this chapter shall lie in the superior court for the county of Providence.
(c) The court may issue any order, process, or judgment that is necessary or appropriate to carry out the provisions of this chapter. No provision of this chapter providing for the raising of an issue by a party in interest shall be construed to preclude the court from, on its own motion, taking any action or making any determination necessary or appropriate to enforce or implement court orders or rules, or to prevent an abuse of process.

§ 27-14.5-3 Notice.
(a) Wherever in this chapter notice is required, the applicant shall, within ten (10) days of the event triggering the requirement, cause transmittal of the notice:
(1) By first class mail and facsimile to the insurance regulator in each jurisdiction in which the applicant is doing business;
(2) By first class mail to all guarantee associations;
(3) Pursuant to the notice provisions of reinsurance agreements or, where an agreement has no provision for notice, by first class mail to all reinsures of the applicant;
(4) By first class mail to all insurance agents or insurance producers of the applicant;
(5) By first class mail to all persons known or reasonably expected to have claims against the applicant including all policyholders, at their last known address as indicated by the records of the applicant;
(6) By first class mail to federal, state, and local government agencies and instrumentalities as their interests may arise; and
(7) By publication in a newspaper of general circulation in the state in which the applicant has its principal place of business and in any other locations that the court overseeing the proceeding deems appropriate.
(b) If notice is given in accordance with this section, any orders under this chapter shall be conclusive with respect to all claimants and policyholders, whether or not they received notice.
(c) Where this chapter requires that the applicant provide notice but the commissioner has been named receiver of the applicant, the commissioner shall provide the required notice.

§ 27-14.5-4 Commutation plans.
(a) Application. Any commercial run-off insurer may apply to the court for an order implementing a commutation plan.
(1) The applicant shall give notice of the application and proposed commutation plan.
(2) All creditors shall be given the opportunity to vote on the plan.
(3) All creditors, assumption policyholders, reinsurers, and guaranty associations shall be provided with access to the same information relating to the proposed plan and shall be given the opportunity to file comments or objections with the court.
(4) Approval of a commutation plan requires consent of: (i) fifty percent (50%) of each class of creditors; and (ii) the holders of seventy-five percent (75%) in value of the liabilities owed to each class of creditors.
(1) The court shall enter an implementation order if: (i) the plan is approved under subdivision (b)(4) of this section; and (ii) the court determines that implementation of the commutation plan would not materially adversely affect either the interests of objecting creditors or the interests of assumption policyholders.
(2) The implementation order shall:
(i) Order implementation of the commutation plan;

(ii) Subject to any limitations in the commutation plan, enjoin all litigation in all jurisdictions between the applicant and creditors other than with the leave of the court;

(iii) Require all creditors to submit information requested by the bar date specified in the plan;

(iv) Require that upon a noticed application, the applicant obtain court approval before making any payments to creditors other than, to the extent permitted under the commutation plan, payments in the ordinary course of business, this approval to be based upon a showing that the applicant’s assets exceed the payments required under the terms of the commutation plan as determined based upon the information submitted by creditors under paragraph (iii) of this subdivision;

(v) Release the applicant of all obligations to its creditors upon payment of the amounts specified in the commutation plan;

(vi) Require quarterly reports from the applicant to the court and commissioner regarding progress in implementing the plan; and

(vii) Be binding upon the applicant and upon all creditors and owners of the applicant, whether or not a particular creditor or owner is affected by the commutation plan or has accepted it or has filed any information on or before the bar date, and whether or not a creditor or owner ultimately receives any payments under the plan.

(3) The applicant shall give notice of entry of the order.

(1) Upon completion of the commutation plan, the applicant shall advise the court.

(2) The court shall then enter an order that:

(i) Is effective upon filing with the court proof that the applicant has provided notice of entry of the order;

(ii) Transfers those liabilities subject to an assumption reinsurance agreement to the assumption reinsurer, thereby notating the original policy by substituting the assumption reinsurer for the applicant and releasing the applicant of any liability relating to the transferred liabilities;

(iii) Assigns each assumption reinsurer the benefit of reinsurance on transferred liabilities, except that the assignment shall only be effective upon the consent of the reinsurer if either:

(A) The reinsurance contract requires that consent; or

(B) The consent would otherwise be required under applicable law; and

(iv) Either:

(A) The applicant be discharged from the proceeding without any liabilities; or

(B) The applicant be dissolved.

(3) The applicant shall provide notice of entry of the order.

(e) Reinsurance. Nothing in this chapter shall be construed as authorizing the applicant, or any other entity, to compel payment from a reinsurer on the basis of estimated incurred but not reported losses or loss expenses, or case reserves for unpaid losses and loss expenses.

(f) Modifications to plan. After provision of notice and an opportunity to object, and upon a showing that some material factor in approving the plan has changed, the court may modify or change a commutation plan, except that upon entry of an order under subdivision (d)(2) of this section, there shall be no recourse against the applicant’s owners absent a showing of fraud.

(1) The commissioner and guaranty funds shall have the right to intervene in any and all proceedings under this section; provided, that notwithstanding any provision of title 27, any action taken by a commercial run-off insurer to restructure pursuant to chapter 14.5, including the formation or re-activation of an insurance company for the sole purpose of entering into a voluntary restructuring shall not affect the guaranty fund coverage existing on the business of such commercial run-off insurer prior to the taking of such action.

(2) If, at any time, the conditions for placing an insurer in rehabilitation or liquidation specified in chapter 14.3 of this title exist, the commissioner may request and, upon a proper showing, the court shall order that the commissioner be named statutory receiver of the applicant.

(3) If no implementation order has been entered, then upon being named receiver, the commissioner may request, and if requested, the court shall order, that the proceeding under this chapter be converted to a rehabilitation or liquidation pursuant to chapter 14.3 of this title. If an implementation order has already been entered, then the court may order a conversion upon a showing that some material factor inapproving the original order has changed.
Attachment Two

(4) The commissioner, any creditor, or the court on its own motion may move to have the commissioner named as receiver. The court may enter such an order only upon finding either that one or more grounds for rehabilitation or liquidation specified in chapter 14.3 of this title exist or that the applicant has materially failed to follow the commutation plan or any other court instructions.

(5) Unless and until the commissioner is named receiver, the board of directors or other controlling body of the applicant shall remain in control of the applicant.

RI Regulation 68 – [link]

Section 2 Purpose
The purpose of this Regulation is to outline the procedural requirements for insurance companies applying for the implementation of a Commutation Plan pursuant to R.I. Gen. Laws § 27-14.5-1, et seq. and related matters.

4. PART VII OF THE FINANCIAL SERVICES AND MARKETS ACT 2000 (FSMA)

[link]

E. REFERENCES


BY E-MAIL
November 30, 2021

Superintendent Elizabeth Kelleher Dwyer
Commissioner Glen Mulready
Co-Chairs, NAIC Restructuring Mechanisms (E) Working Group

Attention: Dan Daveline (ddaveline@naic.org)


Dear Superintendent Dwyer and Commissioner Mulready,


The draft white paper of the Restructuring Mechanisms Working Group provides a comprehensive summation of activities leading to the development of insurance business transfer (IBT) and corporate division (CD) laws. In its review the Working Group concludes that each state will have different needs and approaches to these restructuring mechanisms and it is best left to the states to decide what is required for their purposes.

The recently concluded Allstate Division transaction in Illinois provides a good illustration of how these restructuring tools can be successfully implemented. While each transaction is unique depending on the specific proposals, the Allstate Division provides a solid framework for the division process in Illinois and other states with similar CD legislation and serves as a model for all transactions going forward.

Allstate Division

On February 2, 2021, Allstate Insurance Company filed the first plans of division in the U.S. market to restructure its insurance operations. The Allstate plans of division were filed with the Illinois Department of Insurance (the “Department”) pursuant to the Illinois Domestic Stock Company Division Law.

1 The plans involved eight insurance company subsidiaries under the Allstate, Esurance, and Encompass brands, (the “Dividing Companies”) with each filing a plan of division with the Illinois Director of Insurance (“Director”).


The “Dividing Companies” are: (i) Allstate Insurance Company ("AIC"); (ii) Allstate Indemnity Company; (iii) Allstate Property and Casualty Insurance Company; (iv) Allstate Fire and Casualty Insurance Company ("AFCIC"); (v)
The eight plans of division allocated certain portions of each company’s inactive Michigan automobile insurance business (the “Specified Policies”) to eight (8) new insurance companies created in the division process (“New Companies”). Immediately following the divisions, the eight New Companies merged into three newly formed Illinois domestic insurers pursuant to the Illinois Merger Law, so that there was one surviving insurer for each of the Allstate, Esurance and Encompass brands (the “Merger Companies”) Following the mergers all the assets, liabilities, contracts, and required surplus associated with the Specified Business allocated to the New Companies passed by operation of law to the Merger Companies. Upon the closing of the transaction, the Merger Companies continued to be wholly owned, indirect subsidiaries of Allstate, which is the ultimate controlling person of each of the Merger Companies.

**Division Transaction review and implementation**

Central to any successful restructuring transaction is the effective program management of all the subsidiary projects and tasks involved. Keeping the program and all the relevant staff and advisers focused and on track is fundamental. Arguably the most important roles in delivering a successful transfer on time are those of the project manager, legal advisers, financial advisors and other experts. These key appointments must be considered carefully by the parties to the transfer.

There are a number of key elements to a restructuring transaction using either the IBT or CD legislation that include:

- **a)** Information gathering
- **b)** Selection and appointment of advisers
- **c)** Assessment of capital adequacy and solvency
- **d)** Assessment of notice requirements
- **e)** Assessment of the impact on affected policyholders
- **f)** Contingency planning

For IBT and CD transactions, an important consideration for the regulator is the scale of the transaction. Scale is defined by gross liabilities, obligations to policyholders, other creditors, reinsurance and other assets. Scale will affect the cost of the transfer, and what the parties must do to satisfy the regulatory review. Generally, a regulator will adopt a principle of proportionality, namely the bigger, more complex or controversial a transaction is, then the greater the degree of regulatory scrutiny.

The Allstate transaction was a large, relatively complex transaction and the first of its kind in the U.S. As a result, both the Department and Allstate went above and beyond the legislative

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Encompass Indemnity Company; (vi) Encompass Property and Casualty Company; (vii) Esurance Insurance Company; and (viii) Esurance Property and Casualty Insurance Company. Each Dividing Company is an Illinois domestic insurer, holding a license from the IL DOI, and is licensed as a foreign insurer in Michigan.
requirements of the Illinois Division law in connection with the financial review and notice requirements.

For the Allstate Division, the Department engaged me as project manager to assist in the implementation of the legislation. In addition to my engagement, the Department also engaged Stephen Schwab of DLA Piper as outside counsel to represent the Department. To support the financial review, the Department retained Risk & Regulatory Consulting (“RRC”) as its independent actuarial consultant to focus on reserves and capital. RRC conducted an independent reserve analysis and evaluated the initial capital levels of the Merger Companies.

The Department’s review focused on policyholder and claimant protection and prudent financial analyses. The key areas considered under the financial evaluation scope included:

- Capital adequacy
- Loss reserves
- Financial modelling and projections

Allstate conducted its own internal analysis to determine the capital adequacy of the Merger Companies. Allstate utilized several tools and methodologies, including: (1) Allstate’s estimate of required capital using A.M. Best’s BCAR framework; (2) the NAIC RBC ratio; and (3) a peer company review.

In addition to Allstate’s internal analyses, Allstate retained outside consultants including A.M. Best, a rating agency, to provide an independent rating analysis and a preliminary credit assessment for the Merger Company group. Allstate also retained Lazard, a financial advisory and asset management firm, to analyze the capital adequacy of the Merger Companies. As part of its mandate, Lazard was charged with preparing a report analyzing the business and financial condition of the Merger Companies and assessing this information against certain financial aspects of the Division Law’s requirements. Specifically, Lazard analyzed pro forma financial metrics as provided by Allstate. Lazard also performed a peer benchmarking analysis, comparing key pro forma financial metrics of the Merger Companies to public information regarding selected comparable companies. After consideration of all findings presented, the Department concluded that the initial capital levels were reasonable.

Early engagement with the Department was key to the success of the Allstate transaction. Allstate worked closely with the Department providing detailed information regarding the business to be divided, the assets to be allocated to support the business, how the companies were to be capitalized, and how policyholder considerations were to be addressed. Allstate’s comprehensive planning identified potential sources of areas of objection, and, prior to the hearing, Allstate took the necessary actions to address these concerns. All parties worked together to complete the project and obtain necessary approvals within Allstate’s requested timeline. The collaborative working environment enabled this transaction to be completed on Allstate’s time schedule notwithstanding that it was executed during a Pandemic and was the first transaction of its kind in the U.S.
Notice and Hearing

The Illinois Division Law requires a hearing only if the Director deems it to be in the public interest or if requested by the Dividing Company. Also notice is not required unless the Director deems it to be in the public interest. Because of the significance of this being the first division transaction undertaken in the United States and Allstate’s desire for transparency, Allstate requested a public hearing. Allstate’s division plans also included a Communication Plan that provided notice to affected policyholders, guaranty funds, the Michigan regulator and other relevant stakeholders. Allstate also provided broad public notice through ads published twice in each of The Chicago Tribune and The Detroit Free Press.

The Department closely reviewed and approved Allstate’s Communication Plan and the notice of hearing that was provided to the affected policyholders and claimants, and other stakeholders. In addition, Allstate requested that the Hearing Officer, Judge MaryAnne Mason (ret.), review the notice of hearing. The hearing was held virtually by Zoom and provided the opportunity for any person to submit a comment or intervene in the proceedings.

Any interested person was able to attend the hearing via a Zoom link. No objections or other comments were submitted to the Hearing Officer. On March 19, 2021, based on the Hearing Officer’s Findings of Fact and Conclusions of Law, the Director issued an order approving the eight Plans of Division.

Conclusion

The key “lessons learned” from this transaction include the following:

- Early engagement with the regulator is essential
- Careful selection of project manager, consultants and experts is key
- Communication and transparency are important
- A collaborative working environment facilitates timely execution

Allstate’s Division transaction is a landmark transaction for the insurance industry to successfully implement the Illinois Division legislation in a complex transaction structure. Importantly, the transaction was achieved by Allstate and the Illinois Department working together with their consultants and representatives to put forth a transaction structure that allowed Allstate to accomplish its corporate objectives and better position itself for the future while ensuring that the interests of policyholders and claimants were properly protected.

Respectfully submitted,

Luann Petrellis
December 1st, 2021

Comments to Restructuring Mechanisms Working Group draft white paper

Dear Superintendent Dwyer and Commissioner Mulready:

Thank you to the entire working group and NAIC staff for the time and effort directed into the development of this white paper. As you have recognized, the need for restructuring transactions within the insurance industry continues to grow. The growth of the runoff industry reflects the success this market has achieved to improve the capital and managerial efficiencies of the insurance industry. We appreciate your leadership and recognition of the importance of preparing US regulators for the continued need for these types of transactions.

Enstar is a publicly traded global insurance group and market leader in the active runoff management industry. We recognize that it is often difficult to quantify and differentiate between active runoff management insurers, active insurers that also hold business in runoff, and companies that have transitioned from active insuring to managing their own runoff. As the working group continues to pursue its charges, we would appreciate the opportunity to address how these differences may be relevant to the recommendations of the working group. We believe that these distinctions may give additional insight into the purposes and value of the restructuring transactions identified within the white paper. These distinctions are likely to be developed further by the Restructuring Mechanisms Subgroup in pursuit of its charges, and we hope that this pending work will be added to the white paper once completed.

We appreciate that the white paper recognizes the importance of state licensing on companies looking to aggregate runoff business into a single company. We agree that it is in the interests of policyholders, regulators, and insurers for companies to be able to obtain insurance licenses despite operating a business model that would not necessarily require a license to be granted. We hope that the working group will consider taking on a
charge or referral on this issue and will make a place in this white paper for any additional insights developed during this process.

We have valued and enjoyed the opportunities offered to us to share our perspective on the runoff industry with the working group, and we remain available should there be any further opportunities for us to assist the working group and its subgroups with their charges.

Sincerely,

Robert Redpath
US Legal Director
VIA Electronic Delivery

Restructuring Mechanisms (E) Working Group
National Association of Insurance Commissioners
Attn: Mr. Dan Daveline
Attn: Mr. Casey McGraw
1100 Walnut Street, Suite 1500
Kansas City, MO 64106

Re: Comment on Draft Restructuring Mechanisms White Paper

Dear Restructuring Mechanisms (E) Working Group:

The Virginia State Corporation Commission’s (the “Commission”) Bureau of Insurance (the “Bureau”) appreciates the efforts of the Restructuring Mechanisms (E) Working Group (the “Working Group”) to compile its thoughtful draft white paper on the complex topic of Restructuring Mechanisms (the “White Paper”). The Bureau submits this comment to bring to the attention of the Working Group both § 38.2-136 of the Code of Virginia (the “Code”), which is in essence an anti-novation statute, and how that section of the Code governed the Commission’s approach to a prior Insurance Business Transfer (“IBT”) involving Virginia policies.

The Bureau respectfully proposes that the White Paper should include a discussion of anti-novation statutes, like § 38.2-136 of the Code, because these statutes and analogous legal principles will influence the sections on “Assumption Reinsurance,” “Guarantee Association Issues,” and “How Other Jurisdictions Might Analyze IBT or CD Decisions from Other States.”

**Background:**

*Assumption Reinsurance Model Act.* As the White Paper notes, ten states have enacted the NAIC Assumption Reinsurance Model Act (“Model Act”). Under the Model Act, individual policyholders are notified of a proposed transfer of their policy and “have the right to reject the transfer and novation of their contracts of insurance.” Model Act §§ 4, 5. This core requirement of policyholder consent, however, is not only found in states that have adopted the Model Act. While the details will vary, a state may also require such consent through independent anti-novation statutes or the application of common law principles. In Virginia, the principle of policyholder consent is codified in § 38.2-136 of the Code.

*Section 38.2-136 of the Code.* In relevant part, § 38.2-136 of the Code prohibits the assumption of policy obligations on risks located in Virginia as direct obligations unless (1) the
policyholder consents and (2) the assuming insurer is properly licensed in Virginia. See § 38.2-136 (B) of the Code. Absent policyholder consent, such a transaction requires an order from the Commission approving the transaction. The Commission may enter such an order whenever (i) the Commission finds a licensed insurer to be impaired or in hazardous financial condition, (ii) a delinquency proceeding has been instituted against the licensed insurer for the purpose of conserving, rehabilitating, or liquidating the insurer, or (iii) the Commission finds, after giving the insurer notice and an opportunity to be heard, that the transfer of the contracts is in the best interests of the policyholders. See § 38.2-136 (C) of the Code. Additionally, if granting an approval order, the Commission is required to ensure that policyholders do not lose any rights or claims afforded under their original policies by the Virginia Property and Casualty Insurance Guaranty Association or the Virginia Life, Accident and Sickness Insurance Guaranty Association. Id.

Virginia’s Application of § 38.2-136 of the Code to IBTs. As noted in the section of the White Paper on “Transactions Completed to Date:”

In 2020, the District Court of Oklahoma County approved Providence Washington Insurance Company’s (“PWIC”) IBT plan. The plan transferred all the insurance and reinsurance business underwritten by PWIC, a Rhode Island domestic insurer, to Yosemite Insurance Company (“Yosemite”). (White Paper at 12.)

The transferred business, however, included a number of Virginia workers’ compensation policies. As such, the Bureau informed PWIC and Yosemite that the IBT—as to the Virginia policies—required policyholder consent under § 38.2-136 (B) of the Code because it involved the cessation or assumption of policy obligations on risks located in Virginia. In response, PWIC and Yosemite requested that the Commission waive the policyholder consent requirement by finding that the transfer of the Virginia policies was in the best interests of the policyholders pursuant to § 38.2-136 (C)(iii) of the Code. The Commission found that the transfer of Virginia policies was subject to the requirements of § 38.2-136 (B) of the Code (i.e. policyholder consent and proper licensure), but approved the transfer pursuant to § 38.2-136 (C)(iii) of the Code (i.e. best interests of the policyholders). See Order Approving Application, Case No. INS-2021-00055 (June 17, 2021).

Effect on the White Paper:

The existence of § 38.2-136 of the Code and its application to the PWIC / Yosemite IBT raise important considerations with respect to three sections of the White Paper.

First, in the section on Assumption Reinsurance, the Bureau would encourage the Working Group to not only discuss states with the Model Act, but to also consider jurisdictions—like Virginia—that have independent anti-novation provisions or principles. That addition will prevent any misimpression that the important issues raised in this section only exist in the ten states that have adopted the Model Act.

1 While requesting this order, PWIC and Yosemite did not concede that such an order was necessary.
2 Included with this comment for reference are (1) a copy of the text of § 38.2-136 of the Code and (2) the Commission’s order regarding the PWIC / Yosemite IBT.
Furthermore, this section could be clarified as to whether it is (a) only raising the issue of how statutory restructuring mechanisms would interact with the Model Act if both were included within a single jurisdiction’s laws or (b) also addressing how one state’s statutory restructuring mechanism would interact with the Model Act or an independent anti-novation statute or principle in another jurisdiction. If the White Paper is only addressing the former, the Bureau would propose also flagging the even more complex issue raised by a multi-jurisdictional analysis (e.g. if State A had an IBT statute and State B had the Model Act or an anti-novation statute, how would those statutes interact if State A attempted to approve the transfer of policies located in State B). Understanding the complexity of that multi-state scenario will likely be important for regulators weighing the persuasiveness of the suggestion by some stakeholders noted in the White Paper that the “statutes coexist.” (White Paper at 15.)

The interaction of these statutes can also raise thorny legal and factual issues worth highlighting in the White Paper. Most notably, there are varying standards for approving a transaction. As explained by the White Paper, various IBT statutes require that there be “no material adverse impact on affected policyholders.” (White Paper at 10.) For Virginia to approve an IBT authorized by another jurisdiction with respect to Virginia policyholders, however, the Commission must find the transfer of the Virginia policies to be “in the best interests of the policyholders.” § 38.2-136 (C)(iii) of the Code.3 Simply put, those pursuing novel statutory restructuring mechanisms should be aware that other jurisdictions—like Virginia—may hold the transfer to a higher standard.4

Finally, the White Paper’s observation in this section that “[t]he issue has not yet been addressed by any court nor raised in the proceedings on restructurings,” could be updated to reflect that the Commission, which acts as a court of record, applied Virginia’s anti-novation statute to the PWIC / Yosemite IBT. (White Paper at 15.)

Second, in Virginia and any states with a similar statute, the guaranty association concerns identified in the White Paper’s section on “Guarantee Association Issues” take on added importance. The Bureau certainly agrees with the White Paper’s position that “guaranty association coverage should not be reduced or eliminated by the restructuring.” (White Paper at 13.) Under Virginia law, however, the bar is higher for a transaction that is dependent on an approval order pursuant to § 38.2-136 (C) of the Code due to the lack of policyholder consent. Such an order could not be issued and, therefore, such a restructuring could not occur unless the Commission determined that policyholders would not lose any rights or claims afforded under their original policies by the Virginia guaranty associations.5 As a result, the language in this

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3 In certain circumstances, the Model Act also permits the “transfer and novation” of policies “notwithstanding the provisions of [the Model Act]” if such a transfer “is in the best interest of the policyholders.” Model Act § 7.

4 As a practical matter, this difference in standards (“no material adverse impact” v. “best interests”) may result in the record from an IBT proceeding standing alone not satisfying the heightened standard found in another state.

5 With respect to the PWIC / Yosemite IBT, which involved two insurers who were both licensed in Virginia and guaranty coverage from the Virginia Property and Casualty Insurance Guaranty Association, the Commission determined “[b]ased upon the Bureau’s review of the Application and the Applicants”
section and the corresponding recommendation in Section 6 could be strengthened to reflect that unless and until guaranty association coverage can be ensured, transactions involving policies in states with anti-novation statutes will not be possible.  

* * *

Third, Virginia’s treatment of the PWIC / Yosemite IBT should potentially be referenced in the section on “How Other Jurisdictions Might Analyze IBT or CD Decisions from Other States.” The Commission’s order is one concrete example not just of how another jurisdiction might respond to an IBT, but how another jurisdiction did in fact respond. Regulators approving IBTs and insurers looking to utilize them should be aware that if policies from a state with an anti-novation statute or principle are involved, they are likely to see a response from those jurisdictions similar to Virginia’s response to the PWIC / Yosemite IBT.

* * *

The Bureau again thanks the Working Group for its work on this complex issue and appreciates the opportunity to comment on the draft White Paper. If you have any questions regarding this comment, the Bureau’s staff would be happy to discuss the matter with you and/or provide additional information regarding the above referenced proceedings before the Commission.

Sincerely,

Scott A. White
Commissioner of Insurance

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representations” that “the Virginia policyholders will not lose any rights or claims afforded under their original contracts.” Order Approving Application, Case No. INS-2021-0005, at 3.

* For example, the recommendations section currently advises that “regulators should very carefully consider how plans presented address the guaranty association issues to assure that consumers are not harmed by the transaction.” (White Paper at 19.) This advice could be expanded to also advise states to consider whether a transfer of policies in other jurisdictions will even be possible due to the uncertainty around guaranty association coverage in certain circumstances.
§ 38.2-136. Reinsurance

A. Except as otherwise provided in this title, any insurer licensed to transact the business of insurance in this Commonwealth may, by policy, treaty or other agreement, cede to or accept from any insurer reinsurance upon the whole or any part of any risk, with or without contingent liability or participation, and, if a mutual insurer, with or without membership therein.

B. No insurer licensed in this Commonwealth shall cede or assume policy obligations on risks located in this Commonwealth whereby the assuming insurer assumes the policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under the policies and in substitution for the obligations of the ceding insurer to the payees, unless: (i) the policyholder has consented to the assumption and (ii) the assuming insurer is licensed in this Commonwealth to write the class or classes of insurance applicable to the policy obligations assumed.

C. Notwithstanding the provisions of subsection B, the transfer of risk under any reinsurance agreement may be effected by entry of an order by the Commission approving the transaction whenever (i) the Commission finds a licensed insurer to be impaired or in hazardous financial condition, (ii) a delinquency proceeding has been instituted against the licensed insurer for the purpose of conserving, rehabilitating, or liquidating the insurer, or (iii) the Commission finds, after giving the insurer notice and an opportunity to be heard, that the transfer of the contracts is in the best interests of the policyholders. In granting any such approval, the Commission shall ensure that policyholders do not lose any rights or claims afforded under their original policies pursuant to Chapter 16 (§ 38.2-1600 et seq.) or 17 (§ 38.2-1700 et seq.) of this title. Prior to granting an approval under clause (iii), the Commission shall consider whether there is a reasonable expectation that the ceding insurer may not be able to meet its obligations to all policyholders; whether the ceding insurer’s continued operation in this Commonwealth may become hazardous to policyholders, creditors and the public in this Commonwealth; or whether the ceding insurer may otherwise be unable to comply with the provisions of this title.


The chapters of the acts of assembly referenced in the historical citation at the end of this section(s) may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.
APPLICATION OF

YOSEMITE INSURANCE COMPANY
AND PROVIDENCE WASHINGTON
INSURANCE COMPANY

For approval of the transfer of certain
insurance policies pursuant to
§ 38.2-136 (C)(iii) of the Code of Virginia

ORDER APPROVING APPLICATION

By Application filed with the State Corporation Commission ("Commission") of the
Commonwealth of Virginia ("Virginia") dated April 14, 2021, Yosemite Insurance Company, an
Oklahoma-domiciled insurer ("Yosemite"), and Providence Washington Insurance Company, a
Rhode Island-domiciled insurer ("PWIC" together with Yosemite, "Applicants"), requested
approval of the transfer of 251 Virginia workers' compensation policies from PWIC to Yosemite
("Virginia Transfer") pursuant to § 38.2-136 (C)(iii) of the Code of Virginia ("Code").

Yosemite and PWIC are affiliates within the Enstar Group ("Enstar") and both are licensed to
transact the business of insurance in Virginia and are in good standing.

The transfer of these Virginia workers' compensation policies is part of an Insurance
Business Transfer ("IBT") that PWIC filed with the Oklahoma Insurance Department on
November 13, 2019 pursuant to Oklahoma's Insurance Business Transfer Act. On November 26,
2019, the Commissioner of the Oklahoma Insurance Department approved the IBT after

1 PWIC previously obtained the Virginia policies in question from Reciprocal of America, in receivership, pursuant
to a Loss Portfolio Transfer Agreement approved by an order of the Commission on June 16, 2014. See Final
Order, Case No. INS-2013-00190 at 9 (June 16, 2014) (adopting Hearing Examiner's recommendations and finding
that the "Deputy Receiver has met all the requirements of § 38.2-136 (C) of the Code.").
concluding it would not have a material adverse impact on the interests of the policyholders. On October 15, 2020, the District Court of Oklahoma County approved the IBT following an approval hearing.

The Commission’s Bureau of Insurance (“Bureau”) informed Yosemite and PWIC that the IBT required policyholder consent under § 38.2-136 (B) of the Code to the extent that it involved the cessation or assumption of policy obligations on risks located in Virginia whereby the assuming insurer assumes the policy obligations of the ceding insurer as direct obligations.

Pursuant to § 38.2-136 (C)(iii) of the Code, the Applicants have requested that the Commission waive § 38.2-136 (B) of the Code’s policyholder consent requirement for the Virginia Transfer by finding that the transfer of these policies is in the best interests of the policyholders. The Applicants have waived the right to a hearing under § 38.2-136 (C)(iii) of the Code in their application.

In support of the Application, Yosemite and PWIC state, *inter alia*, that during the Oklahoma IBT proceedings notice of the Virginia Transfer was mailed to the Virginia policyholders and that no policyholder objected prior to or during the approval hearing held before the District Court of Oklahoma County.

Following submission of the Application, Yosemite and PWIC informed the Bureau on May 14, 2021 that Enstar is in the process of selling PWIC and had entered into a stock purchase agreement with Everspan Insurance Company (“Everspan”). As a result, if the Virginia Transfer were not to occur, the Virginia workers’ compensation policies in question would leave Enstar and go to Everspan with PWIC.

While requesting an order pursuant to § 38.2-136 (C)(iii) of the Code, the Applicants do not concede that such an order is necessary for the Virginia Transfer. *See Application at 4.*
The Bureau, based upon the Application, the record in the Oklahoma IBT proceedings and the information available in this matter, has recommended that the Virginia Transfer is in the best interests of the Virginia policyholders. Based upon the Bureau's review of the Application and the Applicants' representations, the Virginia policyholders will not lose any rights or claims afforded under their original contracts pursuant to Chapter 16 of Title 38.2 of the Code.

NOW THE COMMISSION, having considered the Application, the recommendation of the Bureau that the Virginia Transfer is in the best interests of the Virginia policyholders, and the law applicable hereto, is of the opinion that the Virginia Transfer is subject to the requirements of § 38.2-136 (B) of the Code, and that the Application should be approved.

Accordingly, IT IS ORDERED THAT the Application of Yosemite Insurance Company and Providence Washington Insurance Company for the approval of the transfer of 251 Virginia workers' compensation policies from PWIC to Yosemite pursuant to § 38.2-136 (C)(iii) of the Code be, and it is hereby, APPROVED.

A COPY hereof shall be sent by the Clerk of the Commission by electronic mail to: Scott J. Sorkin, Esquire, Bland & Sorkin, P.C., at ssorkin@blandsorkin.com, 5398 Twin Hickory Road, Glen Allen, Virginia 23059; Robert Redpath, Senior Vice President and U.S. Legal Director, Enstar (US) Inc., at robert.redpath@enstargroup.com, 475 Kilvert Street, Suite 330, Warwick, Rhode Island 02886; and a copy shall be delivered to the Commission's Office of General Counsel in care of Attorney, Thomas J. Sanford and the Bureau of Insurance in care of Deputy Commissioner Douglas C. Stolte.
Wayne Mehlman  
Senior Counsel  
(202) 624-2135  
waynemehlman@acli.com

December 1, 2021

Superintendent Elizabeth Kelleher Dwyer, Co-Chair  
Commissioner Glen Mulready, Co-Chair  
Restructuring Mechanisms Working Group  
National Association of Insurance Commissioners  
2301 McGee Street, Suite 800  
Kansas City, MO 64108

RE: Draft White Paper on Restructuring Mechanisms

Superintendent Dwyer and Commissioner Mulready:

The American Council of Life Insurers (ACLI) would like to thank you for this opportunity to comment on the Restructuring Mechanisms Working Group’s draft White Paper on Restructuring Mechanisms.

ACLI believes that certain guardrails, including important process, review, and consumer and company solvency protections, must be in place before a proposed insurance business transfer (IBT) or corporate division transaction can be approved by a state regulator (and in the case of an IBT, by a state court).

Accordingly, in 2019, ACLI’s Board of Directors adopted a comprehensive set of Principles and Guidelines on Insurance Business Transfer & Corporate Division Legislation that ACLI and its members would refer to when evaluating potential legislation, regulations and models. As you finalize this White Paper, we strongly encourage the Working Group to incorporate the following Principles and Guidelines:

Policyholders and Other Impacted Stakeholders Must Have Access to the Process

- All transactions must be subject to a public hearing.
- Individual policyholders, reinsurers, applicable state regulators, guaranty associations, and any other persons determined by the regulator must receive notice of the proposed transaction.

The Regulatory Review Process Must Be Robust

- The Commissioner’s review process must include certain findings, including:
  - The financial condition of an involved insurer will not jeopardize the financial stability of the insurers, or prejudice the interest of its policyholders or reinsurers;
An involved insurer will not have plans or proposals to liquidate another involved insurer, sell its assets, or consolidate or merge or to make any other material change in its business or corporate structure or management, that are unfair or unreasonable to policyholders, reinsurers or the public;

- The involved insurers will be solvent at the time of the transaction;
- The assets allocated to the involved insurers will not be, at the time of the transaction, unreasonably small in relation to the business and transaction;
- The terms of the transaction will not be unfair or unreasonable to any involved insurer’s policyholders or reinsurers;
- The competence, experience and integrity of the persons who would control the operation of an involved insurer are such that it would be in the interest of the involved insurers’ policyholders and reinsurers and the general public to permit the transfer; and
- The transaction is not likely to be hazardous or prejudicial to the insurance-buying public;
- The interest of the policyholders of an involved insurer that may become policyholders of another insurer will be adequately protected; and
- The transaction is not being made for purposes of hindering, delaying or defrauding any policyholders or reinsurers.

In determining whether to approve the transaction, the regulator must consider, among other things, all assets, liabilities, cash flows and the nature and composition of the assets proposed to be transferred including, without limitation:

- An assessment of the risks and quality (including liquidity and marketability) of the proposed transfer portfolio, and
- Consideration of asset/liability matching and the treatment of the material elements of the portfolio for purposes of statutory accounting.

Independent Experts Must be Utilized as Part of the Process

- An independent expert is required for all transactions and the expert’s report must address:
  - Business purposes of the proposed transaction;
  - Capital adequacy and risk-based capital (including consideration of the effects of asset quality, non-admitted assets and actuarial stresses to reserve assumptions);
  - Cash flow and reserve adequacy testing (including consideration of the effects of diversification on policy liabilities);
  - The impact, if any, of concentration of lines of business following the transaction;
  - Business plans; and
  - Management’s competence, experience and integrity.

Court Approval is Required for Insurance Business Transfer Transactions, but Not Necessarily for Corporate Division Transactions

- For insurance business transfer transactions, court approval is required.
- For corporate division transactions, court approval is not required, provided the Principles relating to public hearing, notice, and independent expert report(s) are included in the analysis.

Policyholders and the State-Based Guaranty Association System Should Be Protected

- Involved insurers must be licensed such that policyholders maintain guaranty association coverage in the same state in which they had it immediately prior to the transaction.

In addition, we have some specific comments and suggestions:

- On Pages 4 and 10, Arkansas has not yet enacted corporate division legislation, while Colorado, Georgia and Nebraska have.
- On Page 5, in the first paragraph, the types of runoff business mentioned in the third sentence should also refer to life insurance business.
- On Page 6, in the second full paragraph, it should read: “subject to approval of a court and an independent expert review”.
- On Page 9, in the third full paragraph, it should refer to “UK’s Part VII” instead of “UK’s Part IV”.
- On Page 10, the second paragraph should refer to an “independent expert report”.
- On Page 10, (2) should read: “the resulting insurer would not be eligible to receive a license in the same state(s) as the dividing insurer”.
- On Page 11, in the last paragraph, it should be noted that Colorado’s and Iowa’s corporate division statutes contain independent expert requirements.
- On Pages 13 and 14, it should refer to “guaranty associations” instead of “guarantee associations”.
- On Page 15, at the end of the second paragraph under “Separate Issues in Long-Term Care”, we suggest adding the following sentence: “That being said, there should be increased scrutiny for any block transfers, not just those relating to long-term care insurance, that are currently in a projected deficit situation”.
- On Page 17, the last paragraph should refer to “Allianz” instead of “Allainz”.
- On Page 18, in the Subgroup’s charge, the sentence “Complete by the 2021 Summer National Meeting” should be deleted.
- On Page 19, in the first paragraph under “Guaranty Association Issues”, it states that “A number of states – Connecticut, California, and Oklahoma – have enacted statutory solutions to these issues.” We are not aware of any such solutions and ask that this sentence either be clarified or deleted. In addition, it should mention that some states, such as Colorado and Illinois, and to a certain degree, Arkansas, require an assuming or resulting insurer to be licensed in the the same state(s) as the transferring or dividing insurer.
- On Page 19, under “Statutory Minimums”, we suggest adding the following after the first paragraph:

> The American Council of Life Insurers (ACLI) has developed a set of Principles and Guidelines on Insurance Business Transfers and Corporate Division Legislation which includes the following principles:
> - Policyholders and other impacted stakeholders must have access to the process.
> - The regulatory review process must be robust.
> - Independent experts must be utilized as part of the process.
> - Court approval is required for insurance business transfer transactions, but not necessarily for corporate division transactions.
> - Policyholders and the state-based guaranty association system should be protected.

- On Page 20, after the first sentence that ends with “without a history with the insurer”, we suggest adding the following sentence: “Some stakeholders, however, believe that the expert should not be an employee of the department that is reviewing the proposed IBT or CD transaction and should be independent of the insurer or sponsor who is proposing the transaction.”

Thanks again for this opportunity to provide comments. If you have any questions, feel free to contact me at waynemehlman@acli.com or 202-624-2135.

Sincerely,

Wayne A. Mehlman
Senior Counsel, Insurance Regulation
Dan Daveline  
Director, Financial Regulatory Services  
Casey McGraw  
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1100 Walnut Street  
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December 1, 2021

Re: NAIC Restructuring Mechanisms Working Group White Paper

Thank you for the opportunity to comment on the NAIC's Draft Restructuring Mechanisms White Paper. Swiss Re appreciates the ongoing effort the NAIC is making to identify and address the critical issues in the restructuring mechanisms arena. Our hope is that the White Paper serves as a basis for continuing discussions about these issues and that the NAIC devote time and effort to answering the questions identified and developing any guidance necessary to meet state insurance regulators' financial solvency and consumer protection objectives.

Overall, the White Paper accurately identifies areas in need of additional scrutiny and attention. In addition to the issues delineated, an assessment of the use of protected cells in connection with an insurance business transfer was previously deferred but is still among the issues to be reviewed by the Working Group.

As the NAIC has done with other issues, the creation of specific, technical ad hoc groups representing all stakeholders' interests could be a useful approach that would bring the necessary resources to aid in completing the NAIC's work. Ultimately, a more fulsome discussion of the issues and concerns, pro and con, will benefit regulators, policyholders, and insurers.

Swiss Re supports additional work being done in the areas identified in the White Paper – financial standards, guaranty funds, statutory minimum requirements, and licensure.

Financial Standards

The NAIC Restructuring Mechanisms Subgroup is already tasked with developing best practices to be used in considering the approval of proposed restructuring transactions. Providing clarity
on what decision-making criteria should be applied to insurance business transfers and corporate divisions will establish a known baseline on which all stakeholders can rely in evaluating the merits of any proposed transaction. In addition to the areas of reserves, capital, and liquidity already identified, the Subgroup may want to consider whether different standards should be applied to intragroup versus third-party transfers, including the role, if any, of third-party guarantees or reinsurance.

**Guaranty Funds**

In addition to perfecting guaranty fund statutory language to address the possibility of bulk orphan policyholders and clarify that no coverage will be eliminated, or new coverage created, as the result of a restructuring transaction, the NAIC should discuss whether guaranty fund considerations should also be evaluated in the costing/value of a transaction.

**Statutory Minimum Requirements**

When discussing and developing statutory minimum requirements, the NAIC should consider whether review procedures should differ by line or type of business — consumer P&C, life and health, specialty lines, reinsurance, commercial lines, surplus lines, etc. However, even if such differing requirements are warranted by line or type of business, the NAIC should consider whether statutory minimums should be applied to both insurance business transfers and corporate divisions with some degree of parity. Arguably regulators do not want to create a situation that encourages regulatory arbitrage between the two mechanisms, where a transaction is accomplished under one statute when it would not meet the statutory minimum standards under the other.

**Licensure**

Licensing of insurers seeking to engage in restructuring transactions should be considered in parallel with other issues. In addition to reviewing the appropriate application of licensing rules, the Working Group should consider licensure in the other workstreams involving financial standards, guaranty funds, and statutory minimums.

Swiss Re looks forward to the continuing dialogue on restructuring mechanisms. If you have any questions, please contact me.

Yours sincerely,

Matthew Wulf
Head State Regulatory Affairs Americas
Swiss Re
BY E-MAIL

December 1, 2021

Elizabeth Kelleher Dwyer
Glen Mulready
Co-Chairs, NAIC Restructuring Mechanisms (E) Working Group

Attention: Dan Daveline (ddaveline@naic.org)
Casey McGraw (cmcgraw@naic.org)


Dear Superintendent Dwyer and Commissioner Mulready:

The undersigned companies support the important work being done by the Restructuring Mechanisms (E) Working Group and are grateful for the opportunity to deliver these comments on the draft White Paper. The United States insurance marketplace is highly competitive and we strongly believe that policyholders choose their insurers for very specific reasons, including the insurer’s financial strength and market reputation. A process that substitutes a new insurer for the client’s chosen insurer, without consent, is a significant event that needs to be approached with great respect and with the best interest of the policyholder in mind.

Need for Urgency on the Development of National Accreditation Standards.

As the White Paper highlights, several states have enacted insurance business transfer (“IBT”) and corporate division (“CD”) statutes. Indeed, some states have already approved transactions. As we have emphasized in our prior comment letters (attached for reference), IBT and CD statutes raise significant consumer protection and insurance regulatory framework issues that should be addressed in a nationally uniform manner before any additional transactions are approved, especially for long-duration business such as life, annuity, and long-term care insurance. As we have seen with Senior Health Insurance Company of Pennsylvania (“SHIP”, which was formed in 2008 as a result of what many consider to be one of the first US insurance restructuring transactions), even the best intentioned proposals that receive expert regulatory review have the potential to go awry. The fact is that isolating capital-intensive long-duration business that must endure many different economic cycles is inherently risky. Although best practices and accreditation standards cannot guarantee that every approved restructuring transaction will result in long-term success, the existence of those tools will help ensure consistency across all states, instill confidence in the process, and best ensure that only those proposals that have the highest likelihood of long-term success will be approved. Further, these tools will allow the state-based system to defend its processes if an insurer involved in a restructuring transaction ultimately becomes insolvent.

The Restructuring Mechanism Subgroup has been charged with developing best practices for approving restructuring transactions, including, among other things, the expected level of reserves and capital and the adequacy of long-term liquidity – topics not addressed in the White
Paper. Although COVID understandably delayed many work streams, we note that the initial deadline for this work was Summer 2021. We respectfully request that the White Paper make clear that the work of the Subgroup will be completed by the Summer 2022 NAIC national meeting so that these best practices can be implemented. Our prior comment letters include several specific recommendations for the Subgroup to consider.

It is also important to note that proponents of restructuring laws point to Part VII of the UK Financial Services and Markets Act of 2000 (“Part VII”), and its success to date, to support state adoption of IBT and CD laws, yet safeguards in US laws enacted to date often fall significantly short of UK Part VII. If IBT and CD laws are to be affected in the US, we agree that Part VII, in its entirety with all safeguards, should be used as a regulatory baseline for US laws. Accordingly, we further believe that the White Paper should recommend the development of accreditation requirements that substantially incorporate, at a minimum, the UK Part VII’s robust regulatory and court review process. Accreditation standards would provide uniformity, consistency, and less uncertainty for the industry and consumers, and would preclude forum shopping by insurers seeking approval for an IBT or CD transaction.

*Focus on Potential Adverse Consequences to Policyholders of Long Duration Products and Development of Accreditation Requirements.*

Although the White Paper discusses the advantages of restructuring to both companies and consumers, we believe that it should more fully discuss the potential adverse consequences to policyholders of longer duration personal lines insurance products and policyholders of companies that fund the guaranty association system. In a worst-case scenario, the acquiring or resulting insurer that accepts the existing liabilities would become insolvent while the original insurer remains strong. In that situation, there are several negative consequences that can be anticipated, and the White Paper should propose specific solutions for those consequences.

First and foremost, any insurer failure will be a new strain on the guaranty association system that consumes resources to both manage and fund the liabilities. The burden to provide these resources will fall on member companies of the guaranty associations and their policyholders. Accordingly, the possibility of those burdens should be acknowledged in the White Paper.

Further, many policyholders of a failed company will not receive the full benefits of their policies because coverage under guaranty association laws is limited. And, if the policyholders are not covered by the same guaranty association as they were prior to the restructuring transaction (and instead receive coverage via the insurer’s domestic guaranty association), the domestic guaranty association may not have the necessary assessment capacity to pay claims on a timely basis, nor offer the same level of guaranty association coverage as the previous guaranty association, further harming policyholders. Given these concerns, and the importance of a strong guaranty association safety net, the White Paper should take into account these strains and recommend an accreditation requirement that policyholders must have coverage under the same guaranty association both before and after the transaction, which will require licensing of the acquiring or resulting insurer in each of the jurisdictions where customers of the existing insurer reside.
If an acquiring or resulting insurer were to fail, it would be very damaging to the reputation of the state regulatory system, especially because of the strong public interest in the many issues involved with these transactions. Consequently, the transparency and public trustworthiness of the restructuring approval process must be as sound and defensible as possible. We believe that the White Paper should require restructuring laws to include certain safeguards as accreditation requirements to help instill public confidence in the process:

- For transactions under Part VII, the approving UK regulator has national jurisdiction. In addition, Part VII requires at least the implicit approval of several other national regulators before a transaction is approved. The US insurance regulatory framework, obviously, does not have a national regulator. Accordingly, to provide the equivalent of this protection in the US, every state regulator that has policyholders impacted by the transaction should be consulted so that all concerns are satisfactorily addressed before a transaction is approved.

- As required by Part VII, the US framework should require the use of an independent expert. Restructuring transactions are significant events, and having the independent expert report will be an important data point if a transaction goes awry many years into the future. We appreciate that some regulators have expressed concern with making this a mandatory requirement. We would like to provide additional context for our position:
  - The requirement to have an independent expert report does not speak to the qualifications of experts at the various insurance departments. We agree that, often, employees at the insurance department will have a better understanding of the insurer and its operations. And many departments have employees with the skillset to analyze the proposed transaction. The independent expert report does not, in any way, hamper or serve as a substitute for the authority and accountability of the insurance commissioner to make a final determination.
  - However, not all insurance departments are staffed at the same level or will necessarily remain at their current staffing in the future. The requirement to have an independent expert report puts all states on the same baseline standard regardless of how department expertise ebbs and flows over the years.
  - Additionally, an independent expert report that buttresses the insurance commissioner’s findings provides additional public confidence in the outcome to consumers, creditors, and other regulators and interested parties, which will be critical if an acquiring or resulting insurer has solvency issues. Creating a process that results in heightened confidence is especially important because policyholders do not have the ability to opt out of an approved transaction.

- All impacted policyholders should receive notice of the proposed transaction, and the information the regulators and independent experts use to evaluate the transaction, along with the final reports, should be made publicly available. Although the insurer requesting the restructuring may want to hold information confidential, the public must
be able to understand the transaction and its potential impact. To inform decisions and allow for the opportunity to provide meaningful public comments, there must be public access to: (1) relevant financial analysis, including an independent expert report, (2) a business plan for the dividing/transferring and resulting/transferee insurers, and (3) information on the background and qualifications of controlling persons and management. This public transparency, which allows interested parties from varied backgrounds to review and comment, will be extremely valuable to reduce the risk of failure and to reduce the likelihood of process concerns if an acquiring or resulting company fails to perform as expected. If the requesting insurer does not want to make this information public, then it should not avail itself of the IBT or CD process.

- Given the extraordinary nature of these transactions, and the potentially significant impact on the established contractual rights of policyholders, court approval should be required. Approval should take place in two steps: (1) discretionary approval by the domiciliary insurance commissioner based on the information submitted regarding the proposed transaction, and (2) a court process leading to a formal judgment and a court order once statutory conditions are satisfied, giving all interested parties the benefit of an established legal process and the right to object. Court approval will further legitimize the approval of the transaction if an acquiring or resulting insurer becomes insolvent. Further, court approval may decrease the likelihood that these transactions face Constitutional scrutiny.

*Long-Term Care Insurance Should Be Ineligible for Division or Transfer*

We appreciate that the White Paper devotes a section specifically to long-term care insurance. However, we would recommend that the White Paper specifically state that long-term care insurance should not be eligible for division or transfer. As we have highlighted in our prior comments, the history of reserve deficiencies, rate increases and, in some cases, insolvencies, associated with this product demonstrates the challenges of arriving at satisfactory valuations. Given this history and the long duration of the liabilities, it is clear to us that long-term care blocks should not be separated from other businesses that provide financial stability and diversification for the entity overall.

In addition, the riskiness of the investment strategy/assets backing these liabilities for transferred or divided businesses, particularly if used for long-term care insurance, is of significant concern. Many life/annuity/LTC insolvencies in the past were driven by liability issues, which tend to occur slowly over time. If business transfers or divisions lead to overly aggressive investment strategies, more future insolvencies could be driven by the assets – which could happen more quickly and as a result be much more impactful.

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We appreciate the opportunity to comment. In the end, our comments attempt to drive towards one goal – ensuring that no policyholder should ever be left worse off after a restructuring transaction is completed. We would support a statement in the White Paper that, if there is any
doubt about the ability of a transaction to live up to this standard over the long-term duration of the policies, the presumption should be to protect policyholders and not approve the transaction.

Douglas A. Wheeler  
Senior Vice President, Office of Governmental Affairs  
New York Life Insurance Company

Kevin L. Howard  
Vice President, Deputy General Counsel & Head of Government Affairs  
Western & Southern Financial Group

Andrew T. Vedder  
Vice President – Enterprise Risk Management  
The Northwestern Mutual Life Insurance Company

Dominick M. Ianno  
Head of State Government Relations  
Massachusetts Mutual Life Insurance Company
BY E-MAIL

August 14, 2019

Elizabeth Kelleher Dwyer
Buddy Combs
Co-Chairs, NAIC Restructuring Mechanisms (E) Working Group

Attention: Dan Daveline (ddaveline@naic.org)
Casey McGraw (cmcgraw@naic.org)

Re: The Restructuring Mechanism Working Group’s Charges

Dear Superintendent Dwyer and Deputy Commissioner Combs:

The undersigned companies support the important work being done by the Restructuring Mechanisms (E) Working Group and are grateful for the opportunity to deliver these comments.

**Division and Transfer Laws Have Serious Implications that Demand Procedural Protections**

As life insurers, the financial security that we provide to our policyholders is often delivered gradually, over decades. Consumers have this long-term promise in mind when they enter into life insurance, annuity, and long-term care insurance contracts, and expect that the company that sold them a policy will stand behind it over the years to come. Life insurers, knowing that their obligations will last decades, manage their assets and liabilities conservatively to ensure they will maintain the financial strength needed to fulfil their promises. And the guard rails of our state insurance regulatory framework and backstop provided by our guaranty association system have developed over the years to be efficient and effective counterparts to a system where life insurers remain obligated for their promises.

Insurance business transfer and insurer corporate division statutes have the potential to turn this paradigm on its head. If consumers no longer can expect that the company that sells them their policy will stand behind it, will they trust life insurers to meet their financial security needs? If life insurers anticipate that they have an out for unsuccessful business, will they have less incentive to exercise their traditional conservatism in writing and managing long-term business? And, what strains and gaps might appear in our insurance regulatory system and guaranty backstop if life insurer liabilities become “fungible”?

Put another way, life insurers have options to transfer their policyholder contracts without transfer and division statutes. Those options protect policyholders by requiring a life insurer that wants to be relieved of its promises to give the policyholder the opportunity to say “no”.

Removing this protection not only disadvantages affected policyholders, it raises the broader threats to our life insurance marketplace and regulatory system described above.

For these reasons, we urge extreme caution when considering laws that permit insurers to divide or transfer life, annuity, or long-term care contracts without policyholder consent. A prior letter
from New York Life and Northwestern Mutual to the Restructuring Mechanisms (E) Subgroup recommended principles for the regulatory review of proposed divisions or transfers. That letter (attached here for the Working Group’s reference) focused on financial standards, consistent with the charges of the Subgroup. Given the Working Group’s process-oriented charges, this letter elaborates on procedural safeguards we believe should be included in any such laws. We believe these procedural protections serve the principle that policyholders should never be left worse off by a division or transfer.

Our procedural recommendations follow four themes: (1) protecting policyholders in other states; (2) notice and transparency; (3) two-step approval process; and (4) ensuring uniform application of procedural protections. Robust financial standards can only succeed if they are accompanied by equally robust procedural safeguards. Procedural protections to reduce the potential for harm are particularly important because division and transfer laws do not include an effective proxy for policyholder consent, such as an “opt-out” right or a requirement for a supermajority vote by policyholders.

**Protecting Policyholders in Other States**

Although the dividing or transferring insurer may be licensed in multiple states, transfer and division laws have been silent regarding the process for bringing a division or transfer into force in states outside of the approving state. This omission creates significant uncertainty and magnifies the risk of adverse guaranty association impacts.

Any such law should require notice to the primary insurance regulator in each state with residents holding insurance contracts of a dividing or transferring insurer. Consultation with each foreign commissioner should be required, and each affected commissioner should have a right to object to the transaction, with a robust process to address objections. Policyholders should be able to participate and communicate regarding the transaction through their local insurance commissioner.

Lastly, the law should require that the resulting or transferee insurer be licensed in each state in which policyholders reside. This requirement is necessary to ensure that guaranty association coverage is provided directly in all states in which insureds reside rather than as orphan coverage provided by the domestic state guaranty association. The future of the state guaranty associations could be in jeopardy without this change.

**Notice and Transparency**

Policyholders and others affected by a proposed division or transfer must receive adequate information and the opportunity to make their voices heard. Some division and transfer laws provide even less public access to information than required in connection with a Form A filing. Public hearings should be required prior to commissioner or court action. Any division or transfer law should require delivery of a notice in sufficient detail to inform decision-making, well before any hearing or action, directly to all policyholders, agents, brokers, reinsurers, creditors, regulators and state guaranty associations of the dividing/transferring and resulting/assuming insurers.
Likewise, confidentiality provisions must balance the insurer’s desire to safeguard competitively sensitive information with the public’s interest in understanding the transaction and its potential impact. To inform decisions and allow for the opportunity to provide meaningful public comments, there must be public access to (1) relevant financial analysis, including an independent expert report, (2) a business plan for the dividing/transferring and resulting/transferee insurers, and (3) information on the background and qualifications of controlling persons and management.

Two-Step Approval Process

Unlike Part VII transfers in the United Kingdom and insurance business transfer legislation that has been enacted in the United States (e.g., in Oklahoma), insurer corporate division statutes enacted to date have not required court approval. Given the extraordinary nature of these transactions, and the potentially significant impact on the established contractual rights of policyholders, court approval should be required.

Approval should take place in two steps: (1) discretionary approval by the domiciliary insurance commissioner based on the insurer’s application and the public hearing, and (2) a court process leading to judgment and a court order once statutory conditions are satisfied, giving all interested parties the benefit of an established legal process and the right to object.

Ensuring Uniform Application of Procedural Protections

We have two recommendations to ensure that these important procedural protections are applied uniformly to protect policyholders. First, we suggest they should be set forth directly in statute, rather than being left to implementing regulations or to a set of best practices or guidance. Second, as with the standards for review addressed in the attached letter to the Subgroup, we believe it is essential for the NAIC to establish strong, minimum procedural requirements as accreditation standards. The strength of the procedural safeguards applied to division and transfer transactions will contribute importantly to the solvency implications of those transactions and would eliminate the threat of forum-shopping. And maintaining uniform state laws that protect solvency is the essential purpose of the NAIC’s accreditation system.

*   *   *

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We appreciate the opportunity to comment on this important topic. Please let us know if you need any additional information or would like to discuss our comments.

Sincerely,

Eric DuPont  
Vice President & Counsel, Government Affairs  
The Guardian Life Insurance Company of America

Dominick M. Ianno  
Head of State Government Relations  
Massachusetts Mutual Life Insurance Company

Douglas A. Wheeler  
Senior Vice President, Office of Governmental Affairs  
New York Life Insurance Company

Andrew T. Vedder  
Vice President – Solvency Policy & Risk Management  
The Northwestern Mutual Life Insurance Company
BY E-MAIL

April 26, 2019

Doug Stolte
David Smith
Co-Chairs, NAIC Restructuring Mechanisms (E) Subgroup

Attention: Dan Daveline (ddaveline@naic.org)
Robin Marcotte (rmarcotte@naic.org)

Re: The Restructuring Mechanism Subgroup’s Charges

Dear Messrs. Stolte and Smith,

The undersigned companies are grateful for the opportunity to comment on the charges of the Restructuring Mechanisms (E) Subgroup.

In general, we strongly support the subgroup’s charges. While we endorse all the charges, we ask that the subgroup give special emphasis to the development of uniform minimum standards for restructuring mechanisms.

*The Importance of Strong, Uniform Standards for Divisions and Business Transfers*

Several states have recently enacted new “division” and “insurance business transfer” laws that allow insurers to transfer and novate business without policyholder consent. While these laws offer new flexibility to companies and regulators, they also introduce new dangers for policyholders and the state-based system of insurance regulation. Because we believe there are existing alternatives that provide sufficient flexibility in nearly all circumstances and because we want to maintain policyholder protections, our strong preference is against the enactment or use of division and insurance business transfer statutes for life, annuity or health insurance. However, recognizing that regulators may wish to find a way to permit, in limited circumstances, transactions that are beneficial to all policyholders, our comments in this letter address the minimum standards required if life, annuity or health divisions or transfers are to be considered.

Unlike traditional indemnity reinsurance, where the original insurer remains liable, these new structures allow the original insurer to extinguish liability to policyholders. We have grave concerns about several aspects of these new laws:

- There is no nationally uniform financial standard or actuarial level of confidence for regulators to apply when reviewing the financial strength of a business included in a division or transfer. A strong, nationally uniform standard is necessary to ensure that policyholders are protected against the risk of insolvency. This standard should become an NAIC accreditation requirement. The development of this standard should be a critical area of focus for the subgroup.
In some states, division and insurance business transfer laws are open to any line of business, even when it is difficult or impossible to arrive at a credible long-term valuation of the business involved. For example, a division could allocate distressed, hard-to-value long-term care liabilities to a newly created splinter company. In this scenario, healthier business and associated assets might remain with the original company, endangering policyholders relegated to the splinter company.

Some laws also allow the creation of monoline insurers, potentially depriving policyholders of the benefits of diversification without their consent.

Some laws also allow the division of a multi-state insurer into a splinter company licensed in a single state, potentially overwhelming the state’s domestic guaranty association in the event of insolvency.

Some laws sanction the use of non-admitted assets to support policy liabilities.

Several laws lack other important procedural and substantive safeguards like public notice, requirements to consult with other interested states, independent expert review, a hearing or court process, and requirements to assess corporate governance and owner qualifications.

At their worst, these new laws could enable transactions that enrich shareholders at the expense of policyholders, guaranty associations and the reputations of both the industry and state-based system of insurance regulation. Effective, nationally uniform oversight of solvency has long been a hallmark of state-based insurance regulation. It is essential that the NAIC act to preserve this strength of the state-based system. These new transaction structures must not be allowed to undermine fundamental solvency regulation and policyholder protections. We expect that the subgroup’s work will be a critical part of this effort.

In the discussion below, we suggest several principles that should govern regulatory review of proposed division and business transfer transactions.

**Policyholders Should Never Be Left Worse Off**

Regulators should never approve a division or insurance business transfer if it would leave any class of policyholders worse off. Instead, policyholders should be left in the same or a better position after completion of the transaction. Before the regulator signs off, a valuation should be undertaken by an expert to establish at a high level of confidence that policyholders will experience no adverse effects. The expert should be independent of any influence from the companies involved.

This approach would align the U.S. regulatory framework with well-established international precedents like the United Kingdom’s “Part VII” business transfer regime. A focus on policyholder protection has been fundamental to the success of the U.K. regime. In a Part VII transaction, the regulator must provide a detailed report to the court and certify the solvency of the resulting entity. An independent expert must also provide a detailed report. When there are
questions about the strength of the business involved, the U.K. regulators and the court will 
normally insist on ensuring that the business is transferred to a stronger insurer, not isolated in a 
weaker insurer.

Some state laws provide that a regulator should approve a division or business transfer if there is 
no “material adverse effect” on policyholders. This standard falls far short of what should be 
required. The standard endorses policyholder harm so long as the harm does not rise to a 
vaguely defined materiality threshold. For example, a transaction might accomplish nothing 
more than benefit shareholders at the expense of policyholders. Although the damage to 
policyholders may not rise to the level of a “material adverse effect,” the law should not call on 
the regulator to approve unless the effect on policyholders is neutral or there is some expected 
policyholder benefit.

No Monolines

Regulators should never permit a transaction that transforms a diversified insurance company 
into one or more monoline insurers, especially when the transaction involves long-duration life, 
annuity or health insurance business. It makes little sense to deprive policyholders the benefits 
of diversification. The wisdom of this principle is borne out by the recent experience of carriers 
like Penn Treaty that concentrated their offerings in long-term care insurance.

Hard-to-Value Business Like LTC Should Be Ineligible for Division or Transfer

It is important that standards for approval acknowledge fundamental differences among lines of 
business. A standard that may be appropriate for short-duration commercial property and 
casualty risks is likely to need significant adjustments before it can be applied successfully to 
long-duration retail life, annuity and health businesses.

As a threshold matter, some lines of business are best excluded from division and business 
transfer transactions. Long-term care offers the best example. The history of reserve 
deficiencies, rate increases and, in some cases, insolvencies, associated with this product 
demonstrates the challenges of arriving at satisfactory valuations. Given this history and the 
long duration of the liabilities, it is clear to us that long-term care blocks should not be separated 
from other businesses that provide financial stability and diversification for the entity overall.

The experience of long-term care leads us to suggest the following possible approach to similar 
long-duration life and health businesses: for each such business, the regulator should be able to 
confirm the sufficiency of assets supporting the liabilities based on a reasonable valuation 
relative to an industry standard of experience. To make this determination, the Commissioner 
should first compare the valuation of liabilities to what the valuation would be using 
standardized valuation tables adopted by the NAIC for each line of business. If such 
standardized valuation tables are not available, the business should not be eligible for division or 
transfer.
Require Strong Financial Standards and Stress Testing for Long-Duration Business

Even if a long-duration life or health business is eligible for inclusion in a transaction, regulators will still need a robust framework to evaluate the long-term solvency of the business. Regulators should consider the following principles in the development of this framework:

- For long-duration life, annuity and health business, regulators should start with a focus on policy reserves, and should require stress testing of reserves at a “severely adverse” level. If reserves are not subjected to a high level of stress testing, a division or transfer may appear to leave a business adequately capitalized at the time of the transaction. However, the picture can change over time as long-term experience diverges from assumptions. Again, consider the recent experience of long-term care.

- Starting from a basis of reserves meeting a “severely adverse” standard, formulaic application of risk-based capital will, appropriately, result in a higher level of required capital for the business affected by the division or transfer. However, while risk-based capital may provide a useful starting point to establish capital requirements, it is not designed to measure relative financial strength and therefore would be insufficient on its own to determine the minimum required financial position of a transferred business.

- Instead, in addition to risk-based capital, regulators should explore capital standards for long-duration life and health business that are based on a defined ratio of asset adequacy standards. Capital standards based on this type of cash flow projection technique can help ensure that enough capital is held in a transferred business, supplementing the existing risk-based capital framework.

- Regulators should establish a confidence level based on the greatest present value of accumulated deficiencies over a long-term horizon across stochastic scenarios. The confidence level should be set at a standard that assures solvency over the life of the business so as to provide a robust backstop to the combination of reserves established to meet a “severely adverse” standard and risk-based capital.

- Prescribed assumptions should be included in capital calculations to avoid the manipulation of capital thresholds.

- Actuarial reserve and capital calculations should be performed by an expert that is independent of the insurance companies involved.

Use Uniform NAIC Valuation and Accounting Standards

When evaluating the solvency impact of a proposed transaction, regulators should not give credit for non-admitted assets. Decisions about these transactions should start from the NAIC’s uniform statutory valuation and accounting rules.

The possibility that non-admitted assets might be used to back reserves and capital in these transactions is deeply troubling for the following reasons:
• Most non-admitted assets are classified that way because they are not readily available to satisfy policyholder claims.

• Put another way, many non-admitted assets are not readily marketable or do not produce future cash flows.

• Non-admitted assets can include anything a company owns, from illiquid and contingent letters of credit to office furniture, equipment, hardware and software.

• It makes sense to exclude these items from the pool of assets an insurance company can count toward the payment of future claims, as they are illiquid, unlikely to retain their value, and generally do not produce additional income.

• The distinction between admitted and non-admitted assets should not change in the context of a division or business transaction. In fact, given the risk that companies will use restructuring mechanisms to wall off distressed businesses, it is especially important that regulators scrutinize the quality of the assets involved.

Minimum Requirements Should Become NAIC Accreditation Standards

Ultimately, it will be essential that the NAIC establish strong minimum requirements for these transactions as accreditation standards. The strength of state-based system depends upon the integrity of solvency regulation across the country. Regulators will need to rely on their counterparts in other states to ensure that transferred businesses are uniformly supported by sufficient reserves and capital, and are run off in a solvent manner. Companies should not be allowed to arbitrage their way to diminished solvency oversight by choosing one domicile over another.

Other Procedural Safeguards Are Also Important

In this letter, we have focused primarily on the financial standards that should apply to divisions and insurance business transfers. We expect those standards will be a significant focus of the subgroup. However, there are other procedural safeguards that are equally important for these transactions. For example, since policyholders lose their normal right to consent, court oversight and approval should be required. Policyholders and other affected parties should always be given notice, access to all information needed to meaningfully review a proposed transaction, and an opportunity to be heard in court. Also, the process should require approval or non-objection of all affected states and the resulting entities should be licensed in all states needed so as not to impair policyholders’ access to their state guaranty associations. We believe these protections should also be considered for accreditation requirements. We look forward to providing our views on this and other procedural safeguards to the Restructuring Mechanisms (E) Working Group.

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We appreciate the opportunity to comment on this important topic. Please let us know if you need any additional information or would like to discuss.

Sincerely,

Douglas A. Wheeler  
Senior Vice President, Office of Governmental Affairs  
New York Life Insurance Company

Andrew T. Vedder  
Vice President – Solvency Policy & Risk Management  
The Northwestern Mutual Life Insurance Company
December 1, 2021

Elizabeth Dwyer
Superintendent of Insurance
Rhode Island Department of Insurance
1511 Pontiac Avenue
Cranston, RI 02920

Glen Mulready
Insurance Commissioner
Oklahoma Insurance Department
400 NE 50th Street
Oklahoma City, OK 73105

Dear Superintendent Dwyer and Commissioner Mulready:

We are privileged to serve as counsel to ProTucket Insurance Company (“ProTucket”), a Rhode Island insurer formed to assist in the assumption and restructuring of legacy books of insurance, whether by traditional loss portfolio transactions or by future mechanisms that may result from the study undertaken by the NAIC Restructuring Mechanism Working Group (“RM Working Group”).

We appreciate the opportunity, on behalf of our client, to comment upon the draft White Paper dated October 22, 2021 exposed for comment by the RM Working Group on the subject of Insurance Business Transfers (“IBTs”) and insurer Corporate Divisions (“CDs”) (together, restructuring mechanisms ["RMs"]). We understand that in a related development the Property and Casualty Risk Based Capital Working Group (“RBC Working Group”) issued draft comments dated October 25, 2021 (attached) on Risk Based Capital (“RBC”) (the “RBC Memo”) as applied to run-off insurers.

We respectfully submit comments on the White Paper and the RBC Memo in the form of suggestions, set forth below, that the RM Working Group adopt charges for 2022 to elaborate upon and add to those found in the 2022 Proposed Charges with the objective of formulating a comprehensive evaluation of the issues, risks, benefits, timing and prospects involved in adopting RMs in the U.S. insurance market.

Specifically, we suggest that the RM Working Group:
1) Study and report upon the financial standards to apply to RMs:

   a) Intra-Group vs. Third Party Transactions.

   Recent RM transactions have occurred mainly between affiliated insurers. Regulators and the market are generally more comfortable with transactions where the ultimate controlling party after the transaction remains the same. (In two transactions noted in the White Paper, the post-transfer liabilities in the Enstar IBT and the AllState CD remained within the same group.) These transactions may be enhanced by intra-group guarantees or reinsurance.

   Third party transactions that do not have the benefit of intra-group affiliations may nonetheless achieve similar results with strong third party guarantees or reinsurance.

   We suggest that the RM Working Group consider the differences between intra-group and third party RM transactions and specifically address the standards that should apply to such transactions.


   Domestic state regulators regularly review insurer transactions that affect policyholders in other states, including acquisitions (Form A), dividend distributions, reinsurance protection, affiliate transactions, investment restrictions, mergers and other issues of corporate finance and governance. Many of these domestic state regulatory procedures are governed or influenced by NAIC standards and some involve some coordination among the states. RM transactions could pose similar questions involving how domestic state actions might affect policyholders in other states.

   We suggest that the RM Working Group specifically analyze these and similar financial and regulatory standards and procedures present in law and NAIC standards to compare how domestic regulators affect policyholders in sister states and to review proposals that might achieve similar results in RM transactions.

2) Possible Use of Supplemental Financial Tools.

   In light of the novelty of RMs in the U.S. insurance market, it may be advisable to consider different or modified analytical tools to evaluate RM transactions, such as using longer term projections, imposing capital surcharges onto the assuming insurer or its parent, and conducting enhanced periodic oversight.

   We suggest that the RM Working Group address this subject with specificity to formulate a variety of possible novel tools or methodologies to evaluate RMs.
Elizabeth Dwyer
Glen Mulready
December 1, 2021
Page 3

3) Make a referral to the Capital Adequacy Task Force requesting specific guidance as to:

a) Definition and Licensing of Run-off Insurers.

The RBC Memo offered a suggestion to define “runoff” insurers so as to preclude insurers that may assume more than one book of discontinued business or that have any amount of continuing business. Such a definition would preclude those insurers that may assume more than one book and those that may have a de minimis amount of in-force business. Without prejudgment of the issue, it would appear that a more fulsome review of the options and consequences of such a definition would be important to the development and ultimate operation of a possible RM market. The market options available to those who wish to transfer books of business, the costs associated with such transactions and the profitability and financial viability of those who may wish to assume such business could all depend on such a definition. Of additional concern is that some states decline to license and may, in some cases, threaten the licensed status of runoff insurers. Creating difficulties for the licensing of runoff insurers can call into question protections for policyholders and oversight by regulators over such insurers.

We suggest that the RM Working Group re-refer this specific issue to the Capital Adequacy Task Force requesting reconsideration of the definition of a runoff insurer to allow for greater flexibility and practicality, including allowing such insurers to assume more than one book of business and to maintain a de minimis amount of in-force business. Insofar as some states may currently decline to license insurers in runoff, we suggest that the RM Working Group also refer the issue of the licensing of such insurers to appropriate NAIC committees with the purpose of liberalizing the standards for licensing.

b) Possible Reformulation of RBC.

We understand that the RM Subgroup has not yet completed its review of financial best practices for RMs, and consequently the White Paper does not yet address these issues. Nevertheless, we note that some consideration has already been given to some minor changes to the RBC formula (see the above-mentioned RBC Memo). However, we would posit that the RBC formula was not developed to consider the unique characteristics of insurers in run-off. A couple of examples illustrate this point: RBC factors when applied to RMs may result in distortions that fail to capture the true risk of the transaction to the assuming insurer, and also, insurers assuming business under a RM will not have all of the risks subject to the covariance formula. Consequently, the resulting capital requirements under the RBC formula may be overstated.

We suggest that the RM Working Group make a referral to the Capital Adequacy Task Force requesting that the RBC formula be reviewed to evaluate whether it fairly reflects the risk profile of runoff insurers, specifically in the context of possible RM transactions.
c) Possible Suspension of RBC for RMs.

We understand that considerable timing and policy issues may postpone revisions to the RBC factors.

Under the circumstances, the RM Working Group should request that the RM Subgroup consider whether it would be appropriate to suspend application of the RBC formula (or a portion thereof) in the determination of the capital adequacy of runoff insurers. The RBC laws in most, if not all states, allow the chief insurance regulator latitude in applying the RBC requirements. Consequently, guidance with regards to suspension or easing of those statutory RBC requirements would not necessarily violate financial best practices.¹

4) Make a referral as to financial aspects of U.K. Part VII:

More than 300 Part VII RM transfers have been effected with success in the U.K. over the last 20 years. Solvency II financial standards have been applied to these transactions without controversy. A deeper understanding of the differences between those standards and applicable U.S. financial standards could help U.S. regulators to evaluate the prudential issues in U.S. RMs.

We suggest that the RM Working Group make a referral to appropriate NAIC committees to report to the RM Working Group on the salient differences between Solvency II and U.S. insurer solvency standards as applicable to run-off insurers and RMs.

5) Make a referral as to regulatory standards for RMs:

Currently, approximately four states have adopted IBT statues and a small number have adopted CD statutes. Although a few transactions have been effected under each of these types of RM statutes, most states have yet to adopt such legislation and still remain unfamiliar with the concept, process and implications of these transactions. Uniform standards for RMs would enhance regulatory and market understanding of RMs, and would assure sister states that requisite standards are being followed.

Guidance in the NAIC Financial Analysis Handbook, even short of a Model Law at the moment, may be sufficient to adopt these nationwide standards. Adopting such guidance in an existing NAIC Handbook, such as the Financial Analysis Handbook, may have the result of making such guidance an accreditation standard. Such guidance should include specifics, such as whether a court must participate in the proceeding (as is the case with IBTs, but not CDs), the use of independent experts, and the required degree of input or form of input from guaranty associations.

¹ Although the suspension of RBC requirements was mentioned in a slightly different context, it is interesting to note that a similar suggestion was made in the 1997 Liability Based Restructuring White Paper.
other regulators and affected parties.

We suggest that the RM Working Group make a referral to appropriate NAIC committees to adopt such standards and to do so, if possible, by way of a modification to the Financial Analysis Handbook, if not a Model Law.

6) Study and report upon distinctions by lines of insurance:

Regulators and market participants have commented extensively on the distinctions among lines of insurance that may become subject to RMs. Despite the fact that some RM statutes are not limited by line of insurance or nature of coverage, most regulators agree that RMs may not be appropriate for every line or type of insurance. Among the many relevant distinctions are property/casualty versus life or other long-term products, long-term care, personal lines versus commercial lines, admitted versus surplus lines or reinsurance, workers compensation and numerous others, in addition to the length of run-off or whether run-off liabilities need to be an essential element of the RM transaction. Different analysis may be necessary for these variations.

A study of these variations would be important to focus regulatory attention on those RMs that would be most useful, easiest to regulate and deserving most study. We note that the draft White Paper concludes that long-term care is not likely to be a line of business that is appropriate for RMs.

We suggest that the RM Working Group specifically address the distinctions among the lines and type of insurance to help establish priorities and focus the group’s future work.

7) Make a referral as to guaranty association coverage for RM transactions:

There appears to be substantial consensus among regulators and market participants that whatever the form of RM and whoever the participants, there is no justification for policyholders to be deprived of guaranty fund protection or to gain a guaranty fund windfall as a result of a RM transaction. We have not performed a 50 state survey on the subject and cannot state whether all states have statutes that would assure a neutral result.

We suggest that the RM Working Group make a referral to appropriate NAIC committees to review and propose for adoption appropriate NAIC model laws to clarify that no guaranty fund coverage would be lost or changed and that new coverage would not be created as result of a proposed transaction.

8) Make a referral as to application of Assumption Reinsurance laws to RMs:

We are aware that a number of states have raised the question of whether the NAIC Model Assumption Reinsurance Law or derivative provisions under state law would have the effect of prohibiting IBTs (and perhaps CDs) from becoming effective
for certain policyholders in their states without complying with provisions of those laws.2 While RM transactions by their terms would obviate the basis upon which such laws could prohibit these transactions3, the assertion of this prohibition can pose an obstacle for those who wish a “clean” transfer without objection. While the NAIC cannot enforce its interpretation of state laws upon the states, we would urge the appropriate committee at the NAIC or NAIC staff to clarify this issue as best it can, especially in respect of the NAIC Model Assumption Reinsurance Law. Clarifying its position on the Model law would help to eliminate confusion and discordant positions among the states on the laws that derive from the Model.

Although we believe that the Model does not effectively prohibit RMs as described above, if the appropriate NAIC committee or NAIC staff were to disagree, we would then urge the RM Working Group to refer the matter for amendment of the Model. We believe that a different result would be be contrary to the very objectives of the RM Working Group.

We suggest that the RM Working Group make a referral to appropriate NAIC committees and/or the relevant NAIC staff to consider the application of the Model Assumption Reinsurance Law to IBTs and CDs to policyholders, specifically policyholders with insurance issued on an admitted basis. And, in the event that the determination resulting from such a referral were to indicate that the Model Law would be applicable, we suggest that the referral be amended to seek a revision to the Model to indicate that it would not be applicable.

9) Study and report upon legal recognition of RMs among the states:

ProTucket has previously supplied the RM Working Group with a White Paper (dated March 27, 2019, entitled “ProTucket Insurance Company Paper on Insurance Business Transfer Plans Under Rhode Island Law” [the “ProTucket White Paper”]) settling forth the legal basis for recognition of IBTs among the states. While no legal position can foreclose challenges, it would be helpful for the RM Working Group to report upon its working assumptions on the legal framework of RMs. In addition, nationwide standards for RMs, to be established as suggested above, could assist in the process of clarifying the legal validity of RMs.

We suggest that the RM Working Group specifically study and report upon its working assumptions on the legal framework of RMs and whether it will support a nationwide standard to advance its position on these issues.

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2 Provisions of the Model and derivative laws could effectively prohibit IBTs (and possibly CDs) by calling for an approved novation procedure that could require insurers to obtain approval to notify and obtain consent from policyholders, specifically those with admitted policies, in order to effectuate an assumption of their policies by the assuming insurer.

3 Both the IBT and CD laws are intended to effect a change in corporate structure that, by operation of law, replaces the obligor under the insurance (or reinsurance) contract. Consequently, although frequently spoken of as a statutory novation, the transfer is not a novation requiring consent of the insured (reinsured).
Elizabeth Dwyer  
Glen Mulready  
December 1, 2021  
Page 7

10) Consider adopting interim guidance:

In light of the many issues before the RM Working Group and the limitations of time and resources and the interest and pace of developments in the market, it may be prudent to plan for interim measures pending development of final guidance.

We suggest that the RM Working Group adopt interim guidance on the suggestions raised above pending adoption of final guidance.

11) Review the issue of protected cells in the context of RM:

Pursuant to the 2021 Adopted Charges and 2022 Proposed Charges, the RM Working Group is to identify and address the legal issues associated with restructuring insurers using protected cells. Those issues were addressed in the ProTucket White Paper in 2019, but were not addressed in the White Paper. The ProTucket White Paper also address the financial and accounting issues associated with restructuring insurers using protected cells.

We request that the RM Working Group include a discussion of the relevant issues related to protected cells in the context of RMs, including both legal and financial and accounting issues. Furthermore, if the RM Working Group decides that these protected cell issues should be referred to another committee of the NAIC, we would be pleased to further contribute to this subject.

We thank the RM Working Group for considering these suggestions and are available to answer questions or to supplement this submission at your convenience.

Sincerely,

Robert A. Romano

cc: Dan Daveline, Director, Financial Regulatory Services, NAIC  
Casey McGraw, Legal Counsel, NAIC  
Marvin Mohn, ProTucket Insurance Company  
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MEMORANDUM

TO: David Smith (VA) and Doug Stolte (VA), Co-Chairs of the Restructuring Mechanisms (E) Subgroup
    Judith L. French (OH), Chair of the Capital Adequacy (E) Task Force

FROM: Tom Botsko (OH), Chair of the Property and Casualty Risk-Based Capital (E) Working Group

DATE: Oct. 25, 2021

RE: Response to Request for Input Regarding Runoff Companies

The Property and Casualty Risk-Based Capital (E) Working Group formed a small ad hoc group to discuss this topic and try to determine the best course of action. The Restructuring Mechanisms (E) Subgroup requested that the Working Group take the lead in addressing the charge to “consider the need to make changes to the RBC formula to better assess the minimum surplus requirements for companies in runoff.”

After several discussions about what adjustments should be made to the risk-based capital (RBC) formula, the ad hoc group concluded that the best course of action is to monitor these companies through the state analysis and exam team functions. The characteristics and financial conditions of these runoff companies are very diverse, and it would be difficult to incorporate these varied characteristics into one adjusted formula. Many international countries monitor these companies through the analysis and exam processes and do not have a separate RBC formula.

Of the 2020 RBC filers, we identified 111 companies out of 2,477 that have the characteristics of a runoff company. Most of these companies have an RBC ratio greater than 300%. Five are below 200%.

During a series of discussions, the ad hoc group agreed that a runoff company, voluntary or involuntary, should include the following characteristics: 1) no renewing of policies for at least 12 months; 2) no new direct or new assumed business; and 3) no additional runoff blocks of business. In addition, the amount of renewal premium to reserves has also been identified as a characteristic of these types of companies when this ratio is de minimis.

The ad hoc group also recommends that a general and RBC interrogatory be added for the purpose of identifying a runoff company. The domiciliary state shall have the ability to verify the interrogatory response during the annual company financial analysis process.

As the ad hoc group considered various types and conditions of runoff companies, it became apparent that while many of these companies share the characteristic of very long tail liabilities, there are other characteristics of these companies that are so diverse that it made it difficult to summarize them into their own RBC formula.
The ad hoc group reviewed several international perspectives of runoff companies. The international treatment of runoff companies is handled through the Analysis and Exam Teams. The ad hoc group agrees that a similar treatment of runoff companies is warranted.

The ad hoc group has some recommendations for the Working Group regarding the RBC instructions, specifically to the runoff companies. These include the following:

- Remove the Trend Test from the RBC calculation. These are runoff companies, and the possible retrospective premium should not complicate the already diverse situation.
- Remove the charge for premium growth if the company is no longer writing business.
- Remove $R_{\text{cat}}$ from the formula. Because one of the characteristics of a runoff company is to not have written any new business for at least 12 months, we believe this short-term liability risk is not warranted.

As the ad hoc group shares its findings with the other two RBC working groups, we expect to hear other perspectives regarding the unique conditions of runoff companies from the Life Risk-Based Capital (E) Working Group and the Health Risk-Based Capital (E) Working Group.

Please contact Eva Yeung, NAIC staff support for the Property and Casualty Risk-Based Capital (E) Working Group, at eyeung@naic.org with any questions.

Cc: Robin Marcotte; Dan Daveline; Jane Barr; Eva Yeung
JOINT SUBMISSION OF NOLHGA AND NCIGF TO NAIC'S RESTRUCTURING MECHANISMS WORKING GROUP REGARDING THE RESTRUCTURING MECHANISMS WHITE PAPER DRAFT

December 1, 2021

The National Organization of Life & Health Insurance Guaranty Associations ("NOLHGA") and the National Conference of Insurance Guaranty Funds ("NCIGF") commend the Restructuring Mechanisms Working Group's (the "Working Group") efforts in preparing the draft Restructuring Mechanisms White Paper (the "White Paper"). NOLHGA and NCIGF appreciate the Working Group's recognition of the importance of ensuring that the guaranty association/fund protection a policyholder would have had prior to a restructuring transaction is preserved when the transaction is consummated. We write to offer high-level observations on the White Paper for the Working Group's consideration, along with a few technical notes related to the differences between the life and health guaranty associations and the property and casualty guaranty funds, which are relevant to the effort to preserve guaranty protection.

Overarching Comments: Importance of Maintaining Policyholder Protections

NOLHGA and NCIGF remain neutral on whether restructuring statutes – either insurance business transfer ("IBT") or corporate division ("CD") statutes – should be adopted. We do, however, emphasize that the enactment of an IBT or CD statute should not affect important policyholder protections that existed prior to the transaction. As noted above and recognized by the White Paper, the policyholder protection of guaranty system coverage should not be lost, reduced, created, or otherwise changed as a result of a restructuring transaction. How this standard is satisfied likely differs depending on the type of business involved in the restructuring transaction (see below for additional detail).

The Restructuring Mechanisms Subgroup's work to develop standards for the review of restructuring transactions and identify best practices for the ongoing monitoring of companies post-restructuring also will be important to ensure that policyholders continue to receive the protection of robust solvency regulation. We applaud the recognition of this fact through the subgroup's existing charges and encourage continued focus on coordinated solvency regulation through FAWG, R-FAWG, and similar mechanisms.

1 The White Paper currently provides, "In order to uphold the stated declaration that restructuring should not materially adversely affect consumers, guaranty association coverage should not be reduced or eliminated by the restructuring." White Paper, pg. 13.
Possible Approval Standards – Differences Between Systems

Section 4 of the White Paper appropriately identifies certain differences between the life and health guaranty associations and the property and casualty guaranty funds. As the Working Group considers potential solutions to ensure that restructuring transactions do not result in changes to guaranty association/fund coverage, it will be important to account for and address differences. Similarly, the analysis a regulator engages in to determine whether a restructuring transaction affects guaranty association/fund coverage will differ based on the type of business involved. We encourage the Working Group to consider making changes to Sections 4(A) and 6(B) of the White Paper (regarding guaranty association issues) to recognize that solutions and issues may differ based on the lines of business involved in a restructuring. We summarize the considerations by lines of business below. We have attached specific, proposed edits to the White Paper as Attachment 1 to this letter for the Working Group’s consideration.

Life & Health Guaranty Association Considerations

For life and health insolvencies, there is a concern that restructuring transactions could result in policyholders losing guaranty association coverage as it existed prior to the transaction. One potential remedy is to specifically require that an assuming or resulting insurer must be licensed in all states where the issuing insurer was licensed or had ever been licensed. That would preserve coverage from the guaranty association that would have provided coverage prior to the transaction. If the assuming or resulting insurer is not licensed in a state, it will not be a "member insurer" of the guaranty association in that state. If it is not a "member insurer," the guaranty association will not be statutorily triggered to provide coverage to resident policyholders in the event of the insurer's liquidation. (Such policyholders are sometimes referred to as "orphans.") Instead, policyholders residing in states where the insurer is not licensed may be eligible for guaranty association coverage only in the assuming or resulting insurer's domiciliary state. This could concentrate guaranty association coverage in a single state (the state of domicile). If there is a large enough concentration of coverage, it could strain assessment capacity in the domiciliary state.\(^2\) It also could result in policyholders receiving different guaranty association coverage than they would have received from their state of residence, and create distortions and fairness issues with respect to member insurer assessments.

To address these concerns, restructuring statutes (or the regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so that policyholders maintain eligibility for guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction.

Property & Casualty Guaranty Fund Considerations

The considerations for the property and casualty guaranty funds are equally urgent but substantially different and require different procedures/remedies. For property and casualty insolvencies, and as described more fully in Section 4 of the White Paper, possible technical

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\(^2\) The Baldwin-United insolvency in the 1980s was the tipping point in convincing regulators and stakeholders of the need to change from providing guaranty association coverage based on the state of domicile of the insolvent insurer to the state of residency of the covered person, an approach that has been adopted nationwide.
gaps in guaranty fund coverage may be created if a state has adopted the NAIC P&C Insurance Guaranty Association Model Law. The NCIGF has determined that an amendment to a state's guaranty fund act, or other related law, may be necessary in many states to address this issue. For those states that have adopted the NAIC P&C Insurance Guaranty Association Model Law, NCIGF has developed technical amendatory language to help ensure that guaranty fund protection is not changed as a result of a restructuring transaction. These revisions have been shared with the Working Group and are included as Attachment 2 to this letter. NCIGF believes that state law amendments, along with careful review of guaranty fund issues by regulators reviewing a proposed restructuring transaction, will best protect the claimants that the guaranty fund system is intended to protect. This amendment can easily be tailored to the NAIC model or any state act. We encourage regulators and other sponsors of this legislation to work with the local guaranty fund to appropriately amend their act to achieve neutrality of guaranty fund coverage. As the White Paper recognizes, this needs to be a state-by-state process to fashion the appropriate remedy. The NCIGF stands ready to work in conjunction with the RITF to develop appropriate language for the NAIC model and assist and partner with regulators and other concerned parties in state-specific efforts to enact this remedy nationwide.

Both of the undersigned organizations are prepared to continue this dialogue and to work closely with the Working Group in providing any additional technical changes to the White Paper. Similarly, the organizations are prepared to offer any insight that might be helpful to the Working Group or subgroup as they work through their charges, and with other assigned committees that may take up issues related to restructuring mechanisms.

Thank you for the opportunity to share our perspective on the proposed White Paper, and we look forward to working with you as this important project moves forward.

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Attachment 1

NOLHGA and NCIGF Proposed Edits/Comments to Restructuring Mechanisms White Paper Draft
Restructuring Mechanisms

An NAIC White Paper

October 22, 2021

Created by the
Restructuring Mechanisms (E) Working Group
of the
Financial Condition (E) Committee
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Section 1: Overview of IBT and Corporate Division Laws and Mechanics

A. Introduction

Insurance is a business that sells a promise to pay upon the occurrence of a future event. Policyholders may submit claims many years into the future on covered losses incurred during the policy period requiring insurers to record a liability for these incurred but not reported claims. As such, it is nearly impossible for an insurer to decide to discontinue writing a certain line of business and pay off all its legal obligations to its policyholders because there are almost always unknown potential future policyholder obligations that have not yet been reported. Policies previously written on a line of business that is no longer being written creates a block of business that may no longer be the focus of the insurer’s business model and left to slowly runoff. For some insurance companies, runoff business remains embedded with the core business without the ability to segregate the runoff business. There are even runoff specialists that have developed within the insurance industry that specialize in handling these old blocks of business.

Until recently, U.S. insurance companies wanting to restructure their liabilities had been limited to sale, reinsurance/loss portfolio transfers or individual policy novation. Other than individual policy novation, these solutions do not provide finality as the ultimate liability remain with the original insurer. The only way to transfer a block of business with finality is an individual policy novation. However, the current process of novating individual policies is considered by the industry to be inconsistent among the states, cumbersome, time-consuming, and expensive. The industry suggests that in many instances it will be impossible to obtain positive consent to a novation from all policyholders, especially on older books of business where policyholders are difficult to locate.

The NAIC has addressed aspects of this issue in the following two previous white papers. In 1997, the Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee issued a paper titled “Liability-Based Restructuring White Paper.” (See Attachment 1.) The white paper focused on the efforts by property and casualty insurers attempting to wall off “material exposures to asbestos, pollution and health hazard (APH) claims and other long-tail liabilities” from current insurer operations. The white paper achieves this focus by inclusion of various section on related topics as well as multiple appendixes. In 2009, the Restructuring Mechanisms for Troubled Companies Subgroup of the Financial Condition (E) Committee issued a white paper titled “Alternative Mechanisms for Troubled Companies.” (See Attachment 2.) The white paper focuses on troubled companies although it also addresses the statutory restructuring mechanisms available in the United States (“US”) at that time. This white paper similar to the 1997 white paper, also includes a number of sections on related topics as well as multiple appendixes.

Over the past few years, states have begun enacting statutes which provide opportunities for restructuring of insurance companies with finality. The purpose of this white paper is to update the 1997 and 2009 white papers and provide explanation of these new statutory processes. These processes can be

1 For purposes of this paper “runoff business” is defined as a block of insurance business that is no longer being actively written by an insurance company and no premiums are being collected, except where required to in accordance with contractual or regulatory obligations, and where the existing or assumed group of insurance policies or contracts are managed through their termination. This definition was developed based on comments received by the Restructuring Mechanism Subgroup from both regulators and industry interested parties; however, this definition has not yet been adopted by the subgroup.

broken down into two categories generally referred to as insurance business transfer (“IBT”) and corporate division (“CD”). Several states, including Arkansas, Oklahoma, Rhode Island, and Vermont, have enacted IBT statutes while other states such as Arizona, Connecticut, Illinois, Iowa, Arkansas, Pennsylvania, and Michigan have enacted CD statutes. The stated intent of all these statutes is to enable insurers to take advantage of the statutory process in order to enhance their ongoing operations.

This white paper will discuss and explore these laws within the US and identify the various regulatory and legal issues involving IBT and CD legislation. This white paper is not intended to establish an official position by the NAIC regarding IBTs or CDs. The authors suggest that each state and its various regulatory authorities should make their own determinations on how best to proceed within their respective jurisdictions. In addition, this paper is not intended to address every situation a company may encounter and leaves possible situations to each insurer as well as the review and approval of all applicable regulatory authorities. Because the robust procedures used in the United Kingdom (“UK”) are seen as a means to utilize IBT in the US, the procedures are discussed in Section 2 of this white paper.

A separate workstream was created to develop financial standards appropriate in US to evaluate IBT and CD transactions. Some stakeholders question whether, even with robust standards, adequate consumer protections would exist when IBTs and CDs are utilized. Therefore, this white paper includes a discussion of a UK case which discussed consumer protection issues.

This is a constantly changing area with states adding and amending statutory provisions and considering new and unique transactions on a continuous basis. Therefore, the factual statements in this whitepaper should be considered a “point in time” discussion.

B. Purposes

During the course of the Restructuring Mechanisms (E) Working Group’s (“Working Group”) discussions, stakeholders identified a number of potential purposes for restructuring transactions. Testimony indicated that reinsurers and insurers were looking for new solutions that provide legal and economic finality to runoff insurance risks to improve the efficient allocation of capital and management resources to runoff and on-going insurance operations. Efficiencies that are obtained through restructuring transactions include the segregation and transfer of runoff books of business with the intent to free up capital, better allocate specialized management resources currently being occupied with the oversight of disparate discontinued and on-going businesses and rationalize and facilitate the runoff of discontinued lines of business. Experience outside the US, including in the UK, has shown that prudent allocation of reserves and management of runoff books of business reduces volatility and improves capital efficiency with benefits for reinsureds and policyholders of both runoff and on-going books of business. Furthermore, runoff experts bring focused expertise to managing runoffs compared to on-going enterprises. The focus of an on-going enterprise is the continual generation of increased premium growth. Runoff business can be both a distraction to management’s focus as well as redirect regulatory focus away from the insurer’s on-going business. The isolation of such business from on-going business enhances the visibility of those runoff operations as well as the supervision of runoff operations, by both regulators and the insurer.

Advocates of these restructuring mechanisms argue that efficiencies resulting from the segregation and specialized management of disparate books of business result in transferring insurers releasing resources and allowing these insurers to better focus on improving current operations. Transferring insurers can better focus on core areas, leading ultimately to better service for current and future policyholders and better service for runoff policyholders. In many cases, the runoff business consists of long-tail lines, such
as mass tort, asbestos, environmental and general liability risks. These long-tail lines tie up financial and management resources which are out of proportion compared to the size or importance of the runoff book within the insurer.

As described in the 1997 white paper, restructuring of insurers can be initiated for several reasons that provide value to the insurer. These reasons include restructuring for credit rating, solvency, more effective claims management, need to raise capital and a desire to exit a line of business. With respect to capital and earnings volatility, the 1997 white paper explained that restructuring could allow liabilities to be separated thereby creating the ability to dedicate surplus to support restructured operations, eliminating the drag on earnings in its on-going operations and avoiding further commitment of capital for pre-existing liabilities. One restructuring expert indicated there were three primary reasons that an insurer may choose to restructure: (1) regulatory, capital and earnings volatility; 2) finality of economic transfer and 3) operational efficiencies.

Of note, restructuring mechanisms may also be beneficial for purposes of credit ratings. Credit ratings are often looked at in terms of capital volatility. Credit rating agencies may take a more favorable view of an insurer that has been able to isolate a particular risk which may be more volatile and subject to further reserve development. However, rating agencies also consider the strength of the insurance group when issuing insurance financial strength ratings, which can negate the credit rating benefit that may be found in restructuring. Ratings are critical for insurers that are writing new business in which the rating has value to potential new customers. While insurance groups use different strategies, it is common that some insurers within a particular insurance group are more critical to the ongoing success of the insurance group as a whole. It is therefore not uncommon for rating agencies to recognize this fact and provide separate ratings for individual insurers within an insurance group. While these considerations can lessen the value of restructuring for credit rating in some instances, insurance groups do still choose to restructure for credit rating purposes.

C. Regulator Concerns with Restructuring Plans

While restructuring may provide value to the insurer, regulators are concerned that restructuring does not create new resources from which claims can be paid. Restructuring should not be utilized to allow insurers to escape these liabilities or separate claims in a manner that provides less capital than is needed to satisfy the insurer’s obligation. Restructuring plans that place solvency at risk or threaten consumer benefits will be faced with challenges from regulators. However, when regulators are shown that the restructuring plan benefits both the insurer and the insured, then the regulator may be willing to approve the restructuring plan. Regulators have utilized procedures to ensure the resulting structure will have sufficient assets, both as to quality and duration, to meet policyholder and other creditor obligations. One of the recommendations of this white paper is to memorialize and standardize those procedures.

Section 2: History of Restructuring in the United Kingdom

3 David Scaimbrough (Swiss Re America Holding Corporation) as stated during the April 6, 2019 meeting of the Restructuring Mechanisms (E) Working Group.
A. Part VII Transfers in the United Kingdom

IBT and CD laws and regulations are relatively new in the US, but the legal mechanism for the transfer of insurance business has been implemented and operational in the UK for over twenty years. Part VII of the Financial Services and Markets Act of 2000⁶ (“Part VII” and “FSMA”) enables insurers to transfer portfolios of business to another insurer subject to court approval. At the time of this writing, more than 300⁷ successful Part VII transfers have taken place in the UK providing guidance to American insurers on how this process could continue to unfold in the US.

A Part VII transfer is a regulatory mechanism, governed by sections 104–116 within Part VII of the FSMA. This act allows an insurer or reinsurer to transfer long-term as well as general insurance business from one legal entity to another, subject to approval of a court. Many insurers use the procedure to give effect to group reorganizations and consolidations. Part VII transfers have also been used extensively in response to Brexit.

In accordance with the FSMA, the Prudential Regulatory Authority (“PRA”) and the Financial Conduct Authority (“FCA”) maintain a Memorandum of Understanding which describes each regulator’s role in relation to the exercise of its functions under the FSMA relating to matters of common regulatory interest and how each regulator intends to ensure the coordinated exercise of such functions. Under the Memorandum of Understanding, the PRA will lead the Part VII transfer process and be responsible for specific regulatory functions connected with Part VII applications, including the provision of certificates.

Section 110 of the FSMA allows both the PRA and the FCA to be heard in the proceedings. The Memorandum of Understanding confirms that both the PRA and the FCA may provide the court with written representations setting out their views on the proposed scheme, and the PRA may prepare a report regarding the IBT.

As set out in the Memorandum of Understanding, before nominating or approving an independent expert under section 109(2)(b) of FSMA . . . the PRA will first consult the FCA. Further, the PRA will consult appropriately with the FCA before approving the notices required under the Business Transfers Regulations.

Part VII transfers require a “scheme report.” This report is similar to the independent expert report under US IBTs, however, because the word “scheme” has a different context in the US, the word “scheme” is not used. Under section 109(2) of FSMA an independent expert report may only be made by a person:

(a) appearing to the PRA to have the skills necessary to enable him to make a proper report; and

(b) nominated or approved by the PRA.

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The regulators expect the independent expert making the report to be a neutral person, who:

(a) is independent, that is any direct or indirect interest or connection he, or his employer, has or has had in either the transferor or transferee should not be such as to prejudice his status in the eyes of the court; and

(b) has relevant knowledge, both practical and theoretical, and experience of the types of insurance business transacted by the transferor and transferee.

The PRA may only nominate or approve an independent expert appointment after consultation with the FCA. An independent expert report must accompany an application to the court to approve the Part VII transfer plan. The independent expert report must comply with the applicable rules on expert evidence and contain the specific information set forth in the statute.

The purpose of the independent expert report is to inform the court. The independent expert, therefore, likely has a duty to the court. Further, policyholders, reinsurers, regulators, and others affected by the Part VII transfer will be relying on the independent expert report. For these reasons, a detailed report is necessary. The amount of detail that it is appropriate to include will depend on the complexity of the transfer, the materiality of each factor and the circumstances surrounding each factor.

During the Working Group’s discussion of the Part VII transfers, consumer representatives raised the UK court’s decision in Prudential v Rothesay which imposed several limitations on Part VII transfers. On August 16, 2019, the High Court of Justice issued an opinion rejecting a Part VII transfer between Prudential Assurance Company Limited and Rothesay Life PLC. This Part VII plan was the subject of a four-day hearing in which each insurer was represented by counsel, the PRA and FCA appeared, and a number of policyholders appeared in person. The Court noted that both the PRA and the FCA each produced reports regarding the plan, and both stated that they did not object. The independent expert filed a detailed report that ultimately did not reject the plan either.

The applicant received approximately 7,300 responses from policyholders in response to the approximately 258,000 policyholder packets that were sent out. Of those, about 1,000 were characterized as an objection. The main objection to the plan was that these consumers specifically selected the transferring insurer as their provider. These consumers argued that they should not have their annuity transferred against their will to a smaller insurer with a very different history and reputation just to further the commercial and financial purposes of the transferor.

This decision was appealed and ultimately overturned. The UK Court of Appeals found that the lower court incorrectly exercised its authority finding amongst other things, that the judge was wrong to

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1 As noted by Biny Birnbaum (Center for Economic Justice—CEJ) during the Dec 8, 2019 Meeting of the Restructuring Mechanisms (E) Working Group. Note this was overturned by The Prudential Assurance Company Limited v. Rothesay Life PLC (2020) EWCA Civ 1626.
2 Prudential Assurance Company Ltd and Rothesay Life PLC, Re England and Wales Court of Appeal (Civil Division) (Dec. 2, 2020).
give weight to (i) the different capital management policies of both insurers; and (ii) the objections of a small subset of policyholders.

In so holding, the Court of Appeals stated:

(1) The Court below was wrong to decide that both the independent expert and PRA were not justified in looking at the solvency metrics at a specific date to support their conclusions.

(2) The Court below was wrong to find a material disparity in the parent company structure since the parent companies could never be required to provide support to their subsidiaries’ capital.

(3) The Court below should not have accorded any weight to the fact that the policyholders had chosen Prudential based on its long-established reputation, age, and venerability nor to the fact that they had reasonably assumed that Prudential would be their annuity provider throughout its lengthy term. 10

Despite this set of complex UK decisions, the Part VII transfer continues to be used in the UK and watched closely by the US regulators and stakeholders.

B. Differences between Part VII and Solvent Schemes of Arrangements

Solvent schemes of arrangement are another method of restructuring that exists within the UK. These are primarily designed as a procedure that can allow all liabilities to be settled for an insurer. In doing so, it can achieve many of the objectives set out in this white paper. However, unlike the Part VII transfer, the policies are subject to a court ordered termination instead of transferred. While such an arrangement may provide some of the same features as a Part VII transfer the solvent scheme does not continue the coverage with a new insurer the way a Part VII transfer does. Other differences may exist in law but are not deemed to be relevant to this specific white paper.

Section 3: Survey of US Restructuring Statutes and Regulations

Various states have enacted corporate restructuring statutes or regulations. Those generally following the UK structure began with Rhode Island in 2002 adopting a statute titled Voluntary Restructuring of Solvent Insurers 11 patterned after Solvent Schemes of Arrangements. This type of process was renamed Commutation Plans and differs from the UK law in a number of areas including an enhanced role for the regulator, designating the independent expert as a consultant to the regulator and limiting the process to commercial property and casualty risks. One commutation plan was adjudicated by the Rhode Island court in 2011 and withstood a constitutional challenge. 12 Commutation Plans continue to be available under RI law.

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10 Id. at Page 6 of Appeal Nos: A2/2019/2407 and 2409 Case No: 1236/5/7/15
In 2015 Rhode Island adopted an Insurance Business Transfer Plan regulation structured similar to the Part VII transfers. Again, in contrast to the UK, the regulation provides an enhanced role for the regulator, designates the independent expert as a consultant to the regulator and limits the process to commercial property and casualty risks. The RI regulation provides for notice at the time the plan is filed with the regulator and an ability to comment at that time. If the regulator, after a thorough review of the Plan and comments received, continues to believe that it meets the statutory requirements, it will authorize the Plan to be filed with the Court. The Court will require notice to policyholders and hearings to allow all comments and objections to be considered. A Rhode Island domestic insurer has been formed specifically to undertake IBTs, but a plan has not yet been filed with the regulator.

In 2013, Vermont adopted the Legacy Insurance Management Act ("LIMA"). LIMA is limited to surplus lines risks and reinsurance, involves department approval but not court approval and allows policyholders to opt-out of the plan. As of this date, no transactions have been completed under LIMA.

In 2018, Oklahoma adopted the Insurance Business Transfer Act modeled after UK’s Part IV regulation with a few significant differences. The differences include no restriction on the type of insurance nor restrictions on the age of the business. Oklahoma law provides for both insurers to nominate a potential independent expert with the Insurance Commissioner appointing one or another if he or she is not satisfied with the nominations. The independent expert report is submitted with the IBT application to the Oklahoma Insurance Department which approves the IBT plan to be submitted to the court upon satisfactory showing that statutory standards are met. The court requires notice and opportunity to be heard prior to court approval of implementation of the plan. As of this writing, Oklahoma has completed two IBTs in October 2020 and September 2021, involving a Rhode Island and Wisconsin insurer respectively, which are described below. Neither of the plans were challenged in the state court proceedings.

In 2021, Arkansas adopted the Insurance Business Transfer Act which is based on the Oklahoma and Rhode Island statutes. The key differences are: the assuming insurer must be licensed in each line of business in each state where the transferring insurer is licensed unless an exception is made for an extraordinary circumstance; specific factors are provided in the Arkansas IBT law that the Commissioner must consider before approving the IBT including the impact on contract holders and reinsurers in addition to policyholders, additional guidance on what would be a material adverse impact; specific guidance for proposed long-term care IBTs and additional requirements for the expert opinion report.

The National Council of Insurance Legislators has promulgated a model IBT law modeled after the Oklahoma IBT statutes, as well as a model CD law. A number of states have adopted CD statutes, whether specific to insurance or based on the state’s general power over corporations. Those states include Arizona, Connecticut, Illinois, Iowa, Michigan, Arkansas, and Pennsylvania. All of these statutes allow for corporate restructures. As discussed in more detail below, Pennsylvania and Illinois have each completed CD transactions.

13 230 RICR 20-45-6.
15 Insurance Business Transfer Act, OKLA. STAT. tit. 36, §§ 1681 et seq.
A. Similarities and Differences between Statutes

Rhode Island’s IBT law permits transfers of property and casualty commercial blocks of business that have been closed for at least 60 months. In contrast, Oklahoma and Arkansas IBT laws permit transfers of both open and closed books of business and are not limited in the line of business that can be transferred. All three states require approval by a court and no material adverse impact on affected policyholders. The approval of the ceding and assuming insurer’s domestic insurance regulator is also required. All states require an expert report that contains an opinion on the likely effects of the transfer plan on policyholders considering whether the security position of policyholders is materially adversely affected by the transfer. All states also require notification to all affected policyholders as well as the opportunity to be heard at a public hearing.

As noted above, several states have also enacted CD laws, rules, and regulations. While differences exist between IBTs and CDs, there are also many similarities between the two mechanisms: they require a regulatory review of the effect on policyholders, they have balance sheet considerations, and they are a way to separate run-off certain books of business from an insurer.

The Illinois’ Domestic Stock Company Division Law\(^{20}\) requires disclosure of the allocation of assets and liabilities among companies. Although not statutorily required, the Illinois Department of Insurance Director has committed to providing an opportunity to comment at a public hearing. The standard in the Illinois statute is that the plan must be approved by the Director unless the following characteristics exist:

(1) policyholder/shareholder interest are not protected;
(2) each insurer would not be eligible to receive a license in the state;
(3) division violates the uniform fraudulent act;
(4) division is made for the purpose of hindering, delaying, or defrauding other creditors;
(5) any of the companies are insolvent after the division is complete.

The Connecticut CD statute\(^{21}\) creates something legally distinct from a merger, consolidation, dissolution, or formation. The resulting insurers are deemed legal successors to the dividing insurer, and any of the assets or obligations allocated are done as a result of succession and not by direct or indirect transfer. The plan must include among other things (1) the name of the domestic insurer; (2) the resulting insurer(s); (3) proposed corporate by-laws for new insurers; (4) manner for allocating liabilities and reasonable description of policies; (5) other liabilities and capital and surplus to be allocated, including the manner by which each reinsurance contract is allocated; and (6) all other terms and conditions. Connecticut requires approval by the board of directors, stockholders, and other owners before being considered by the Department of Insurance. The plan is then discussed with the Department which will determine whether the liabilities and policies are clearly defined and identifiable and whether the assumptions are conservative based upon actuarial findings. Connecticut law does not require an independent expert or a communication strategy as part of the application, but the Department of Insurance has stated that it will.

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require certain notifications related to a hearing (e.g., newspaper or print publications). Connecticut does not require notice of hearing however the insurance commissioner may require a hearing if in the public interest. Similar to Illinois law, the insurance commissioner must approve a plan of division unless he or she finds that (1) the interest of any policyholder or interest holder would not be adequately protected or (2) the division constitutes a fraudulent transfer. The division itself must be effectuated within 90 days of the filing.

The Pennsylvania CD statute was enacted in 1990 and is the subject of the NAIC 1997 white paper on Liability Based Restructuring. The statute upon which the transaction discussed in the 1997 white paper is based is not specific to insurance. The law is brief with only four paragraphs—requiring the plan to be submitted in writing, reasonable notice and opportunity for a hearing, investigations and supplemental studies and approval through an order from the Department and subject to judicial review. The associated procedural regulations essentially are those that exist under the states equivalent of the NAIC Insurance Holding Company System Regulatory Act (Model 440).

While the Rhode Island, Oklahoma and Arkansas laws have approval processes that are similar to UK Part VII transfers, there are differences between the three statutes. Rhode Island permits transfers of mature (at least 60 months) closed commercial property and casualty books of business or non-life reinsurance but no other lines of business. Oklahoma does not have similar restrictions and specifically allows property and casualty, life, and health lines of business. Oklahoma and Arkansas do not require the book of business to be closed.

While the CD laws enacted to date all require regulatory review of the effect on policyholders, balance sheet considerations and other operational requirements, the most significant differences that exist in CD laws are not among themselves, but rather in comparison to the IBT statutes. This is because the CD statutes do not require approval by a court or the same level of notification to policyholders. In addition, while CD states reserve the right to hire their own external expert—similar to a Form A (Change in Control), these states may perform their review based upon their own internal experts.

B. Transactions Completed to Date

One of the earliest transactions completed under these types of laws occurred in Pennsylvania in announced that it had approved a transaction that transferred a book of business from one entity to another. This transaction is discussed within Attachment 1, which is the 1997 Liability-Based Restructuring White Paper, and is commonly referred to as “the Brandywine” transaction, but within the 1997 White Paper is discussed within Appendix 1 and relates to Cigna, where more information is available. During the Working Group’s discussions in 2019, the Pennsylvania Insurance Department, which is captured in the following paragraph.

The Brandywine transaction was subject to an insurance department review, which included an actuarial review, a review of the financial information by a consultant and participation by other states that had an interest to understand how the plan would be restructured. There were four actuarial firms that opined on the transaction as well as two opinions from investment banks, one contracted by the insurer and another contracted by the Department. Issues regarding guaranty coverage were not addressed, but it did require Pennsylvania policyholders to be covered by the Pennsylvania fund. Confidentiality was applied to

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22 15 PA. CONS. STAT. §§ 361 et seq.
any examination document prepared in the process, actuarial reports, and questions and comments, but insurer responses were made available to the public. The transaction was a large commercial transaction and immaterial to the policyholders, therefore reducing some of the concerns that may have otherwise existed.

In 2011, GTE Re23 completed a commutation plan in Rhode Island. The plan was approved by the Rhode Island court and the insured was ordered dissolved after all assureds had been paid full value for their policies. The GTE Re Plan was objected to, on a theoretical basis, and the Providence County Superior Court issued a decision24 on a contract clause issue.

In 2020, the District Court of Oklahoma County approved Providence Washington Insurance Company’s (”PWIC”) IBT plan.25 The plan transferred all the insurance and reinsurance business underwritten by PWIC, a Rhode Island domestic insurer, to Yosemite Insurance Company. Later in 2020, the Oklahoma Insurance Commissioner issued an order authorizing Sentry Insurance a Mutual Company (“Sentry”), a Wisconsin-based insurer, to submit its IBT Plan to the District Court of Oklahoma County for approval.26 This IBT transfers a block of reinsurance business underwritten by Sentry to National Legacy Insurance Company, an insurer domiciled in Oklahoma and a subsidiary of Randall & Quilter Investment Holdings Ltd (NLIC). The Sentry transfer was approved by the Court in August of 2021.

Illinois completed a transaction under their CD statute in early 2020. The transaction was a transfer of risks with distinct characteristics into a single insurer within a holding company structure. All the transfers originated and ended within the same holding company. The Illinois Department of Insurance has indicated that it will issue a detailed regulation as experience develops with CD plans proposed and completed under the statute.

Section 4: Impact of IBTs and CDs to Personal Lines

A. Guarantee Association Issues

An important issue for corporate restructuring is the availability of guaranty association coverage in the event of the insolvency of the restructured insurer. In order to uphold the stated declaration that restructuring should not materially adversely affect consumers, guaranty association coverage should not be reduced, eliminated or otherwise changed by the restructuring. Each state guaranty association is a separate entity governed by the laws of that state, and those statutes will determine association coverage. Although most states pattern their laws after the NAIC model law, there could potentially be different results concerning guaranty association coverage depending on where the insured resides. Guaranty association coverage. It is possible that a corporate restructuring could result in the reduction, elimination or change in guaranty association coverage provided to a policyholder in the event of the restructured insurer’s insolvency if steps are not taken to prevent that result. The potential coverage issues are different

24 State of Rhode Island Providence County Superior Court C.A. No. PB 10-3777
https://www.courts.ri.gov/Courts/SuperiorCourt/DecisionsOrders/decisions/10-3777.pdf
26 Approval Order in Case No. 20-0582-IBT from Oklahoma Insurance Commissioner, filed on November 23, 2020, at
for life and health guaranty association coverage and property and casualty guaranty fund coverage. We
address them separately below.

Transactions Involving Life or Health Insurance

The Working Group received input from both the National Organization of Life and Health
Insurance Guaranty Associations (“NOLHGA”) and the National Conference of Insurance Guaranty Funds
(“NCIGF”). NOLHGA described how about the concerns for insurance consumers of personal lines life and
health insurance business in particular are pronounced.

NOLHGA indicated that for there to be guaranty association coverage in the event of a life or
health insurer insolvency, there are three conditions that must be present. Those conditions are:

1. The consumer seeking protection must be an eligible person under the guaranty association
   statute; typically, this is achieved by being a resident of the guaranty association’s state
   at the time of the insurer’s liquidation;
2. The product must be a covered policy; and
3. The failed insurer for which protection is being sought must be a member insurer of the
   guaranty association of the state where the policyholder resides. To be a member insurer,
   the insurer must be licensed in that state, or have been licensed in the state to write the lines
   of business covered by the guaranty association.

In most states, coverage can be provided for an “orphan” policyholder of the insurer whereby
the coverage is issued but the policyholder has since moved to a state that is not a guaranty association
member. Those policies are covered under the state in which the insolvent insurer’s domiciled.
Orphan policyholders are policyholders who are residents of states where the guaranty association
cannot provide coverage because the insolvent insurer is domiciled. This provision is intended to
plug the gap in these rare situations. Orphan coverage was not designed to provide
coverage to all policyholders regardless of domicile as might occur if

A key factor when considering a life or health IBT or CD transaction is whether the resulting
insurer in an IBT does not meet the requirements for guaranty association coverage. These issues can or
will be addressed in legislative and regulatory manners including maintaining a certificate of authority in
each state, so the insurer is a guaranty association a member insurer in each state. However, if any of the
same guaranty associations where the transferring insurer is insolvent an unable was a member insurer of
the resulting insurer is a member insurer of the same guaranty associations as the transferring insurer,
guaranty association coverage will be preserved and not changed for all policyholders. Of course, specific
guaranty association coverage will be determined if/when the resulting insurer is placed under an order of
liquidation with a finding of insolvency. If the resulting insurer is not a member insurer of the same
guaranty associations as the transferring insurer, policyholders may lose guaranty association coverage or
be covered as orphans by the guaranty association in the insurer’s domestic state. Orphan coverage was not designed to plug the gap in this situation. Shifting the coverage obligation to meet such requirements in the domestic state guaranty association could impair the ability of guaranty association coverage being concentrated in that state.

To address these concerns with respect to complete restructuring IBT and CD transactions involving life or health insurance, restructuring statutes (or regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so that policyholders maintain eligibility for guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means that the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred.

Transactions Involving Property and Casualty Insurance

The Working Group received input from the National Conference of Insurance Guaranty Funds (“NCIGF”) about the concerns for insurance consumers of personal lines property and casualty insurance business.

One interpretation of the NAIC Property and Casualty Insurance Guaranty Association Model Act (Model # 540) is that based on the definitions of “Covered Claim,” “Member Insurer,” “Insolvent Insurer,” and “Assumed Claim Transaction” an orphan policyholder could not be covered by the state guaranty association. Consequently, there is a concern that no guaranty association coverage would be provided if policies are transferred to a nonmember insurer. Many property and casualty guaranty fund statutes require that the policy be issued by the now-insolvent insurer and that it must have been licensed either at the time of issue or when the insured event occurred. These limitations, however, are designed to avoid coverage being provided when the policy at issue did not “contribute” to the association, which would not exist in the case of an accessible policy later transferred to a nonmember insurer. Moreover, the restrictions exist to prevent claims resulting from a company regulated as a surplus lines or a similar structure to benefit from the protections afforded licensed business when a licensed company is liquidated.

NCIGF’s position is that where there was guaranty fund coverage before the IBT or CD, state regulators should ensure that there is coverage after the IBT or CD. An IBT or CD should not reduce, eliminate or in any way impact guaranty fund coverage. An CD or IBT should not create, expand, or in any way impact coverage. NCIGF suggested that possible technical gaps may exist in states that have adopted the NAIC Property & Casualty Insurance Guaranty Association Model Act. These gaps could include the definitions of Covered Claim, Member Insurer, Insolvent Insurer, and the Assumed Claims Transaction found in Section 5 of the model law.

Fulfilling this intent may require property and casualty guaranty association fund statutes be amended in each of the states where the original insurer was a member of a guaranty association before the transaction becomes final. NCIGF indicated that it had created a subcommittee to address this issue and

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oversee a coordinated, national effort to enact the necessary changes in each state. Further discussion of this subcommittee’s work is discussed in the Recommendations section below.

B. Assumption Reinsurance

Existing assumption reinsurance statutes exist to provide policyholder disclosures and rights for rejection of a proposed novation of their policy. These statutes are primarily designed for the benefit of individual policyholder with regard to personal lines coverages, whether for automobile, homeowners, life insurance or long-term care insurance, in situations where the solvency of the insurer might be at risk. There are currently ten states that have enacted the NAIC Assumption Reinsurance Model Act. 30

The Assumption Reinsurance Model Act was drafted by state insurance regulators and initially adopted by the NAIC on December 5, 1993. The effect of an assumption reinsurance transaction is to relieve the transferring insurer of all related insurance obligations and to make the assuming insurer directly liable to the policyholder for the transferred risks. Under these statutes, individual policyholders receive a notice of transfer and may reject or accept the transfer. If the policyholder does not respond, the policyholder is deemed to have given implied consent, and the novation of the contract will be affected. When a new agreement replaces an existing agreement, a novation has occurred. There is no judicial involvement under the Assumption Reinsurance Model Act.

Some stakeholders have questioned whether the existence of rights under the Assumption Reinsurance Model Act by implication prohibit an IBT or a CD. The argument is that the existence of the assumption reinsurance statute prohibits other statutory restructuring mechanisms without the policyholders express individual consent. Other stakeholders have suggested that these statutes coexist with restructuring mechanisms since the restructuring statutes are not addressing individual novations of policies. The argument is that the restructuring statutes address transfers of books of business not individual novation of policies and, therefore, are completely separate from assumption reinsurance statutes.

This is not an issue that can be resolved in this white paper. The issue has not yet been addressed by any court nor raised in the proceedings on restructurings. Therefore, while it is raised here for informational purposes, resolution of the issue is left unanswered for now and for the courts to determine in the future.

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30 Assumption Reinsurance Model Act NAIC Model #803 (Adopted by Colorado, Georgia, Kansas, Maine, Missouri, Nebraska, North Carolina, Oregon, Rhode Island, and Vermont)
C. Separate Issues in Long-Term Care

Long-tail liabilities are naturally subject to greater reserve uncertainty and may impact the regulators’ willingness to consider the restructuring of certain lines of business. During the Working Group’s discussion, it was noted by a number of regulators that restructuring of certain lines of business, such as long-term care insurance, could be problematic since the specific line of business has presented significant challenges in determining appropriate reserving and capital required to support the business. The Working Group acknowledges that, regardless of whether some state laws would permit it, use of a corporate restructuring mechanism in certain lines, such as long-term care insurance, is likely to be subject to a great deal of opposition and higher capital requirements for the insurers involved.

The nature of long-term care insurance policyholders will make restructuring challenging especially with a transfer to a completely new insurer in a new holding company system. Long-term care insurance policyholders are individuals who may find it much more challenging to assert their rights in a court proceeding than a corporate entity would. This fact, along with the traditional inability of insurers to properly estimate future liabilities in this line of business, makes it a line of business that likely is not appropriate for restructuring mechanisms. This conclusion, however, could be refuted if the appropriate plan addresses these issues and provides benefit to the policyholders.

Section 5: Legal Impacts of IBT and CD Laws

A. How Other Jurisdictions Might Analyze IBT or CD Decisions from Other States

As previously discussed by others, a restructuring mechanism in one state will not provide finality unless the decision is recognized by other jurisdictions. The US Constitution includes the Full Faith and Credit Clause as well as the Privileges and Immunities Clause (also referred to as the doctrine of Comity) in Article IV. These clauses create methods of extending the effect of a restructuring mechanism beyond the state that issued the judgment and giving that state’s judgment effect in all other states in which the insurer does business.

Thus, the Privileges and Immunities Clause or the Full Faith and Credit Clause are two methods stemming from the US Constitution that provide for recognition of court orders from other states. We will briefly touch on both concepts but leave these non-core insurance topics to others to discuss in more depth.

The policyholder challenging the decision must first identify the property of which they are being deprived. Assuming the resulting insurer is sufficiently capitalized, a policyholder who has been reallocated to the resulting insurer, but alleges no additional harm, may have difficulty identifying the property interest of which they have been deprived. The determination on full faith and credit will likely rely upon the issues raised and considered in the Court of the domestic state.

The issue is not likely to be ripe until an insolvency occurs with the assuming insurer. At that point, if the assuming insurer is insolvent and the original insurer is still financially sound, will a court give full


32 The same analysis does not apply to jurisdictions outside the United States and is not addressed in this white paper.
faith and credit to the approval of the IBT or CD? This is an open question that is unlikely to be resolved until the specific factual scenario presents itself to the courts. The fact that this issue exists makes it even more important that only transactions with the greatest chance for success be subject to corporate restructuring process.

Comity is typically understood to be a courtesy provided between jurisdictions, not necessarily as a right but rather out of deference and good will. As such, comity might not require in this context that a state honor the decision of another state. This is an analysis to be conducted by the individual jurisdictions.

B. Impact of UK Part VII Transactions in the US

Although there has been limited experience in the US courts in approving commutations and IBTs, some US courts have had opportunities to review these types of issues because US insurers have been involved with UK-based commutations or transfers. Since the 2000 and 2005 revisions to UK laws, solvent schemes and Part VII transfers have been employed much more frequently in the UK. This has led to more frequent reviews by US courts of the underlying UK transactions. Some of the impact in the US is felt in bankruptcy courts, which often are implicated because US policyholders obtain coverage from UK-based insurers on a regular basis, while others involve non-bankruptcy situations, such as when a policyholder wants to submit a claim for payment but no longer has coverage.

There are several interesting cases that provide some guidance on these issues. Narragansett Electric Co. v. American Home Assurance Co. is one such case. In Narragansett Electric Co., the court reviewed claims by London-based insurer, Equitas, that the plaintiff had sued the wrong insurer on a claim that was alleged to have occurred more than sixty years earlier. Equitas argued that it had not assumed the obligations at issue. As the court summarized, “Equitas’s motion to dismiss raises the question whether this [Part VII] transfer of insurance obligations from Lloyd’s to Equitas is effective and enforceable under U.S. law.” First, the court decided that it was sitting in diversity jurisdiction and that the appropriate substantive law to apply was English. Next, the court discussed a prior District Court case where another Part VII transfer was discussed at length and not recognized as a foreign bankruptcy proceeding. In reaching a conclusion to reject the request for dismissal, the court relied on a letter sent by Equitas to US policyholders notifying them that Equitas was assuming the obligations of the original insurer. The court found that regardless of whether the Part VII had any effect the letter sent by Equitas raised sufficient basis to let the suit continue. Equitas attempted to argue that the Part VII transfer did not state that it would become effective in the US, rather that it was only effective in certain countries of Europe. Nevertheless, the utility company alleged that it had not relied on the English High

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Court Order executing the Part VII transfer, but rather relied on the notice letter it received as the evidence of obligation by the new named insurer.

_Air & Liquid System Corp. v. Allianz Insurance Co._, dealt with a discovery dispute as to whether a policyholder impacted by a Part VII transfer could later have access to the information that went into a UK’s independent expert’s report. Ultimately, the special master in the District Court allowed discovery to proceed with a deposition of the expert. _Allianz Insurance Co._ is an example of one way that Part VII transfers can be used to add complication to an insurance coverage dispute, embroiling all involved in later litigation. _Allianz Insurance Co._ also shows how the approval of such a transfer, even though well vetted originally, can later come under scrutiny in unintended or unforeseen locations.

_Allianz Insurance Co._ concerned General Star, which wrote policies for excess coverage outside the US for only three years, 1998–2000, and then was put into runoff and ceased writing new policies. By 2010, it had substantially wound down its business and decided to transfer its policies to a new insurer via a Part VII transfer. Both General Star (the transferor) and the transferee taking over the policies shared an ultimate parent company—Berkshire Hathaway. At issue here was whether the expert who opined on the Part VII transfer had properly included one particular US-based insured, Howden North America (“Howden”), and all three policies it had purchased from General Star. That insurance contract had been for excess coverage, and Howden had informed General Star of 13,500 potential asbestos related claims that were likely to exceed the initial layers of insurance, making it likely that the General Star excess policy would be required to pay out claims. The real issue in _Allianz Insurance Co._ seemed to be that the post-Part VII insurer was put into voluntary liquidation days after the Part VII transfer concluded, leading to questions about whether and how the independent expert had valued Howden’s potential asbestos claims.

_In re Board of Directors of Hopewell International Insurance Ltd._ involved a New York bankruptcy judge analyzed a solvent scheme of arrangement that occurred in Bermuda, and applied Bermuda law, rather than the requested Minnesota law. The court determined that, given the location of the petitioner’s assets, Respondents had failed to object to the solvent scheme as proposed when they had been provided notice, and that petitioner had been subjected to a foreign proceeding, it had jurisdiction. As such, the court enjoined the respondent from taking action against petitioner based on the underlying action. The court in _Hopewell_ also recognized the Bermuda solvent scheme as one qualifying as a foreign proceeding under US Bankruptcy Code.

### Section 6: Recommendations

#### A. Financial Standards Developed by Subgroup


38 Id. at *12. This interrelated nature is not unusual and is referred to as an intra-company transaction.


40 Written by then the Chief United States bankruptcy judge in the Southern District of New York Tina Brozman, this decision detailed relevant history behind the Bermuda schemes of arrangement, including the different methods available to companies. One arrangement involved a cut-off scheme, developed in 1995, in which companies have no more than five years to submit additional claims prior to a bar date. This scheme greatly reduced the time for a run-off to wind down its business.

41 Citing to 11 U.S.C. § 101(23)(2012), The court applied a standard that “a foreign proceeding is a foreign judicial or administrative process whose end is to liquidate the foreign estate, adjust its debts or effectuate its reorganization.” Id. at 49 (internal quotations omitted).
As reflected in this whitepaper, these restructuring mechanisms depend considerably upon the specific plan being proposed. Currently, each state with relevant statutes is being presented with plans for evaluation with no standard set of criteria under which to judge the financial underpinnings of the plan. The Working Group believes that trust in these mechanisms and protection of the policyholders who will be impacted by them, demands a standard set of financial principles under which to judge the transaction. As such, the Working Group created a subgroup to specifically address these financial issues.

The Restructuring Mechanism Subgroup (“Subgroup”) has been charged with the following initial work related to this White Paper:

- Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer along with the adequacy of long-term liquidity needs. Also develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for its consideration. Complete by the 2021 Summer National Meeting.  

- Members of the Subgroup have studied and acknowledge that UK Part VII procedures set forth robust processes and that setting similar requirements should be applied to IBT and CDs. As of the date of this paper, the charge related to best practices has not been completed. The Subgroup will continue its work with the goal of developing financial best practices. Those practices will be exposed for comment and discussion prior to referral to other groups.

B. Guaranty Association Issues

As discussed above, when these restructuring mechanisms are applied to personal lines serious issues arise over the continuation of guaranty association coverage. A number of states—Connecticut, California, and Oklahoma—have enacted statutory solutions to these issues. In addition, NCIGF has provided proposed statutory language. The Working Group would suggest that these issues, and the potential solutions, be referred to the Receivership Task Force for consideration to include language in the Guaranty Association Model Act.

On the life and health side, as noted above, restructuring statutes (or regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so that policyholders maintain eligibility for life and health guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means that the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred.

On the property and casualty side, amendments to the guaranty fund statutes likely will be necessary. A number of states—California, Illinois, and Oklahoma—have enacted statutory solutions to the property and casualty guaranty association issues similar to what NCIGF has suggested to the working group. In addition, NCIGF has provided proposed statutory language for other states to consider. The Working Group would suggest that these issues, and the potential solutions, be referred to the Receivership Task Force for consideration to include language in the Guaranty Association Model Act.

42 Charges were adopted by the Financial Condition (E) Committee Oct. 27, 2020 (see NAIC Fall National Meeting Minutes for the Financial Condition (E) Committee-Attachment Two).
and Insolvency Task Force for consideration. Specifically, the Working Group recommends that the language proposed by NCIGF be included in the NAIC Property and Casualty Insurance Guaranty Association Model Act. Regulators, guaranty funds and other appropriate industry stakeholders should work cooperatively to implement this statutory remedy with all deliberate speed.

Inclusion in the model, of course, only provides a roadmap for a state. The Working Group, therefore, suggests that, once appropriate language has been drafted, a serious effort be undertaken to obtain changes to the statutes in the various states to address this issue. Until that is accomplished, regulators should very carefully consider how plans presented address the property and casualty guaranty association issues to assure that consumers are not harmed by the transaction.

C. Statutory Minimums

During the Working Group hearing, stakeholders made a number of suggestions as to provisions which should be required to be included in IBT and CD statutes. Those include:

1. Requirement of court approval must be required for all restructuring mechanisms. Currently the IBT statutes (except for Vermont) require court approval, but the CD statutes generally do not.

2. Requirement of the use of an independent expert to assist the state in both IBT and CD transactions, even though none of the states require this independent expert assistance for a CD.

3. Requirement of a notice to stakeholders, a public hearing, robust regulatory process, and an opportunity to submit written comments are necessary for all policyholders, reinsurers, and guaranty associations.

None of the restructuring mechanism are based on an NAIC model. While the Rhode Island, Oklahoma and Arkansas statutes are similar and are based on the Part VII processes in the UK, all CD processes are different and drafted by the legislatures of the states which enacted the statutes. Each of these recommendations is designed to address possible impairment of the financial position of the policyholders of the companies involved in the IBT and CD. As some commenters indicated, each of these suggestions would be beneficial in some transaction. Other transactions, however, may not need all of these provisions. For example, an intra holding company transaction may not need full faith and credit.

While independent experts can be of value, the mere fact that someone is employed by an insurance department does not mean that their skill set is not sufficient for certain transactions. Depending upon the transaction, department staff with a deep understanding of the insurer might provide more protection for consumers than a newly hired individual without a history with the insurer. Thus far, none of the transactions have been undertaken without a robust regulatory process; however, there would be concern from other regulators if this quality of regulatory process was not in place.

D. Impact of Licensing Statutes

Insurers formed for the purpose of effectuating restructuring mechanisms may, in the right transactions, provide value to consumers in the efficient management of runoff liabilities. However, these newly formed companies have difficulty getting licensed in the various states either because of...
“seasoning” issues or because they are not writing ongoing business so the state may be hesitant to grant a license. Lack of licensure can provide a lack of regulatory control which can lead to actions which harm consumers. The Working Group, therefore, recommends that the appropriate committee look at licensing standards to consider whether any changes should be made to the licensure process for runoff companies resulting from restructuring transactions of runoff blocks. A streamlined process that still ensures appropriate regulatory oversight (and any licensure necessary to preserve guaranty association coverage) may be appropriate in limited circumstances.

Commented [A5]: If possible, we suggest that the appropriate committee be identified here.
Attachment 2

NCIGF Proposed Edits to Property and Casualty Insurance Guaranty Association Model
PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

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Section 1. Title

This Act shall be known as the [State] Insurance Guaranty Association Act.

Section 2. Purpose

The purpose of this Act is to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and to the extent provided in this Act minimize financial loss to claimants or policyholders because of the insolvency of an insurer, and to provide an association to assess the cost of such protection among insurers.

Section 3. Scope

This Act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

A. Life, annuity, health or disability insurance;
B. Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;
C. Fidelity or surety bonds, or any other bonding obligations;
D. Credit insurance, vendors’ single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;
E. Insurance of warranties or service contracts including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;
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F. Title insurance;

G. Ocean marine insurance;

H. Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or

I. Any insurance provided by or guaranteed by government.

Drafting Note: This Act focuses on property and liability kinds of insurance and therefore exempts those kinds of insurance deemed to present problems quite distinct from those of property and liability insurance. The Act further precludes from its scope certain types of insurance that provide protection for investment and financial risks. Financial guaranty is one of these. The NAIC Life and Health Insurance Guaranty Association Model Act provides for coverage of some of the lines excluded by this provision.

For purposes of this section, “Financial guaranty insurance” includes any insurance under which loss is payable upon proof of occurrence of any of the following events to the damage of an insured claimant or obligee:

1. Failure of any obligor or obligors on any debt instrument or other monetary obligation, including common or preferred stock, to pay when due the principal, interest, dividend or purchase price of such instrument or obligation, whether failure is the result of a financial default or insolvency and whether or not the obligation is incurred directly or as guarantor by, or on behalf of, another obligor which has also defaulted;

2. Changes in the level of interest rates whether short term or long term, or in the difference between interest rates existing in various markets;

3. Changes in the rate of exchange of currency, or from the inconvertibility of one currency into another for any reason;

4. Changes in the value of specific assets or commodities, or price levels in general.

For purposes of this section, “credit insurance” means insurance on accounts receivable.

The terms “disability insurance” and “accident and health insurance,” and “health insurance” are intended to be synonymous. Each State will wish to examine its own statutes to determine which is the appropriate phrase.

A State where the insurance code does not adequately define ocean marine insurance may wish to add the following to Section 5, Definitions: “Ocean marine insurance” means any form of insurance, regardless of the name, label or marketing designation of the insurance policy, which insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurance, such as hull and machinery, marine builders risk, and marine protection and indemnity. Perils and risk insured against include without limitation loss, damage, expense or legal liability of the insured for loss, damage or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways for commercial purposes, including liability of the insured for personal injury, illness or death or for loss or damage to the property of the insured or another person.

Section 4. Construction

This Act shall be construed to effect the purpose under Section 2 which will constitute an aid and guide to interpretation.

Section 5. Definitions

As used in this Act:

[Optional:

A. “Account” means any one of the three accounts created by Section 6.]

Drafting Note: This definition should be used by those States wishing to create separate accounts for assessment purposes. For a note on the use of separate accounts for assessments see the Drafting Note after Section 6. If this definition is used, all subsequent subsections should be renumbered.

A. “Affiliate” means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer.
B. “Association” means the [State] Insurance Guaranty Association created under Section 6.

C. “Association similar to the association” means any guaranty association, security fund or other insolvency mechanism that affords protection similar to that of the association. The term shall also include any property and casualty insolvency mechanism that obtains assessments or other contributions from insurers on a preinsolvency basis.

Drafting Note: There are two options for handling claims assumed by a licensed carrier from an unlicensed carrier or self insurer. Alternative 1 provides that these claims shall be covered by the guaranty association if the licensed insurer becomes insolvent subsequent to the assumption. Alternative 2 provides coverage only if the assuming carrier makes a payment to the guaranty association in an amount equal to that which the assuming carrier would have paid in guaranty association assessments had the insurer written the assumed business itself. If a State wishes to adopt Alternative 1, it must select Alternative 1 in Section 5D and Alternative 1a or 2a in Section 8A(3). If a State wishes to adopt Alternative 2, it must select Alternative 2 in Section 5D and Q and Alternative 1b or 2b in Section 8A(3).

D. [Alternative 1] “Assumed claims transaction” means the following:

1. Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies; or

2. An assumption reinsurance transaction in which all of the following has occurred:
   a. The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies; and
   b. The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and
   c. As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.

[Alternative 2] “Assumed claims transaction” means the following:

1. Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, through a merger between the insolvent insurer and another entity obligated under the policies, and for which Assumption Consideration has been paid to the applicable guaranty associations, if the merged entity is a non-member insurer; or

2. Policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by the domestic commissioner of the assuming insurer, which:
   a. Transfers the direct policy obligations and future policy renewals from one insurer to another insurer; and
   b. For which Assumption Consideration has been paid to the applicable guaranty associations, if the assumption is from a non-member insurer.
   c. For purposes of this section the term non-member insurer also includes a self-insurer, non-admitted insurer and risk retention group; or

3. An assumption reinsurance transaction in which all of the following has occurred:
   a. The insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer or entity obligated under the claims or policies;
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(b) The assumption of the claim or policy obligations has been approved, if such approval is required, by the appropriate regulatory authorities; and

(c) As a result of the assumption, the claim or policy obligations became the direct obligations of the insolvent insurer through a novation of the claims or policies.

E. “Claimant” means any person instituting a covered claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

F. “Commissioner” means the Commissioner of Insurance of this State.

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

G. “Control” means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

H. “Covered claim” means the following:

(1) An unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies, if the insurer becomes an insolvent insurer after the effective date of this Act and:
   
   (a) The claimant or insured is a resident of this State at the time of the insured event, provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the State in which its principal place of business is located at the time of the insured event; or
   
   (b) The claim is a first party claim for damage to property with a permanent location in this State.

   (c) Notwithstanding any other provision in this Act, an insurance policy issued by a member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of another insurer, pursuant to a state statute providing for the division of an insurance company or the statutory assumption or transfer of designated policies and under which there is no remaining obligation to the transferring entity (commonly known as “Division” or “Insurance Business Transfer” statutes), shall be considered to have been issued by a member insurer which is an Insolvent Insurer for the purposes of this Act in the event that the insurer to which the policy has been allocated, transferred, assumed or otherwise made the sole responsibility of is placed in liquidation.

   (d) An insurance policy that was issued by a non-member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of a member insurer under a state statute described in subsection (a) shall not be considered to have been issued by a member insurer for the purposes of this Act.
(2) Except as provided elsewhere in this section, “covered claim” shall not include:

(a) Any amount awarded as punitive or exemplary damages;

(b) Any amount sought as a return of premium under any retrospective rating plan;

(c) Any amount due any reinsurer, insurer, insurance pool or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set forth in Section 8 of this Act;

(d) Any claims excluded pursuant to Section 13 due to the high net worth of an insured;

(e) Any first party claims by an insured that is an affiliate of the insolvent insurer;

(f) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;

(g) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;

(h) Any claims for interest; or

(i) Any claim filed with the association or a liquidator for protection afforded under the insured’s policy for incurred-but-not-reported losses.

Drafting note: The language in this provision referring to claims for incurred-but-not-reported losses has been inserted to expressly include the existing intent of this provision and make it clear that “policyholder protection” proofs of claim, while valid to preserve rights against the State of the insolvent insurer under the Insurer Receivership Model Act, are not valid to preserve rights against the association.

I. “Insolvent insurer” means an insurer that is licensed to transact insurance in this State, either at the time the policy was issued, when the obligation with respect to the covered claim was assumed under an assumed claims transaction, or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer’s State of domicile.

Drafting Note: “Final order” as used in this section means an order which has not been stayed. States in which the “final order” language does not accurately reflect whether or not the order is subject to a stay should substitute appropriate language consistent with the statutes or rules of the State to convey the intended meaning.

J. “Insured” means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy.

K. (1) “Member insurer” means any person who:
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(a) Writes any kind of insurance to which this Act applies under Section 3, including the exchange of reciprocal or inter-insurance contracts; and

(b) Is licensed to transact insurance in this State (except at the option of the State).

(2) An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which this Act applies, however, the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied prior to the termination or expiration of the insurer’s license and assessments levied after the termination or expiration, which relate to any insurer that became an insolvent insurer prior to the termination or expiration of the insurer’s license.

L. “Net direct written premiums” means direct gross premiums written in this State on insurance policies to which this Act applies, including policy and membership fees, less the following amounts: (1) return premiums, (2) premiums on policies not taken, and (3) dividends paid or credited to policyholders on that direct business. “Net direct written premiums” does not include premiums on contracts between insurers or reinsurers.

M. “Novation” means that the assumed claim or policy obligations became the direct obligations of the insolvent insurer through consent of the policyholder and that thereafter the ceding insurer or entity initially obligated under the claims or policies is released by the policyholder from performing its claim or policy obligations. Consent may be express or implied based upon the circumstances, notice provided and conduct of the parties.

N. “Person” means any individual, aggregation of individuals, corporation, partnership or other entity.

O. “Receiver” means liquidator, rehabilitator, conservator or ancillary receiver, as the context requires.

Drafting Note: Each State should conform the definition of “receiver” to the definition used in the State’s insurer receivership act.

P. “Self-insurer” means a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.

Q. [Alternative 2b] “Assumption Consideration” shall mean the consideration received by a guaranty association to extend coverage to the policies assumed by a member insurer from a non-member insurer in any assumed claims transaction including liabilities that may have arisen prior to the date of the transaction. The Assumption Consideration shall be in an amount equal to the amount that would have been paid by the assuming insurer if the business had been written directly by the assuming insurer.

In the event that the amount of the premiums for the three year period cannot be determined, the Assumption Consideration will be determined by multiplying 130% against the sum of the unpaid losses, loss adjustment expenses, and incurred but not reported losses, as of the effective date of the Assummed claims transaction, and then multiplying such sum times the applicable guaranty association assessment percentage for the calendar year of the transaction.

The funds paid to a guaranty association shall be allocated in the same manner as any assessments made during the three year period. The guaranty association receiving the Assumption Consideration shall not be required to recalculate or adjust any assessments levied during the prior three calendar years as a result of receiving the Assumption Consideration. Assumption Consideration paid by an insurer may be recouped in the same manner as other assessments made by a guaranty association.

Section 6. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5K shall be and remain members of the association as a condition of their authority to

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transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7.

[Alternate Section 6. Creation of the Association]

There is created a nonprofit unincorporated legal entity to be known as the [State] Insurance Guaranty Association. All insurers defined as member insurers in Section 5KJ shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under Section 9 and shall exercise its powers through a board of directors established under Section 7. For purposes of administration and assessment, the association shall be divided into three separate accounts:

A. The workers’ compensation insurance account;
B. The automobile insurance account; and
C. The account for all other insurance to which this Act applies.

Drafting Note: The alternate Section 6 should be used if a State, after examining its insurance market, determines that separate accounts for various kinds of insurance are necessary and feasible. The major consideration is whether each account will have a base sufficiently large to cover possible insolvencies. Separate accounts will permit assessments to be generally limited to insurers writing the same kind of insurance as the insolvent company. If this approach is adopted the provision of alternate Sections 8A(3) and 8B(6) and optional Section 5A should also be used.

Section 7. Board of Directors

A. The board of directors of the association shall consist of not less than five (5) nor more than [insert number] persons serving terms as established in the plan of operation. The insurer members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining insurer members subject to the approval of the commissioner. If no members are selected within sixty (60) days after the effective date of this Act, the commissioner may appoint the initial members of the board of directors. Two (2) persons, who must be public representatives, shall be appointed by the commissioner to the board of directors. Vacancies of positions held by public representatives shall be filled by the commissioner. A public representative may not be an officer, director or employee of an insurance company or any person engaged in the business of insurance. For the purposes of this section, the term “director” shall mean an individual serving on behalf of an insurer member of the board of directors or a public representative on the board of directors.

Drafting Note: A State adopting this language should make certain that its insurance code includes a definition of “the business of insurance” similar to that found in the NAIC Insurer Receivership Model Act.

B. In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.

C. Members of the board of directors may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors.

D. Any board member who is an insurer in receivership shall be terminated as a board member, effective as of the date of the entry of the order of receivership. Any resulting vacancies on the board shall be filled for the remaining period of the term in accordance with the provisions of Subsection A.

E. In the event that a director shall, because of illness, nonattendance at meetings or any other reason, be deemed unable to satisfactorily perform the designated functions as a director by missing three consecutive board meetings, the board of directors may declare the office vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

F. If the commissioner has reasonable cause to believe that a director failed to disclose a known conflict of interest with his or her duties on the board, failed to take appropriate action based on a known conflict of
interest with his or her duties on the board, or has been indicted or charged with a felony, or misdemeanor involving moral turpitude, the commissioner may suspend that director pending the outcome of an investigation or hearing by the commissioner or the conclusion of any criminal proceedings. A company elected to the board may replace a suspended director prior to the completion of an investigation, hearing or criminal proceeding. In the event that the allegations are substantiated at the conclusion of an investigation, hearing or criminal proceeding, the office shall be declared vacant and the member or director shall be replaced in accordance with the provisions of Subsection A.

Section 8. Powers and Duties of the Association

A. The association shall:

1. (a) Be obligated to pay covered claims existing prior to the order of liquidation, arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:

   i. The full amount of a covered claim for benefits under a workers’ compensation insurance coverage;

   ii. An amount not exceeding $10,000 per policy for a covered claim for the return of unearned premium;

   iii. An amount not exceeding $500,000 per claimant for all other covered claims.

(b) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include a claim filed with the guaranty fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

For the purpose of filing a claim under this subsection, notice of claims to the liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of claims shall be periodically submitted to the association or association similar to the association in another State by the liquidator.

Drafting Note: On the general subject of the relationship of the association to the liquidator, the working group/task force takes the position that since this is a model State bill, it will be able to bind only two parties, the association and the in-State liquidator. Nevertheless, the provisions should be clear enough to outline the requests being made to out-of-State liquidators and the requirements placed on in-State liquidators in relation to out-of-State associations.

Drafting Note: Because of its potential impact on guaranty association coverage, it is recommended that the legislation include an appropriate provision stating that the bar date only applies to claims in liquidation commencing after its effective date. Drafters should insure that the State’s insurance liquidation act would permit, upon closure, payments to the guaranty association and any association similar to the association for amounts that are estimated to be incurred after closure for workers compensation claims obligations. The amounts should be payable on these obligations related to losses both known and not known at the point of closure.

(c) Any obligation of the association to defend an insured shall cease upon the association’s payment or tender of an amount equal to the lesser of the association’s covered claim obligation limit or the applicable policy limit.

Drafting Note: The obligation of the association is limited to covered claims unpaid prior to insolvency, and to claims arising within thirty days after the insolvency, or until the policy is cancelled or replaced by the insured, or it expires, whichever is earlier. The basic principle is to permit policyholders to make an orderly transition to other companies. There appears to be no reason why the association should become in effect an insurer in competition with member insurers by continuing existing policies, possibly for several years. It is also felt that the control of the policies is properly in the hands of the liquidator. Finally, one of the major objections of the public to rapid termination, loss of unearned premiums with no corresponding coverage, is ameliorated by this bill since unearned premiums are permissible claims, up to $10,000, against the association. The maximums ($10,000 for the return of unearned premium; $500,000 for all other covered claims) represent the working group’s concept of practical limitations, but each State will wish to evaluate these figures.
(2) Be deemed the insurer to the extent of its obligation on the covered claims and to that extent, subject to the limitations provided in this Act, shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association. The association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction.

(3) [Alternative 1a] Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer’s net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer’s financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

[Alternative 2a] Assess insurers amounts necessary to pay the obligations of the association under Subsection A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any year an amount greater than two percent (2%) of that member insurer’s net direct written premiums and any premiums received for an assumed contract after the effective date of an assumed claims transaction with a non-member insurer for the calendar year preceding the assessment. The 2% limitation on assessments shall not preclude a full payment for assumption consideration. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer’s financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the company, credited against future assessments.

(3) [Alternate 1b] Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the
Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the association under Subsection 8A(1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. A member insurer may not be assessed in any one year on any account an amount greater than two percent (2%) of that member insurer’s net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of a member insurer, if the assessment would cause the member insurer’s financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by a jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of the company, credited against future assessments. A member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of claims by the member insurer if they are chargeable to the account for which the assessment is made.}
(4) Investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association’s obligation and deny all other claims. The association shall pay claims in any order that it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims.

(5) Notify claimants in this State as deemed necessary by the commissioner and upon the commissioner’s request, to the extent records are available to the association.

Drafting Note: The intent of this paragraph is to allow, in exceptional circumstances, supplementary notice to that given by the domiciliary receiver.

(6) (a) Have the right to review and contest as set forth in this subsection settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:

(i) The association is not bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was:

(I) Executed or entered within 120 days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment; or

(II) Executed by or taken against an insured or the insurer based on default, fraud, collusion or the insurer’s failure to defend.

(ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Subparagraph (a)(i), the settlement, release, compromise, waiver or judgment shall be set aside, and the association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver or judgment may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Act.

(iii) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.

(b) As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and shall be permitted to defend the claim on the merits.

(7) Handle claims through its own employees, one or more insurers, or other persons designated as servicing facilities, which may include the receiver for the insolvent insurer. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.
(8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.

(9) Submit, not later than 90 days after the end of the association’s fiscal year, a financial report for the preceding fiscal year in a form approved by the commissioner.

B. The association may:

(1) Employ or retain persons as are necessary to handle claims and perform other duties of the association;

(2) Borrow funds necessary to effect the purposes of this Act in accordance with the plan of operation;

(3) Sue or be sued;

(4) Negotiate and become a party to contracts necessary to carry out the purpose of this Act;

(5) Perform other acts necessary or proper to effectuate the purpose of this Act;

(6) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

[Alternate Section 8B(6)

(6) Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year.]

Drafting Note: The working group/task force feels that the board of directors should determine the amount of the refunds to members when the assets of the association exceed its liabilities. However, since this excess may be quite small, the board is given the option of retaining all or part of it to pay expenses and possibly remove the need for a relatively small assessment at a later time.

C. Suits involving the association:

(1) Except for actions by the receiver, all actions relating to or arising out of this Act against the association shall be brought in the courts in this State. The courts shall have exclusive jurisdiction over all actions relating to or arising out of this Act against the association.

(2) The exclusive venue in any action by or against the association is in [designate appropriate court]. The association may, at its option, waive this venue as to specific actions.

[Optional Section 8D]

D. The legislature finds:

(a) The potential for widespread and massive damage to persons and property caused by natural disasters such as earthquakes, windstorms, or fire in this State can generate insurance claims of such a number as to render numerous insurers operating within this State insolvent and therefore unable to satisfy covered claims;

(b) The inability of insureds within this State to receive payments of covered claims or to timely receive the payments creates financial and other hardships for insureds and places undue burdens on the State, the affected units of local government, and the community at large;
The insolvency of a single insurer in a material amount or a catastrophic event may result in the same hardships as those produced by a natural disaster;

The State has previously taken action to address these problems by adopting the [insert name of guaranty association act], which among other things, provides a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer; and

In order for the association to timely pay claims of insolvent insurers in this State and otherwise carry out its duties, the association may require additional financing options. The intent of the Legislature is to make those options available to the association in the event that a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection A(3). In cases where the association determines that it is cost effective, the association may issue bonds as provided in this subsection. In determining whether to issue bonds, the association shall consider the transaction costs of issuing the bonds.

In the event a natural disaster such as an earthquake, windstorm, fire or material insolvency of any member insurer results in covered claim obligations currently payable by the association in excess of its capacity to pay from current funds and current assessments under Subsection 8A(3), the association, in its sole discretion, may by resolution request the [insert name of agency] Agency to issue bonds pursuant to [insert statutory authority], in such amounts as the association may determine to provide funds for the payment of covered claims and expenses related thereto. In the event bonds are issued, the association shall have the authority to annually assess member insurers for amounts necessary to pay the principal of, and interest on those bonds. Assessments collected pursuant to this authority shall be collected under the same procedures as provided in Subsection 8A(3) and, notwithstanding the two percent (2%) limit in Subsection 8A(3), shall be limited to an additional [insert percentage] percent of the annual net direct written premium in this State of each member insurer for the calendar year preceding the assessment. The commissioner’s approval shall be required for any assessment greater than five percent (5%). Assessments collected pursuant to this authority may only be used for servicing the bond obligations provided for in this subsection and shall be pledged for that purpose.

In addition to the assessments provided for in this subsection, the association in its discretion, and after considering other obligations of the association, may utilize current funds of the association, assessments made under Subsection 8A(3) and advances or dividends received from the liquidators of insolvent insurers to pay the principal and interest on any bonds issued at the board’s request.

Assessments under this subsection shall be payable in twelve (12) monthly installments with the first installment being due and payable at the end of the month after an assessment is levied, and subsequent installments being due not later than the end of each succeeding month.

In order to assure that insurers paying assessments levied under this subsection continue to charge rates that are neither inadequate nor excessive, within ninety (90) days after being notified of the assessments, each insurer that is to be assessed pursuant to this subsection shall make a rate filing for lines of business additionally assessed under this subsection. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of the assessment and the rate of the previous year’s assessment under this subsection, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of [cite appropriate statutory authority for provisions on filing and approval of rates].

Drafting Note: This provision should only be considered by those States that have serious concerns that circumstances could result in a substantial capacity problem resulting in unpaid or pro rata payment of claims. An association intending to consider this provision should first consult with experienced bond
counsel in its State to identify an appropriate State agency or bonding authority to act as vehicle for issuing the bonds. That agency or authority’s statute may also have to be amended to specifically authorize these types of bonds and to cross-reference this provision in the guaranty association law. It is possible that in some situations a new bonding authority may have to be created for this purpose.

Regardless of the vehicle used, it is important that the decision-making authority on whether bonds are needed and in what amounts be retained by the association’s board.

The extent of additional assessment authority under this subsection has not been specified. When considering the amount of additional authority that will be needed, a determination should be made as to the amount of funds needed to service the bonds. More specifically, consideration should be given to the amount of the bonds to be issued, interest rate and the maturity date of the bonds. The association should be able to raise sufficient funds through assessments to pay the interest and retire the bonds after some reasonable period (e.g. ten (10) years). Subsection D(2) requires the Commissioner’s approval before the association can impose an additional assessment in excess of 5%. This is to assure that the additional assessment will not result in financial hardship to the member insurers and additional insolvencies.

The intent of Subsection D(4) is to permit recoupment by member insurers of the additional cost of assessments under this subsection without any related regulatory approval. A State enacting this subsection may need to revise Subsection D(4) so that it conforms to the particular State’s recoupment provisions, as well as the provisions on filing and approval of rates.

Section 9. Plan of Operation

A. (1) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and amendments shall become effective upon approval in writing by the commissioner.

(2) If the association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall:

(1) Establish the procedures under which the powers and duties of the association under Section 8 will be performed;

(2) Establish procedures for handling assets of the association;

(3)Require that written procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer;

(4) Require that written procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 7;

(5) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;

(6) Establish regular places and times for meetings of the board of directors;

(7) Require that written procedures be established for records to be kept of all financial transactions of the association, its agents and the board of directors;

(8) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision;
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(9) Establish the procedures under which selections for the board of directors will be submitted to the commissioner;

(10) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

D. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8A(3) and 8B(2), are delegated to a corporation, association similar to the association or other organization which performs or will perform functions similar to those of this association or its equivalent in two (2) or more States. The corporation, association similar to the association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 10. Duties and Powers of the Commissioner

A. The commissioner shall:

(1) Notify the association of the existence of an insolvent insurer not later than three (3) days after the commissioner receives notice of the determination of the insolvency. The association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction;

(2) Provide the association with a statement of the net direct written premiums of each member insurer upon request of the board of directors.

B. The commissioner may:

(1) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on a member insurer that fails to pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that a fine shall not be less than $100 per month;

(2) Revoke the designation of a servicing facility if the commissioner finds claims are being handled unsatisfactorily.

(3) Examine, audit, or otherwise regulate the association.

Drafting Note: This section does not require periodic examinations of the guaranty associations but allows the commissioner to conduct examinations as the commissioner deems necessary.

C. A final action or order of the commissioner under this Act shall be subject to judicial review in a court of competent jurisdiction.

Section 11. Coordination Among Guaranty Associations

A. The association may join one or more organizations of other State associations of similar purposes, to further the purposes and administer the powers and duties of the association. The association may designate one or more of these organizations to act as a liaison for the association and, to the extent the association authorizes, to bind the association in agreements or settlements with receivers of insolvent insurance companies or their designated representatives.
B. The association, in cooperation with other obligated or potentially obligated guaranty associations, or their
designated representatives, shall make all reasonable efforts to coordinate and cooperate with receivers, or
their designated representatives, in the most efficient and uniform manner, including the use of Uniform Data
Standards as promulgated or approved by the National Association of Insurance Commissioners.

Section 12. Effect of Paid Claims

A. Any person recovering under this Act shall be deemed to have assigned any rights under the policy to the
association to the extent of his or her recovery from the association. Every insured or claimant seeking the
protection of this Act shall cooperate with the association to the same extent as the person would have been
required to cooperate with the insolvent insurer. The association shall have no cause of action against the
insured of the insolvent insurer for sums it has paid out except any causes of action as the insolvent insurer
would have had if the sums had been paid by the insolvent insurer and except as provided in Subsection B
and in Section 13. In the case of an insolvent insurer operating on a plan with assessment liability, payments
of claims of the association shall not operate to reduce the liability of the insureds to the receiver, liquidator
or statutory successor for unpaid assessments.

B. The association shall have the right to recover from any person who is an affiliate of the insolvent insurer all
amounts paid by the association on behalf of that person pursuant to the Act, whether for indemnity, defense
or otherwise.

C. The association and any association similar to the association in another State shall be entitled to file a claim
in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as
determined under this Act or similar laws in other States and shall receive dividends and other distributions
at the priority set forth in [insert reference to State priority of distribution in liquidation act].

D. The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the
covered claims paid by the association and estimates of anticipated claims on the association which shall
preserve the rights of the association against the assets of the insolvent insurer.

Section 13 [Optional] Net Worth Exclusion

Drafting Note: Various alternatives are provided for a net worth limitation in the guaranty association act. States may choose any of the Subsection B alternatives below or may elect to not have any net worth limitation. Subsection A, which defines “high net worth insured,” has two alternates allowing States to choose different net worth limitations for first and third party claims if that State chooses alternatives 1 or 2 to Subsection B. Subsections C, D and E are recommended to accompany any of the Subsection B alternatives. In cases where States elect not to include net worth, States may either omit this section in its entirety or include only Subsection C, which excludes from coverage claims denied by other States’ net worth restrictions pursuant to those States’ guaranty association laws.

A. For purposes of this section “high net worth insured” shall mean any insured whose net worth exceeds $50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer, provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.

Alternate Section 13A

A. (1) For the purposes of Subsection B(1), “high net worth insured” shall mean any insured whose net worth exceeds $25 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.

(2) For the purpose of Subsection B(2) [and B(4) if Alternative 2 for Subsection B is selected] “high net worth insured” shall mean any insured whose net worth exceeds $50 million on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured’s net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.
Drafting Note: States may wish to consider the impact on governmental entities and charitable organizations of the application of the net worth exclusion contained in the definition of "covered claim." The Michigan Supreme Court, in interpreting a “net worth” provision in the Michigan guaranty association statute, held that governmental entities possess a “net worth” for purposes of the provision in the Michigan guaranty association statute that prohibits claims against the guaranty association by a person who has a specified net worth. Oakland County Road Commission vs. Michigan Property & Casualty Guaranty Association, 575 N.W. 2d 751 (Mich. 1998).

[Alternative 1 for Section 13B]
B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.

(2) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.]

[Alternative 2 for Section 13B]
B. (1) The association shall not be obligated to pay any first party claims by a high net worth insured.

(2) Subject to Paragraph (3), the association shall not be obligated to pay any third party claim relating to a policy of a high net worth insured. This exclusion shall not apply to third party claims against the high net worth insured where:

(a) The insured has applied for or consented to the appointment of a receiver, trustee or liquidator for all or a substantial part of its assets;

(b) The insured has filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law; or

(c) An order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.

(3) Paragraph (2) shall not apply to workers’ compensation claims, personal injury protection claims, no-fault claims and any other claims for ongoing medical payments to third parties.

(4) The association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise.]

[Alternative 3 for Section 13B]
B. The association shall not be obligated to pay any first party claims by a high net worth insured.

C. The association shall not be obligated to pay any claim that would otherwise be a covered claim that is an obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the State of residence of the claimant at the time specified by that State’s applicable law, and which association has denied coverage to that claimant on that basis.

D. The association shall establish reasonable procedures subject to the approval of the commissioner for requesting financial information from insureds on a confidential basis for purposes of applying this section, provided that the financial information may be shared with any other association similar to the association and the liquidator for the insolvent insurer on the same confidential basis. Any request to an insured seeking financial information must advise the insured of the consequences of failing to provide the financial information. If an insured refuses to provide the requested financial information where it is requested and available, the association may, until such time as the information is provided, provisionally deem the insured to be a high net worth insured for the purpose of denying a claim under Subsection B.
E. In any lawsuit contesting the applicability of this section where the insured has refused to provide financial information under the procedure established pursuant to Subsection D, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the association its full costs, expenses and reasonable attorneys’ fees in contesting the claim.

Section 14. Exhaustion of Other Coverage

A. (1) Any person having a claim against an insurer, shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.

(2) Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy, or if there are no applicable stated limits under the policy, the association shall receive a full credit for the total recovery.

[Alternative 1 for Section 14A(2)(a)]

(a) The credit shall be deducted from the lesser of: (i) The association’s covered claim limit; (ii) The amount of the judgment or settlement of the claim; or (iii) The policy limits of the policy of the insolvent insurer.

[Alternative 2 for Section 14A(2)(a)]

The credit shall be deducted from the lesser of: (i) The amount of the judgment or settlement of the claim; or (ii) The policy limits of the policy of the insolvent insurer.

(b) In no case, however, shall the obligation of the association exceed the covered claim limit embodied in Section 8 of this Act.

(3) Except to the extent that the claimant has a contractual right to claim defense under an insurance policy issued by another insurer, nothing in this section shall relieve the association of the duty to defend under the policy issued by the insolvent insurer. This duty shall, however, be limited by any other limitation on the duty to defend embodied in this Act.

(4) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.

(5) For purposes of this section, a claim under an insurance policy other than a life insurance policy shall include, but is not limited to:

(a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy; and

(b) Any amount payable by or on behalf of a self-insurer.
The person insured by the insolvent insurer’s policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association’s obligation is reduced by the application of this section.

B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property. If it is a workers’ compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from another insurance guaranty association or its equivalent.

Drafting Note: This subsection does not prohibit recovery from more than one association, but it does describe the association to be approached first and then requires that any previous recoveries from like associations must be set off against recoveries from this association.

Section 15. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

A. The board of directors may, upon majority vote, make recommendations to the commissioner on matters generally related to improving or enhancing regulation for solvency.

B. At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may, upon majority vote, prepare a report on the history and causes of the insolvency, based on the information available to the association and submit the report to the commissioner.

C. Reports and recommendations provided under this section shall not be considered public documents.

Section 16. Tax Exemption

The association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions except taxes levied on real or personal property.

Section 17. Recoupment of Assessments

Drafting Note: States may choose how they wish to allow member insurers to recoup assessments paid by selecting one of three alternatives for Section 17.

[Alternative 1 for Section 17]

A. Except as provided in Subsection D, each member insurer shall annually recoup assessments it remitted in preceding years under Section 8. The recoupment shall be by means of a policyholder surcharge on premiums charged for all kinds of insurance in the accounts assessed. The surcharge shall be at a uniform percentage rate determined annually by the commissioner that is reasonably calculated to recoup the assessment remitted by the insurer, less any amounts returned to the member insurer by the association. Changes in this rate shall be effective no sooner than 180 days after insurers have received notice of the changed rate.

B. If a member insurer fails to recoup the entire amount of the assessment in the first year under this section, it shall repeat the surcharge procedure provided for herein in succeeding years until the assessment is fully recouped or a de minimis amount remains uncollected. Any such de minimis amount shall be collected as provided in Subsection D of this section. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.

C. The amount and nature of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The surcharge shall not be considered premium for any purpose, including the [insert all appropriate taxes] or agents’ commission.
D. A member may elect not to collect the surcharge from its insureds only when the expense of collecting the surcharge would exceed the amount of the surcharge. In that case, the member shall recoup the assessment through its rates, provided that:

1. The insurer shall be obligated to remit the amount of surcharge not collected by election under this subsection; and

2. The last sentence in Subsection C above shall not apply.

E. In determining the rate under Subsection A for the first year of recoupment under this section, under rules prescribed by the commissioner, the commissioner shall provide for the recoupment in that year, or in such reasonable period as the commissioner may determine, of any assessments that have not been recouped as of that year. Insurers shall not be required to recoup assessments through surcharges under this section until 180 days after this section takes effect.

[Alternative 2 for Section 17]
A. Notwithstanding any provision of [insert citation to relevant tax and insurance codes] to the contrary, a member insurer may offset against its [insert all appropriate taxes] liability the entire amount of the assessment imposed under this Act at a rate of [insert number] percent per year for [insert number of years] successive years following the date of assessment. If the assessment is not fully recovered over the [insert number of years] period, the remaining unrecovered assessment may be claimed for subsequent calendar years until fully recovered.

Drafting Note: States may choose the number of years to allow an insurer to offset an assessment against the insurer’s premium tax liability.

B. Any tax credit under this section shall, for the purposes of Section [insert citation to retaliatory tax statute] be treated as a tax paid both under the tax laws of this State and under the laws of any other State or country.

C. If a member insurer ceases doing business in this State, any uncredited assessment may be credited against its [insert all appropriate taxes] during the year it ceases doing business in this State.

D. Any sums that are acquired by refund from the association by member insurers and that have been credited against [insert all appropriate taxes], as provided in this section, shall be paid by member insurers to this State as required by the department. The association shall notify the department that the refunds have been made.

[Alternative 3 for Section 17]
The rates and premiums charged for insurance policies to which this section applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association. Rates shall not be deemed excessive because they contain an additional amount reasonably calculated to recoup all assessments paid by the member insurer.

Section 18. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against a member insurer, the association or its agents or employees, the board of directors, or any person serving as an alternate or substitute representative of any director, or the commissioner or the commissioner’s representatives for any action taken or any failure to act by them in the performance of their powers and duties under this Act.

Section 19. Stay of Proceedings

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this State shall, subject to waiver by the association in specific cases involving covered claims, be stayed for six (6) months and such additional time as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the State, whichever is later, to permit proper defense by the association of all pending causes of action.

The liquidator, receiver or statutory successor of an insolvent insurer covered by this Act shall permit access by the board or its authorized representative to such of the insolvent insurer’s records which are necessary for the board in carrying out its
functions under this Act with regard to covered claims. In addition, the liquidator, receiver or statutory successor shall provide the board or its representative with copies of those records upon the request by the board and at the expense of the board.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1993 Proc. 2nd Quarter 12, 33, 227, 600, 602, 621 (amended).
This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state’s activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC’s interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.
# PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

## KEY:

**MODEL ADOPTION:** States that have citations identified in this column adopted the most recent version of the NAIC model in a substantially similar manner. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

**RELATED STATE ACTIVITY:** Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column only (and nothing listed in the Model Adoption column) have not adopted the most recent version of the NAIC model in a substantially similar manner.

**NO CURRENT ACTIVITY:** No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

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## PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

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## PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

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# Property and Casualty

**Insurance Guaranty Association Model Act**

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### PROPERTY AND CASUALTY

**INSURANCE GUARANTY ASSOCIATION MODEL ACT**

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<td>Virginia</td>
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<tr>
<td>Wisconsin</td>
<td>WIS. STAT. §§ 646.01 to 646.73 (1979/2013) (&quot;Insurance Security Fund&quot;).</td>
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A regulator discussed the history of revising this model in relation to the new NAIC model law process. He stated that the draft was re-exposed for new comments. 2008 Proc. 1st Quarter Vol. II 10-440.

The Financial Condition (E) Committee adopted amendments to this model. The Committee summarized the more significant changes including the Task Force’s recommendation on the assumed business options. 2008 Proc. 4th Quarter Vol. II 10-5.

The joint Executive Committee/Plenary adopted amendments to this model. A commissioner noted that an interested party provided a comment requesting reconsideration of the optional net worth exclusion provision. The commissioner reiterated that the provision was optional and intended to provide uniform language for states interested in implementing a net worth exclusion. 2009 Proc. 1st Quarter Vol. I 3-5.

Section 1. Title

Section 2. Purpose

In 1969 the NAIC prepared a statement of position on automobile insurance. One part of that study concerned automobile insurer insolvencies. It was stated that the “… position of the NAIC [is] that no innocent person should suffer as a result of the insolvency of an insurer…” and the association vowed to take action to assure that end. They recommended serious consideration be given to the establishment of an industry facility regulated by the states to guarantee solvency and to indemnify the public against the insolvency of any casualty insurer. A federal guaranty corporation was suggested in a congressional bill, but a resolution was adopted by the NAIC in opposition to this proposal. The resolution emphasized the fact that the NAIC was recommending a program in each state to establish a means to guarantee the payment of claims against insolvent insurers. 1969 Proc. II 549-552.

Every insurance company failure undermines public confidence in, and the value of, the insurance institution whose continued existence is the result of the public’s desire and need to be secure from risk. Like taxes, the over-all cost of the solvency of an individual company and of such industry-wide schemes as guaranty funds ultimately falls upon the consumer. 1970 Proc. I 262.

An insurer association recommended that Section 2 be deleted because it added no substance to the model. 1994 Proc. 2nd Quarter 510.

The working group decided instead to retain the section, but decided to replace the word “avoid” with “the extent provided in this act, minimize.” The group also deleted a phrase that said one of the purposes was “the detection and prevention of insurer insolvencies.”

The working group felt that the two changes made the section better reflect the purpose of the guaranty association. 1994 Proc. 3rd Quarter 419.

The Receivership Model Act Working Group voted to delete this section. A couple of regulators made a motion to restore the original language. The argument was that the clause expanded the coverages provided by the guaranty associations. The Task Force voted to retain the original language. 2008 Proc. 1st Quarter 10-440.

Section 3. Scope

In a report comparing losses of insurance companies and banks, it was pointed out that the property/casualty insurance industry is quite different from the life insurance industry. 1969 Proc. II 564. The first priority was drafting legislation implementing the NAIC position on automobile insurance problems. 1970 Proc. I 1252.
Basic to drafting a model bill is the determination of its scope. What types of insurance and insurers should be included and excluded? The existing bills range from including only automobile insurance to one embracing both life and property coverages. What contacts must there be with the state before recourse may be had against the fund? \textit{1970 Proc. I 263}.

Section 3

The task force was charged with the task of considering whether the term “direct” needed to be defined. There has been litigation and many questions arising as to the types of coverage considered “direct” by the model act language. Courts have found large self-insured groups who purchase excess and aggregate stop loss coverage to be covered by the guaranty associations since there was no underlying contract of insurance, even though the coverage was more in the nature of reinsurance coverage. \textit{1989 Proc. II 331}.

A. The drafters intended that a state choose the term “health insurance,” “disability insurance,” or “accident and sickness insurance” to conform to the terminology found elsewhere in the insurance code of the state in question. \textit{1973 Proc. I 1157}.

Amendments proposed in 1985 were considered a “radical departure” from the original model by the task force chair. The proposed amendments excluded products unless they were specifically listed as included. That meant new products would be excluded unless they fit under a generic term. Some of the items not included under the industry-suggested approach were based on a desire to exclude them, such as financial guarantee insurance. Other exclusions resulted from the belief that, recognizing the extraordinary nature of a guaranty fund, many insured exposures did not represent an extreme hardship to the person involved. Still others may have resulted from drafting difficulties. \textit{1985 Proc. II 473-475}.

By the time the amendments were adopted at the end of 1985, the mechanics of the scope section had changed from the earlier draft. Rather than limiting coverage only to stated types of insurance, the list excluded certain types of coverage. One listed item was removed just before adoption of the model. It had provided an exclusion from the act for errors and omissions insurance for directors and officers of for-profit organizations. \textit{1986 Proc. I 294}.

B. The task force was unanimously in favor of excluding financial guarantee insurance from the coverage of the guaranty fund. \textit{1986 Proc. I 431}.

C. After the insolvencies of two large writers of surety business the federal government urged the NAIC to consider coverage of surety bonds under the guaranty association. It had not been the policy to do so because such bonds were generally associated with commercial ventures. \textit{1986 Proc. I 429}.

D. Clarification of the subsection was made in 1986. Originally the model only said “credit insurance” but the additional language was inserted to make clear other types of collateral protection insurance similar to credit insurance were also originally intended to be excluded. \textit{1987 Proc. I 450}.

E. In 1995 the NAIC considered an amendment to Subsection E to amplify the exclusion of coverage for insurance of warranties or service contracts. This provision was included in the package of amendments adopted in 1996. \textit{1995 Proc. 3rd Quarter 586, 1996 Proc. 1st Quarter 571}.

I. When model amendments were adopted in 1985, consideration was given to adding a subsection to exclude coverage for claims covered under a governmental insurance program. The exclusion was not adopted at that time, but instead Section 12 was amended to add a requirement to exhaust governmental benefits before the guaranty fund would be responsible for the claim. \textit{1986 Proc. I 296, 304}. In 1986 the Section 12 limitation was deleted and the exclusion contained in Subsection I added. \textit{1987 Proc. I 421}.
An industry association suggested that the comment at the end of the section be amended to note that the Life and Health
Insurance Guaranty Association Model Act addresses some of the lines of coverage excluded by this provision. 1994 Proc.
2nd Quarter 510.

When considering amendments to the model in the latter part of 1995, the working group agreed to add a comment at the end
of Section 3. It contained a definition of ocean marine insurance for states whose codes did not contain a definition, so that
there would be no question as to the coverages encompassed by the exclusion of ocean marine insurance. The working group
agreed to limit the exclusion to craft used for commercial purposes. The working group also decided not to include within the
Section 3
definition coverage written pursuant to the Jones Act or the Longshore and Harbor Worker's Compensation Act. It was the
opinion of the group that these coverages were properly classified as workers' compensation insurance. 1995 Proc. 3rd
Quarter 586.

Section 4. Construction

An industry association recommended that Section 4 be deleted because it added no substance to the model act. 1994 Proc. 2d
Quarter 510.

The working group recommended that the section be retained to encourage appropriate construction of the Act by the courts
and to lessen the likelihood that courts would strain to interpret the Act in a manner inconsistent with the intentions of the
drafters. The group did remove one word so that the model no longer said liberally construed. 1994 Proc. 3rd Quarter 419.

The Receivership Model Act Working Group voted to delete this section. A couple of regulators made a motion to restore the
original language. The argument was that the clause expanded the coverages provided by the guaranty associations. The Task
Force voted to retain the original language. 2008 Proc. 1st Quarter 10-440.

Section 5. Definitions

F. “Covered claim” was considered for modification in 1985. An industry draft suggested a net worth exclusion under which
no protection was extended to wealthy persons. The draft recommended exclusion of coverage for any claim in favor of a
person having a net worth of $50 million or more. It was their belief that an insured with that much net worth ought to buy
insurance intelligently enough so that it would not be insured by an unsound insurer. They suggested it was not good public
policy to send bills for such wealthy persons’ losses or claims to all of the homeowners and small business insureds to pay.

The net worth exclusion was adopted because of potential capacity problems for guaranty funds. The advisory committee felt
the suggested change would provide a more even balance between those who really need the protection of guaranty funds and

Just before adoption of the model revisions in December 1985, the Guaranty Fund Task Force voted to remove a net worth
limit of $10 million that had been included in the draft. A net worth provision was added instead to Section 11. 1986 Proc. I
294.

The National Committee on Insurance Guaranty Funds approved a document called “Guiding Principles for Settling Disputes
Between Property and Casualty Insurance Guaranty Associations as to Responsibility for Claims” and asked the NAIC’s
acceptance of the program. The purpose was to answer questions about which state’s fund should handle the covered claim.
A suggestion made to the working group considering amendments to the model in 1994 was to revise the definition of “covered claim” to make it clear that unearned premium claims are covered by the guaranty fund in the state where the policyholder resided at the time the policy was issued. 1994 Proc. 2nd Quarter 510.

The working group did not follow the suggestion because of a concern that the proposed revised language would be construed to limit the claims that would be covered. 1994 Proc. 3rd Quarter 419.

Just before adoption of the amendments by the working group, further discussion was held on the suggestion to assign coverage of an unearned premium claim to the guaranty association in the state where the insured resided at the time of issuance of the policy. One regulator said the proposed amendment would place an additional burden on receivers of insolvent insurers, who often must deal with policy records that are unorganized, inadequate or non-existent. Another regulator agreed the proposal could cause delays in paying claims and increase the workload of both receivers and guaranty associations. The working group agreed to defer action on the suggestion.

1994 Proc. 4th Quarter 575.

Amendments were considered again later in 1995 and Paragraph (2) was revised. It clarifies which guaranty association is primarily liable for the claim for property damage and does not narrow coverage. 1995 Proc. 3rd Quarter 586.

At a hearing on the proposed amendments held in early 1996 one regulator objected to this proposed amendment. An interested party responded that the amendment does not restrict guaranty association coverage, but only determines the guaranty association that has primary responsibility for a property damage claim. The purpose of the amendment is to clarify that the guaranty association in the jurisdiction where the property giving rise to the claim is located has primary responsibility for the claim. 1996 Proc. 1st Quarter 569.

An association of guaranty funds recommended that the exclusion from “covered claim” be expanded to exclude claims for reinsurance recoveries, contribution and indemnification brought by other insurers and to prohibit insurers from pursuing such claims against an insolvent company up to the guaranty fund limits. 1994 Proc. 2nd Quarter 510.

Paragraph (3)(d) was added in the 1994 revisions. It contains a net worth exclusion for first party claims by an insured whose net worth exceeds $25 million. The association of guaranty funds had suggested $10 million as the appropriate level. 1994 Proc. 3rd Quarter 419.

G. “Insolvent insurer” was modified in 1972 to change the definition from an insurer “authorized” to transact to one “licensed” to transact insurance. It was the intent of the NAIC committee which drafted the bill to provide coverage only for carriers licensed in the state. In other words, coverage was not to be included for unauthorized insurers since they were not subject to the state’s regulation for solvency. “Authorized” might have been construed to include eligible surplus lines insurers. 1973 Proc. I 155.

At the June 1976 meeting the industry advisory committee submitted a recommendation for an amendment to the definition of “insolvent insurer.” They contended the law was designed to apply to companies being liquidated, but the language of the model was not sufficiently precise to accomplish that limited objective. The suggestion to add specific language to clarify this point was not acted upon at that time. 1978 Proc. I 277. It was, however, adopted in December 1978. 1979 Proc. I 217.

The definition was revised in 1994 to require a final order of liquidation with a finding of insolvency. A drafting note explaining that “final order” means an order that has not been stayed was also included in the amendments. 1994 Proc. 3rd Quarter 419.
H. Paragraph (2) was added in 1994 to incorporate language concerning termination of membership and liability for assessment in the event of a termination. 1994 Proc. 3rd Quarter 419.

Section 6. Creation of the Association

Section 7. Board of Directors

A. This provision was modified to allow vacancies to be filled by a majority vote of the remaining board members. By the terms of the original model, it would have been necessary to call a meeting of all member insurers, which would have been extremely cumbersome. 1972 Proc. I 480.

An advisory group was asked to consider the issue of public representation on guaranty association boards in 1992. The committee report recommended against it, but one member proposed that a drafting note be added to include a provision for public representation on the board where the state had a premium tax offset. 1993 Proc. IB 703.

Section 7

One member of the advisory group submitted a minority report explaining her reasons for recommending public representation on guaranty association boards. The main reasons given by the consumer representative were because the public ultimately bears the cost of guaranty fund assessments, because a different perspective is needed, and because accountability is needed. 1993 Proc. I 707.

As a follow-up from that minority report, the working group decided to draft amendments to both the Life and Health Insurance Guaranty Association Model Act and the Post-Assessment Property and Liability Insurance Guaranty Association Model Act, which were designed to add two public representatives as members of the board of directors of the guaranty associations without increasing the overall number of members on the boards. The amendments also addressed potential conflicts of interest by requiring that the public representatives not be employed or contracted by any entity regulated by the state insurance department or required to register as a lobbyist in the state, or related to either. 1993 Proc. 2nd Quarter 619.

A representative from an association of guaranty funds said an earlier suggestion for public representatives failed to gain support because of a perception that the commissioner was the representative of the public. Another association representative said his organization’s position was that it was a public policy question for the legislatures to determine. The underlying question related to the individual members themselves: their expertise, accountability and responsibility. 1993 Proc. 2nd Quarter 619.

The consumer representative who authored the minority report restated her position. She believed that because the public ultimately bears the burden of insolventcies either through increased taxes or policy surcharges, the public was entitled to representation on the boards. Any problem experienced with incentive to attend meetings or structure of the board should be addressed separately from the overall issue of representation and should not result in a denial of representation of the public. 1993 Proc. 2nd Quarter 619.

In a letter of comment on the exposure draft providing for public representation, one association said it had developed a position opposed to public representation when the model was originally drafted. The association’s position was that there were substantial conflicts of interest in having consumers and other public representatives on the board. The state guaranty funds stand in the shoes of the insolvent insurer and must pay claims and decide coverage issues as the insolvent insurer would have done. Had the insolvent insurer remained solvent, it would not have had consumers involved in its internal claims process. 1993 Proc. 2nd Quarter 605.

The consumer representative said insurers also faced a conflict of interest because their interests were not aligned with those of policyholders either, but rather with the solvent insurers who paid the assessment. 1993 Proc. 2nd Quarter 619.
Another insurer association gave conditional support for the amendment. Its experience had been that qualified public representatives can make a positive contribution to board deliberations. The association expressed some concern about selecting qualified individuals who should be knowledgeable about the insurance industry. It recommended the draft be revised to require only one public member, who should not be eligible to serve as the chair of guaranty fund boards. 1993 Proc. 2nd Quarter 604.

Before the Executive Committee voted on adoption of the amendment regarding public representatives, further discussion took place. The chair of the Financial Condition Subcommittee said the purpose of the amendment was to improve communication among regulators, the insurance industry and consumers on guaranty fund and insurer insolvency issues. The addition of public representatives to the governing boards would provide consumers with access to the guaranty fund process and a direct means to express concerns. The addition of public representatives also recognizes the impact of insurer insolvencies on the general revenues of states and taxpayers. Another commissioner stated that he occupied a position on the guaranty association boards and acted as a public representative since it was his function to protect the public interest. A third commissioner said that public input into the guaranty fund process would be valuable, and that even though the commissioner’s function was protection of the consumers, the issue was one of direct public access. He did not favor inclusion of this provision in the financial regulation standards for accreditation. The chair of the subcommittee responded that this was not being recommended. 1993 2nd Quarter 32.

Section 7

Before final adoption the NAIC plenary body considered the matter again. Concern was expressed that this amendment would be required for a state to be accredited. After a sure that the amendments were not being considered, indeed were not even related to financial solvency, the model amendment was adopted. 1993 Proc. 2nd Quarter 12.

In 1994 language was added to Section 7A to allow the commissioner to appoint the initial members of the board of directors if not selected by the member insurers within 60 days. A provision was also added to allow the commissioner to fill any vacancies in position held by public representatives. 1994 Proc. 3rd Quarter 419.

Late in 1995 the working group reviewing suggestions for change to the model recommended that Subsection A be amended to simplify the qualifications for serving as a public member of the board of directors of a guaranty association. 1995 Proc. 3rd Quarter 586.

The amendment to Subsection A was adopted in 1996, as well as the drafting note following the subsection. 1996 Proc. 1st Quarter 573.

Section 8. Powers and Duties of the Association

One of the major areas of concern when initially drafting the model was the manner in which the guaranty function was to be performed. Should the program be administered by the commissioner or through an industry association? What functions should the group perform? Shall they be authorized to delegate functions to a servicing insurer? 1970 Proc. I 263.

A. The drafters started with the promise that the first draft should be a post-assessment rather than a prefunded plan. Then a number of decisions needed to be made in determining those assessments. Should insurers be assessed by lines of business? What, if any, should the maximum rate of assessment be? Should assessments be recognized in the making of premium rates? 1970 Proc. I 263.

Paragraph (3) of this subsection was amended in December 1971. As the model existed before, if the amount raised by a maximum assessment was insufficient to pay all covered claims, the association would have to marshal all the claims before it
could make any payment on any one particular claim. Language was added giving the association the right to pay claims in the order it deemed reasonable, thus avoiding administrative problems and delay. 1972 Proc. I 480.

A second amendment in December 1971 provided that if a company had deferred payment of an assessment due to its financial condition, that company could not pay any dividends to shareholders or policyholders during the period of deferment, and would have to pay the deferred amount as soon as payment would not reduce capital or surplus below required minimums. 1971 Proc. I 480.

A December 1978 amendment added a sentence to the last paragraph of Subsection A(1) to eliminate claims filed after the final date set by the court for filing claims against the liquidator. 1979 Proc. I 217.

The model originally contained a $100 deductible provision that was deleted in December 1980. At the same time a sentence was added at the end of Subsection A(1) to pay only the amount of unearned premium over $100. The reasoning for this was that certain consumers bore a disproportionate share of the losses; if there were no deductibles, the losses would be borne more equitably by all insureds. The administrative costs of handling the deductibles were high in relation to the amounts involved, sometimes exceeding what would have been paid out in claims. 1981 Proc. I 225, 228.

The most notable of the amendments to the model act considered in 1994 included deletion of the $100 deductible for unearned premium claims. 1994 Proc. 4th Quarter 574.

The working group was asked to consider deletion of the provision that allows the guaranty fund to pay only that portion of an unearned premium claim in excess of $100. In support of his proposal, the regulator said his state’s receiver spent $91.18 in costs to adjudicate each policyholder claim for the deductible. He said the substantial number of these claims filed a lso
Section 8A (cont.)

creates an administrative burden, as well as depleting assets of the insolvent insurer. An industry spokesperson said the industry favored the deductible because it had the effect of spreading the loss due to insolvency and also reduced the cost of each insolvency to the guaranty association. The working group decided to recommend the deletion of the provision for the deductible. 1994 Proc. 3rd Quarter 419.

Several industry associations commented on the proposal to delete the $100 deductible and indicated a desire to retain the provision. A regulator responded that the costs to the estate associated with the deductible were out of proportion to any benefit to policyholders. Another regulator said she received numerous complaints from policyholders about the application of the deductible to their claims. Another regulator said that, although guaranty associations might initially derive some cost savings from the deductible, those savings were offset by the cost to the estate, which ultimately results in less money available for distribution to policyholders, guaranty associations and other creditors. Another added that the necessity of processing claims for the deductible unnecessarily prolongs the administration of estates, which is detrimental to the guaranty association. A guaranty association representative argued that the cost savings related to the deductible was important to guaranty associations. He said in one state it was estimated that the deductible had resulted in savings of more than $13 million. He suggested other options for addressing the issue, including an exclusion of nominal claims from payment by the receiver and lowering the priority of claims for reimbursement of the deductible. He said costs of the guaranty associations are passed on to the public through rate surcharges and premium tax offsets, and that it was appropriate for policyholders to share some of the costs associated with an insolvency. After much discussion the working group decided to dispense with the deductible for unearned premium claims. 1994 Proc. 4th Quarter 574-575.

The amendments adopted in December 1985 included a revision of this section, including a limit of $10,000 per policy for claims on return of unearned premiums. The advisory committee also suggested a limit of $50,000 on non-economic loss, but this suggestion was not adopted. 1986 Proc. I 300, 344.

In 1986 an alternative provision was drafted to give the liquidator authority to sell a limited extended reporting period to insureds of an insolvent company that would provide coverage for the time period for filing claims with the liquidator. To prevent inconsistencies the time period was set for 18 months. 1986 Proc. II 409-411. This provision was adopted six months later. 1987 Proc. I 421.

Revisions were made to this section in 1994 to eliminate the alternative section that had been included for states with a provision in the liquidation law giving the liquidator authority to sell a limited extended reporting period for claims made policies. 1994 Proc. 3rd Quarter 424-425.

The last sentence of the subsection originally read “Each member insurer may set off against any assessment authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer.” That sentence was deleted as being unnecessary and a potential cause of conflict. 1987 Proc. I 450.

Section 8A(1) was amended to be consistent with the revised definition in Section 5G by replacing “determination of insolvency” with “order of liquidation.” Language was added at the end of Paragraph (1) that provided that the association’s duty to defend ceased upon payment or tender of an amount equal to the lesser of the association covered claim limit or the applicable policy limit. 1994 Proc. 3rd Quarter 419.

Late in 1995 a working group considering amendments to the model discussed a proposal from a group suggesting a change to the provision regarding the date at which liability to the guaranty association is cut off and discussed the exclusion from coverage of policyholder protection claims. After lengthy discussion the regulators decided not to recommend the proposed amendments. The group also considered amending Paragraph (1)(b) to provide for an aggregate limit of $10 million per insured. 1995 Proc. 3rd Quarter 586.
Members of the working group expressed their support for the idea of an aggregate limit per insured in general, but raised some specific concerns with the proposal. These concerns included the difficulty of application of the aggregate limit if not adopted uniformly by all states and whether the amendment would create an incentive for a guaranty association to delay claim payments so that payments by other guaranty associations would satisfy the limit, thereby avoiding its statutory responsibility. Another concern was that guaranty association coverage would be exhausted by those who filed claims early, leaving other claimants without any coverage. 1996 Proc. 1st Quarter 569.

The working group decided to adopt the proposed package of amendments without including the aggregate limit, but to consider a revised proposal in the future. 1996 Proc. 1st Quarter 570.

A provision was added to Paragraph (2) authorizing the association to pursue and retain salvage and subrogation as to claims paid by the association. 1994 Proc. 3rd Quarter 419.

An association of guaranty funds recommended that the guaranty funds have the exclusive right to appoint and direct legal counsel retained to defend liability claims. The working group decided to add a provision to Paragraph (4) giving the association the right to choose legal counsel for the defense of covered claims. 1994 Proc. 3rd Quarter 419. Section 8 (cont.)

B. A suggestion was made by an association of guaranty funds to amend Subsection B(3) to afford guaranty associations the right to intervene in a proceeding involving an insolvent insurer. Some members of the working group expressed concern that this provision would result in the estate incurring unnecessary litigation expenses. Another concern expressed was that other creditors would, by extension, also be granted a right to intervene. One regulator felt that guaranty associations should not have rights superior to those of other creditors. No amendments to this subsection were included in the recommendations adopted in 1996. 1995 Proc. 3rd Quarter 586, 1996 Proc. 1st Quarter.

C. The working group agreed to create an optional Subsection C providing a method of raising funds in excess of the association’s normal assessment capacity to pay claims resulting from a natural disaster. This provision was patterned after legislation already enacted in one state. 1995 Proc. 3rd Quarter 586.

The amendments adopted in 1996 included an optional Subsection C and a comment on that subsection. 1996 Proc. 1st Quarter 576.

Section 9. Assessments

Section 10. Plan of Operation

To supplement the model bill a separate model plan of operation was also adopted. 1970 Proc. IIB 1092-1096.

When considering revisions to the model in 1994, a suggestion was made to the working group that provision be made for disposition of dividends and other advances received by a guaranty fund from an estate. 1994 Proc. 2nd Quarter 510.

Section 11. Duties and Powers of the Commissioner

A. The second sentence was added to Paragraph (1) in December 1972. Receipt of a copy of the commissioner’s petition for insolvency upon the filing of such a petition with a court would assist the guaranty funds in beginning to prepare to handle an insolvency once declared by a court of competent jurisdiction. 1973 Proc. I 156.

B. Subsection B contained a provision requiring the association to notify insureds and other interested parties of the insolvency. This provision was deleted in 1994. 1994 Proc. 3rd Quarter 420.
Section 11. Effect of Paid Claims (Previous version of model)

In 1975 the drafters considered an amendment which would have given guaranty funds immediate access to insolvent company assets, declare the guaranty funds priority creditors, and offer a “rescue” funding mechanism. 1976 Proc. I 296.

The recommendation was not adopted by the executive committee, but was sent back to the drafting task force. 1975 Proc. I 9.

B. On a close vote the Guaranty Fund Task Force decided to include an amendment to this section limiting covered claims to claimants whose net worth was under $50 million. All of Subsection B was new material added in December 1985. 1986 Proc. I 340, 347.

The task force generally favored the net worth exclusion as long as third-party liability claimants who may not have a sufficient net worth were protected. This approach would serve as an incentive to risk managers for commercial insureds to shop wisely in placing their insurance. 1986 Proc. I 431.

The footnote in Subsection B was added to clarify the original drafter’s intent that the net worth provision apply to workers’ compensation claims. 1987 Proc. I 451.

A working group considering amendments in 1995 was asked to lower the net worth exclusion to $25 million but declined to make that recommendation. 1995 Proc. 3rd Quarter 586.

C. In 1994 Subsection C was substantially amended to clarify the rights of the association as claimant in the estate of an insolvent insurer and to require receivers to accept settlements of covered claims and determination of covered claim eligibility by guaranty associations. 1994 Proc. 3rd Quarter 420.

In late 1995 an amendment was proposed to Subsection C to address the concern of some members that guaranty association determination of covered claims not affect the receiver’s adjudication of excess claims. 1995 Proc. 4th Quarter 728.

A second issue identified by the working group was whether the receiver should be bound to accept the guaranty fund’s determination of a covered claim and the amount paid by the guaranty fund in satisfaction of the claim. The suggested amendments addressed the concerns of regulators. 1995 Proc. 4th Quarter 728.

Section 12. Exhaustion of Other Coverage (Previous version of model)

Section 12 was titled “Nonduplication of Recovery” from the time the original model was adopted in 1962. The title was changed in 1996 to better reflect the intent of the section. 1996 Proc. 1st Quarter 570.

A new Subsection B was added in December 1985 requiring a person with any right of recovery under a governmental insurance program to exhaust his right there first before submitting a claim to the guaranty association. 1986 Proc. I 296, 304. A year later this paragraph was deleted and the model returned to its original language. Instead Section 3 was amended to add an additional subsection excluding any insurance provided by or guaranteed by the government. This would have the effect of excluding flood and crop hail insurance guaranteed by the federal government from covered claims. 1987 Proc. I 421.

A. In 1994 Subsection A was amended to clarify that “other insurance” was not limited to coverage provided by a member insurer. 1994 Proc. 3rd Quarter 420.
Protection against insolvency is one of the paramount objectives of insurance regulation. Two approaches are used to achieve this objective. First, insolvency funds have been created to afford protection when insolvencies actually occur. Second, statutes have armed insurance departments with various regulatory standards, procedures and tools to prevent or reduce the likelihood of insolvencies. The drafters also questioned whether additional insolvency preventive measures should be incorporated in the model bill.

1970 Proc. I 263

The section was rewritten in 1983 at the urging of the guaranty funds because they felt the section imposed duties on the guaranty funds boards which were more appropriately carried out by insurance departments. 1983 Proc. I 350. The recommended changes allowed interaction between the guaranty funds and the insurance commissioners. 1984 Proc. I 326.

A. The old Subsection A was deleted in 1994 to address antitrust concerns. It had required the board of directors to make recommendations to the commissioner for ways to detect and prevent insolvency and to discuss and make recommendations about the status of any member insurer whose financial condition might be hazardous to its policyholders. This was replaced with a provision authorizing the board of directors to make general recommendations concerning solvency regulation. 1994 Proc. 3rd Quarter 420.

Section 13. Credits for Assessments Paid (Tax Offsets) – OPTIONAL

A regulator stated that the E Committee requested the Task Force reconsider a solution regarding assumed claims transactions. Another regulator stated that the Working Group considered the topic twice and agreed that something should be covered by the guaranty associations. A regulator suggested optional language to avoid controversy and ensure a timely response. After extensive discussion, the Task Force agreed to further study the issue. 2008 Proc. 2nd Quarter Vol. II 10-490 to 10-492.

A regulator recommended including two options – one option where assumed business was covered, and a second option where assumed business was not covered. Another regulator explained a third option as having two parts. This alternative would be a way to take care of all assumed claims, not necessarily with guaranty fund coverage but by means of a segregated account. The Task Force discussed comments received on these options and whether drafting notes would resolve the issue. A commissioner summarized the four existing options and the potential fifth option. The Task Force decided to draft a background summary and finalize a decision at the 2008 Fall National Meeting. 2008 Proc. 3rd Quarter Vol. II 10-368 to 10-370.

A commissioner stated that the Committee requested that the Task Force reconsider the assumed business language by considering optional language. A regulator stated that Option Three appeared to be an interim step for when insolvency takes place before a company issues their own policies. This option would be a way to handle the previous incurred losses before the assumption. The Task Force discussed issues related to this option. 2008 Proc. 4th Quarter Vol. II 10-622.

A commissioner stated that Option Four followed Virginia Law. An interested party stated that Option Four is the mechanism by which Virginia implemented Option One. A regulator asked for clarification on the options. Another regulator said that Option Five was an attempt to be in the middle ground. The Task Force discussed the various aspects of Option Five. An interested party stated that he had an alternative that achieved Option Five’s goal through a different mechanism. Another interested party stated that the option they were most supportive of was Option Three. This option leaves parties as close as possible to the position into which they put themselves while still providing relief on a going forward basis for those people finding themselves with a new insurer, but after the transaction date, their claims would be covered just as if they had been issued by the assuming carrier. The Task Force discussed the pros and cons of Option Three. A regulator polled the members on the different options. Options One and Five, received positive support from the majority. Options Two and Three did not receive support. 2008 Proc. 4th Quarter Vol. II 10-624 to 10-625.

The Task Force voted to send Option One and Option Five to the Financial Condition (E) Committee as optional language within the model. 2008 Proc. 4th Quarter 10-626.
At the December 1972 meeting of the NAIC Property and Liability Guaranty Fund Subcommittee, it was suggested that a task force consisting of both regulators and industry actuaries and rate-making personnel create a recoupment formula under the model law. 1973 Proc. 1395.

The task force made the following recommendations: (1) In making rates consideration should be given to past assessments paid. It is the intent of the guaranty fund law that the assessments are to be borne by the policyholders eventually through their premium payments. (2) The language is quite clear on the point that, if assessments have been paid, rates are not to be considered excessive because they contain an amount to recoup the assessments paid. Because rate-making is prospective in nature, the rating law required that due consideration be given to prospective expenses as well as past expenses. (3) The task force recommended numeric formulas considering available information from prior insolvencies covered by guaranty funds. 1973 Proc. II 396-397.

In 1995 the working group recommended the deletion of the assessment recoupment formula because it appeared that the formula had not been utilized by any state. 1995 Proc. 3rd Quarter 586.

Section 17. Immunity

An amendment to this section was made in December 1986. The words “... for any action taken or any failure to act by them ...” were added to strengthen the immunity and reflect more clearly the intent of the drafters. 1987 Proc. I 451.

A provision was added in 1994 amendments to extend immunity to those persons substituting for a member of the board of directors. 1994 Proc. 3rd Quarter 420.

Section 18. Stay of Proceedings

Three years after the model was originally adopted, a change was made allowing a proceeding to be stayed for six months instead of the 60 days in the original model. It was found that the records of an insolvent company were in many cases nonexistent, and it took time to determine what actions were pending. The amendment allowed the association up to six months within which to prepare a proper defense, and such time thereafter as the court may grant in its discretion. 1973 Proc. I 156.

The liquidator of an insolvent insurance company was reluctant, in some cases, to turn over the insolvent company’s claims files to the servicing carrier. Because the association couldn’t function without access to the insolvent company’s files, the second paragraph of Section 18 was added. 1973 Proc. I 156-157.

The language in the first sentence of this section was modified to remove the words “up to” which had preceded “six months.” It was the view of the committee that the words “up to six months” imposed an unnecessary restriction upon the staying power of the court. 1987 Proc. I 451.

An association of guaranty funds recommended that the stay be extended to the claim filing deadline to allow the guaranty funds more time to obtain and review claim files and determine what actions need to be taken. 1994 Proc. 2nd Quarter 511.

The drafting group declined to follow the suggestion and recommended retention of the six-month period. The group did, however, add a provision allowing the association to waive the stay in instances where circumstances justify or require quicker action. 1994 Proc. 4th Quarter 588.
PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION MODEL ACT

Proceedings Citations
Cited to the Proceedings of the NAIC

Section 18 (cont.)

A set of general comments had been included after Section 18 with further suggestions for drafters. When amendments were considered in 1994, one suggestion was to omit these comments. An insurer association suggested that many comments in the model were outdated and no longer applicable and should be deleted. 1994 Proc. 2nd Quarter 521.

Chronological Summary of Actions

June 1969: Model adopted.
December 1971: Amended Section 7 to provide method for filling board vacancies and Section 8 to allow payment of claims in any order deemed reasonable.
December 1972: Amended definition of insolvent insurer and added procedures to assist the guaranty association in its duties.
June 1973: Recoupment formula adopted.
December 1978: Revised definition of insolvent insurer and added sentence to limit covered claims to those timely filed.
December 1980: Eliminated $100 claims deductible but added sentence to retain $100 unearned premium deductible.
December 1983: Modified Section 13 to aid in detection and prevention of insolvencies.
December 1985: Extensive amendments adopted to clarify and limit scope of act, to add definitions of “claimant” and “control” and to expand section on limits of payments. The net worth limit in Section 11 was added.
December 1986: Amendments adopted to provide for extended reporting period endorsement of a claims-made policy, to exclude flood and crop hail damage insurance provided or guaranteed by the federal government, and to make technical amendments.
September 1993: Adopted amendment to Section 7 to provide for public representatives on the guaranty fund board.
March 1995: Adopted amendments to clarify and update the model.
June 1996: Adopted amendments to clarify and update the model.
January 2009: Adopted amendments to clarify and update the model.
Restructuring Mechanisms

*An NAIC White Paper*

October 22, 2021

Created by the
Restructuring Mechanisms (E) Working Group
of the
Financial Condition (E) Committee
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June 2020

Section 1: Overview of IBT and Corporate Division Laws and Mechanics

A. Introduction

Insurance is a business that sells a promise to pay upon the occurrence of a future event. Policyholders may submit claims many years into the future on covered losses incurred during the policy period requiring insurers to record a liability for these incurred but not reported claims. As such, it is nearly impossible for an insurer to decide to discontinue writing a certain line of business and pay off all its legal obligations to its policyholders because there are almost always unknown potential future policyholder obligations that have not yet been reported. Policies previously written on a line of business that is no longer being written creates a block of business that may no longer be the focus of the insurer’s business model and left to slowly runoff. For some insurance companies, runoff business remains embedded with the core business without the ability to segregate the runoff business. There are even runoff specialists that have developed within the insurance industry that specialize in handling these old blocks of business.

Until recently, U.S. insurance companies wanting to restructure their liabilities had been limited to sale, reinsurance/loss portfolio transfers or individual policy novation. Other than individual policy novation, these solutions do not provide finality as the ultimate liability remain with the original insurer. The only way to transfer a block of business with finality is an individual policy novation. However, the current process of novating individual policies is considered by the industry to be inconsistent among the states, cumbersome, time-consuming, and expensive. The industry suggests that in many instances it will be impossible to obtain positive consent to a novation from all policyholders, especially on older books of business where policyholders are difficult to locate.

The NAIC has addressed aspects of this issue in the following two previous white papers. In 1997, the Liability-Based Restructuring Working Group of the NAIC Financial Condition (EX4) Subcommittee issued a paper titled “Liability-Based Restructuring White Paper.” (See Attachment 1.) The white paper focused on the efforts by property and casualty insurers attempting to wall off “material exposures to asbestos, pollution and health hazard (APH) claims and other long-tail liabilities” from current insurer operations. The white paper achieves this focus by inclusion of various section on related topics as well as multiple appendices. In 2009, the Restructuring Mechanisms for Troubled Companies Subgroup of the Financial Condition (E) Committee issued a white paper titled “Alternative Mechanisms for Troubled Companies.” (See Attachment 2.) The white paper focuses on troubled companies although it also addresses the statutory restructuring mechanisms available in the United States (“US”) at that time. This white paper similar to the 1997 white paper, also includes a number of sections on related topics as well as multiple appendices.

Over the past few years, states have begun enacting statutes which provide opportunities for restructuring of insurance companies with finality. The purpose of this white paper is to update the 1997 and 2009 white papers and provide explanation of these new statutory processes. These processes can be

1 For purposes of this paper “runoff business” is defined as a block of insurance business that is no longer being actively written by an insurance company and no premiums are being collected, except where required to in accordance with contractual or regulatory obligations, and where the existing or assumed group of insurance policies or contracts are managed through their termination. This definition was developed based on comments received by the Restructuring Mechanism Subgroup from both regulators and industry interested parties; however, this definition has not yet been adopted by the subgroup.

broken down into two categories generally referred to as insurance business transfer (“IBT”) and corporate division (“CD”). Several states, including Arkansas, Oklahoma, Rhode Island, and Vermont, have enacted IBT statutes while other states such as Arizona, Connecticut, Illinois, Iowa, Arkansas, Pennsylvania, and Michigan have enacted CD statutes. The stated intent of all these statutes is to enable insurers to take advantage of the statutory process in order to enhance their ongoing operations.

This white paper will discuss and explore these laws within the US and identify the various regulatory and legal issues involving IBT and CD legislation. This white paper is not intended to establish an official position by the NAIC regarding IBTs or CDs. The authors suggest that each state and its various regulatory authorities should make their own determinations on how best to proceed within their respective jurisdictions. In addition, this paper is not intended to address every situation a company may encounter and leaves possible situations to each insurer as well as the review and approval of all applicable regulatory authorities. Because the robust procedures used in the United Kingdom (“UK”) are seen as a means to utilize IBT in the US, the procedures are discussed in Section 2 of this white paper.

A separate workstream was created to develop financial standards appropriate in US to evaluate IBT and CD transactions. Some stakeholders question whether, even with robust standards, adequate consumer protections would exist when IBTs and CDs are utilized. Therefore, this white paper includes a discussion of a UK case which discussed consumer protection issues.

This is a constantly changing area with states adding and amending statutory provisions and considering new and unique transactions on a continuous basis. Therefore, the factual statements in this whitepaper should be considered a “point in time” discussion.

B. Purposes

During the course of the Restructuring Mechanisms (E) Working Group’s (“Working Group”) discussions, stakeholders identified a number of potential purposes for restructuring transactions. Testimony indicated that reinsurers and insurers were looking for new solutions that provide legal and economic finality to runoff insurance risks to improve the efficient allocation of capital and management resources to runoff and on-going insurance operations. Efficiencies that are obtained through restructuring transactions include the segregation and transfer of runoff books of business with the intent to free up capital, better allocate specialized management resources currently being occupied with the oversight of disparate discontinued and on-going businesses and rationalize and facilitate the runoff of discontinued lines of business. Experience outside the US, including in the UK, has shown that prudent allocation of reserves and management of runoff books of business reduces volatility and improves capital efficiency with benefits for reinsureds and policyholders of both runoff and on-going books of business. Furthermore, runoff experts bring focused expertise to managing runoffs compared to on-going enterprises. The focus of an on-going enterprise is the continual generation of increased premium growth. Runoff business can be both a distraction to management’s focus as well as distract regulatory focus away from the insurer’s on-going business. The isolation of such business from on-going business enhances the visibility of those runoff operations as well as the supervision of runoff operations, by both regulators and the insurer.

Advocates of these restructuring mechanisms argue that efficiencies resulting from the segregation and specialized management of disparate books of business result in transferring insurers releasing resources and allowing these insurers to better focus on improving current operations. Transferring insurers can better focus on core areas, leading ultimately to better service for current and future policyholders and better service for runoff policyholders. In many cases, the runoff business consists of long-tail lines, such
as mass tort, asbestos, environmental and general liability risks. These long-tail lines tie up financial and management resources which are out of proportion compared to the size or importance of the runoff book within the insurer.

As described in the 1997 white paper, restructuring of insurers can be initiated for several reasons that provide value to the insurer. These reasons include restructuring for credit rating, solvency, more effective claims management, need to raise capital and a desire to exit a line of business.³ With respect to capital and earnings volatility, the 1997 white paper explained that restructuring could allow liabilities to be separated thereby creating the ability to dedicate surplus to support restructured operations, eliminating the drag on earnings in its on-going operations and avoiding further commitment of capital for pre-existing liabilities.⁴ One restructuring expert indicated there were three primary reasons that an insurer may choose to restructure: (1) regulatory, capital and earnings volatility; (2) finality of economic transfer and (3) operational efficiencies.⁵

Of note, restructuring mechanisms may also be beneficial for purposes of credit ratings. Credit ratings are often looked at in terms of capital volatility. Credit rating agencies may take a more favorable view of an insurer that has been able to isolate a particular risk which may be more volatile and subject to further reserve development. However, rating agencies also consider the strength of the insurance group when issuing insurance financial strength ratings, which can negate the credit rating benefit that may be found in restructuring. Ratings are critical for insurers that are writing new business in which the rating has value to potential new customers. While insurance groups use different strategies, it is common that some insurers within a particular insurance group are more critical to the ongoing success of the insurance group as a whole. It is therefore not uncommon for rating agencies to recognize this fact and provide separate ratings for individual insurers within an insurance group. While these considerations can lessen the value of restructuring for credit rating in some instances, insurance groups do still choose to restructure for credit rating purposes.

C. Regulator Concerns with Restructuring Plans

While restructuring may provide value to the insurer, regulators are concerned that restructuring does not create new resources from which claims can be paid. Restructuring should not be utilized to allow insurers to escape these liabilities or separate claims in a manner that provides less capital than is needed to satisfy the insurer’s obligation. Restructuring plans that place solvency at risk or threaten consumer benefits will be faced with challenges from regulators. However, when regulators are shown that the restructuring plan benefits both the insurer and the insured, then the regulator may be willing to approve the restructuring plan. Regulators have utilized procedures to ensure the resulting structure will have sufficient assets, both as to quality and duration, to meet policyholder and other creditor obligations. One of the recommendations of this white paper is to memorialize and standardize those procedures.

Section 2: History of Restructuring in the United Kingdom

⁵ David Scasbrook (Swiss Re America Holding Corporation) as stated during the April 6, 2019 meeting of the Restructuring Mechanisms (E) Working Group.
A. Part VII Transfers in the United Kingdom

IBT and CD laws and regulations are relatively new in the US, but the legal mechanism for the transfer of insurance business has been implemented and operational in the UK for over twenty years. Part VII of the Financial Services and Markets Act of 20006 (“Part VII” and “FSMA”) enables insurers to transfer portfolios of business to another insurer subject to court approval. At the time of this writing, more than 307 successful Part VII transfers have taken place in the UK providing guidance to American insurers on how this process could continue to unfold in the US.

A Part VII transfer is a regulatory mechanism, governed by sections 104–116 within Part VII of the FSMA. This act allows an insurer or reinsurer to transfer long-term as well as general insurance business from one legal entity to another, subject to approval of a court. Many insurers use the procedure to give effect to group reorganizations and consolidations. Part VII transfers have also been used extensively in response to Brexit.

In accordance with the FSMA, the Prudential Regulatory Authority (“PRA”) and the Financial Conduct Authority (“FCA”) maintain a Memorandum of Understanding which describes each regulator’s role in relation to the exercise of its functions under the FSMA relating to matters of common regulatory interest and how each regulator intends to ensure the coordinated exercise of such functions. Under the Memorandum of Understanding, the PRA will lead the Part VII transfer process and be responsible for specific regulatory functions connected with Part VII applications, including the provision of certificates.

Section 110 of the FSMA allows both the PRA and the FCA to be heard in the proceedings. The Memorandum of Understanding confirms that both the PRA and the FCA may provide the court with written representations setting out their views on the proposed scheme, and the PRA may prepare a report regarding the IBT.

As set out in the Memorandum of Understanding, before nominating or approving an independent expert under section 109(2)(b) of FSMA . . . the PRA will first consult the FCA. Further, the PRA will consult appropriately with the FCA before approving the notices required under the Business Transfers Regulations.

Part VII transfers require a “scheme report.” This report is similar to the independent expert report under US IBTs, however, because the word “scheme” has a different context in the US, the word “scheme” is not used. Under section 109(2) of FSMA an independent expert report may only be made by a person:

(a) appearing to the PRA to have the skills necessary to enable him to make a proper report; and

(b) nominated or approved by the PRA.


The regulators expect the independent expert making the report to be a neutral person, who:

(a) is independent, that is any direct or indirect interest or connection he, or his employer, has or has had in either the transferor or transferee should not be such as to prejudice his status in the eyes of the court; and

(b) has relevant knowledge, both practical and theoretical, and experience of the types of insurance business transacted by the transferor and transferee.

The PRA may only nominate or approve an independent expert appointment after consultation with the FCA. An independent expert report must accompany an application to the court to approve the Part VII transfer plan. The independent expert report must comply with the applicable rules on expert evidence and contain the specific information set forth in the statute.

The purpose of the independent expert report is to inform the court. The independent expert, therefore, likely has a duty to the court. Further, policyholders, reinsurers, regulators, and others affected by the Part VII transfer will be relying on the independent expert report. For these reasons, a detailed report is necessary. The amount of detail that it is appropriate to include will depend on the complexity of the transfer, the materiality of each factor and the circumstances surrounding each factor.

During the Working Group’s discussion of the Part VII transfers, consumer representatives raised the UK court’s decision in *Prudential v Rothesay*⁸ which imposed several limitations on Part VII transfers. On August 16, 2019, the High Court of Justice issued an opinion rejecting a Part VII transfer between Prudential Assurance Company Limited and Rothesay Life PLC. This Part VII plan was the subject of a four-day hearing in which each insurer was represented by counsel, the PRA and FCA appeared, and a number of policyholders appeared in person. The Court noted that both the PRA and the FCA each produced reports regarding the plan, and both stated that they did not object. The independent expert filed a detailed report that ultimately did not reject the plan either.

The applicant received approximately 7,300 responses from policyholders in response to the approximately 258,000 policyholder packets that were sent out. Of those, about 1,000 were characterized as an objection. The main objection to the plan was that these consumers specifically selected the transferring insurer as their provider. These consumers argued that they should not have their annuity transferred against their will to a smaller insurer with a very different history and reputation just to further the commercial and financial purposes of the transferor.

This decision was appealed and ultimately overturned. The UK Court of Appeals⁹ found that the lower court incorrectly exercised its authority finding amongst other things, that the judge was wrong to

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⁸ As noted by Birny Birnbaum (Center for Economic Justice—CEJ) during the Dec 8, 2019 Meeting of the Restructuring Mechanisms (E) Working Group. Note this was overturned by The Prudential Assurance Company Limited v. Rothesay Life PLC [2020] EWCA Civ 1626.

⁹ *Prudential Assurance Company Ltd and Rothesay Life Plc, Re*, England and Wales Court of Appeal (Civil Division)(Dec. 2, 2020).
give weight to (i) the different capital management policies of both insurers; and (ii) the objections of a small subset of policyholders.

In so holding, the Court of Appeals stated:

(1) The Court below was wrong to decide that both the independent expert and PRA were not justified in looking at the solvency metrics at a specific date to support their conclusions.

(2) The Court below was wrong to find a material disparity in the parent company structure since the parent companies could never be required to provide support to their subsidiaries’ capital.

(3) The Court below should not have accorded any weight to the fact that the policyholders had chosen Prudential based on its long-established reputation, age, and venerability nor to the fact that they had reasonably assumed that Prudential would be their annuity provider throughout its lengthy term.10

Despite this set of complex UK decisions, the Part VII transfer continues to be used in the UK and watched closely by the US regulators and stakeholders.

B. Differences between Part VII and Solvent Schemes of Arrangements

Solvent schemes of arrangement are another method of restructuring that exists within the UK. These are primarily designed as a procedure that can allow all liabilities to be settled for an insurer. In doing so, it can achieve many of the objectives set out in this white paper. However, unlike the Part VII transfer, the policies are subject to a court ordered termination instead of transferred. While such an arrangement may provide some of the same features as a Part VII transfer the solvent scheme does not continue the coverage with a new insurer the way a Part VII transfer does. Other differences may exist in law but are not deemed to be relevant to this specific white paper.

Section 3: Survey of US Restructuring Statutes and Regulations

Various states have enacted corporate restructuring statutes or regulations. Those generally following the UK structure began with Rhode Island in 2002 adopting a statute titled Voluntary Restructuring of Solvent Insurers11 patterned after Solvent Schemes of Arrangements. This type of process was renamed Commutation Plans and differs from the UK law in a number of areas including an enhanced role for the regulator, designating the independent expert as a consultant to the regulator and limiting the process to commercial property and casualty risks. One commutation plan was adjudicated by the Rhode Island court in 2011 and withstood a constitutional challenge. The written decision in that case addressed many of the issues raised with restructuring plans generally.12 Commutation Plans continue to be available under RI law.

10 Id. at Page 6 of Appeal Nos: A2/2019/2407 and 2409 Case No: 1236/5/7/15
In 2015 Rhode Island adopted an Insurance Business Transfer Plan regulation structured similar to the Part VII transfers. Again, in contrast to the UK, the regulation provides an enhanced role for the regulator, designates the independent expert as a consultant to the regulator and limits the process to commercial property and casualty risks. The RI regulation provides for notice at the time the plan is filed with the regulator and an ability to comment at that time. If the regulator, after a thorough review of the Plan and comments received, continues to believe that it meets the statutory requirements, it will authorize the Plan to be filed with the Court. The Court will require notice to policyholders and hearings to allow all comments and objections to be considered. A Rhode Island domestic insurer has been formed specifically to undertake IBTs, but a plan has not yet been filed with the regulator.

In 2013, Vermont adopted the Legacy Insurance Management Act (“LIMA”). LIMA is limited to surplus lines risks and reinsurance, involves department approval but not court approval and allows policyholders to opt-out of the plan. As of this date, no transactions have been completed under LIMA.

In 2018, Oklahoma adopted the Insurance Business Transfer Act modeled after UK’s Part IV regulation with a few significant differences. The differences include no restriction on the type of insurance nor restrictions on the age of the business. Oklahoma law provides for both insurers to nominate a potential independent expert with the Insurance Commissioner appointing one or another if he or she is not satisfied with the nominations. The independent expert report is submitted with the IBT application to the Oklahoma Insurance Department which approves the IBT plan to be submitted to the court upon satisfactory showing that statutory standards are met. The court requires notice and opportunity to be heard prior to court approval of implementation of the plan. As of this writing, Oklahoma has completed two IBTs in October 2020 and September 2021, involving a Rhode Island and Wisconsin insurer respectively, which are described below. Neither of the plans were challenged in the state court proceedings.

In 2021, Arkansas adopted the Insurance Business Transfer Act which is based on the Oklahoma and Rhode Island statutes. The key differences are: the assuming insurer must be licensed in each line of business in each state where the transferring insurer is licensed unless an exception is made for an extraordinary circumstance; specific factors are provided in the Arkansas IBT law that the Commissioner must consider before approving the IBT including the impact on contract holders and reinsurers in addition to policyholders; additional guidance on what would be a material adverse impact; specific guidance for proposed long-term care IBTs and additional requirements for the expert opinion report.

The National Council of Insurance Legislators has promulgated a model IBT law modeled after the Oklahoma IBT statutes, as well as a model CD law. A number of states have adopted CD statutes, whether specific to insurance or based on the state’s general power over corporations. Those states include Arizona, Connecticut, Illinois, Iowa, Michigan, Arkansas, and Pennsylvania. All of these statutes allow for corporate restructures. As discussed in more detail below, Pennsylvania and Illinois have each completed CD transactions.

13 230 RICR 20-45-6.
15 Insurance Business Transfer Act, OKLA. STAT. tit. 36, §§ 1681 et seq.
A. Similarities and Differences between Statutes

Rhode Island’s IBT law permits transfers of property and casualty commercial blocks of business that have been closed for at least 60 months. In contrast, Oklahoma and Arkansas IBT laws permit transfers of both open and closed books of business and are not limited in the line of business that can be transferred. All three states require approval by a court and no material adverse impact on affected policyholders. The approval of the ceding and assuming insurer’s domestic insurance regulator is also required. All states require an expert report that contains an opinion on the likely effects of the transfer plan on policyholders considering whether the security position of policyholders is materially adversely affected by the transfer. All states also require notification to all affected policyholders as well as the opportunity to be heard at a public hearing.

As noted above, several states have also enacted CD laws, rules, and regulations. While differences exist between IBTs and CDs, there are also many similarities between the two mechanisms: they require a regulatory review of the effect on policyholders, they have balance sheet considerations, and they are a way to separate runoff certain books of business from an insurer.

The Illinois’ Domestic Stock Company Division Law20 requires disclosure of the allocation of assets and liabilities among companies. Although not statutorily required, the Illinois Department of Insurance Director has committed to providing an opportunity to comment at a public hearing. The standard in the Illinois statute is that the plan must be approved by the Director unless the following characteristics exist:

1. policyholder/shareholder interest are not protected;
2. each insurer would not be eligible to receive a license in the state;
3. division violates the uniform fraudulent act;
4. division is made for the purpose of hindering, delaying, or defrauding other creditors;
5. any of the companies are insolvent after the division is complete.

The Connecticut CD statute21 creates something legally distinct from a merger, consolidation, dissolution, or formation. The resulting insurers are deemed legal successors to the dividing insurer, and any of the assets or obligations allocated are done as a result of succession and not by direct or indirect transfer. The plan must include among other things (1) the name of the domestic insurer; (2) the resulting insurer(s); (3) proposed corporate by-laws for new insurers; (4) manner for allocating liabilities and reasonable description of policies; (5) other liabilities and capital and surplus to be allocated, including the manner by which each reinsurance contract is allocated; and (6) all other terms and conditions. Connecticut requires approval by the board of directors, stockholders, and other owners before being considered by the Department of Insurance. The plan is then discussed with the Department which will determine whether the liabilities and policies are clearly defined and identifiable and whether the assumptions are conservative based upon actuarial findings. Connecticut law does not require an independent expert or a communication strategy as part of the application, but the Department of Insurance has stated that it will

require certain notifications related to a hearing (e.g., newspaper or print publications). Connecticut does not require notice of hearing however the insurance commissioner may require a hearing if in the public interest. Similar to Illinois law, the insurance commissioner must approve a plan of division unless he or she finds that (1) the interest of any policyholder or interest holder would not be adequately protected or (2) the division constitutes a fraudulent transfer. The division itself must be effectuated within 90 days of the filing.

The Pennsylvania CD statute was enacted in 1990 and is the subject of the NAIC 1997 white paper on Liability Based Restructuring. The statute upon which the transaction discussed in the 1997 white paper is based is not specific to insurance. The law is brief with only four paragraphs—requiring the plan to be submitted in writing, reasonable notice and opportunity for a hearing, investigations and supplemental studies and approval through an order from the Department and subject to judicial review. The associated procedural regulations essentially are those that exist under the states equivalent of the NAIC Insurance Holding Company System Regulatory Act (Model 440).

While the Rhode Island, Oklahoma and Arkansas laws have approval processes that are similar to UK Part VII transfers, there are differences between the three statutes. Rhode Island permits transfers of mature (at least 60 months) closed commercial property and casualty books of business or non-life reinsurance but no other lines of business. Oklahoma does not have similar restrictions and specifically allows property and casualty, life, and health lines of business. Oklahoma and Arkansas do not require the book of business to be closed.

While the CD laws enacted to date all require regulatory review of the effect on policyholders, balance sheet considerations and other operational requirements, the most significant differences that exist in CD laws are not among themselves, but rather in comparison to the IBT statutes. This is because the CD statutes do not require approval by a court or the same level of notification to policyholders. In addition, while CD states reserve the right to hire their own external expert—similar to a Form A (Change in Control), these states may perform their review based upon their own internal experts.

B. Transactions Completed to Date

One of the earliest transactions completed under these types of laws occurred in Pennsylvania in announced that it had approved a transaction that transferred a book of business from one entity to another. This transaction is discussed within Attachment 1, which is the 1997 Liability-Based Restructuring White Paper, and is commonly referred to as “the Brandywine” transaction, but within the 1997 White Paper is discussed within Appendix 1 and relates to Cigna, where more information is available. During the Working Group’s discussions in 2019, the Pennsylvania Insurance Department, which is captured in the following paragraph.

The Brandywine transaction was subject to an insurance department review, which included an actuarial review, a review of the financial information by a consultant and participation by other states that had an interest to understand how the plan would be restructured. There were four actuarial firms that opined on the transaction as well as two opinions from investment banks, one contracted by the insurer and another contracted by the Department. Issues regarding guaranty coverage were not addressed, but it did require Pennsylvania policyholders to be covered by the Pennsylvania fund. Confidentiality was applied to

17 15 PA. CONS. STAT. §§ 361 et seq.
any examination document prepared in the process, actuarial reports, and questions and comments, but insurer responses were made available to the public. The transaction was a large commercial transaction and immaterial to the policyholders, therefore reducing some of the concerns that may have otherwise existed.

In 2011, GTE Re\(^3\) completed a commutation plan in Rhode Island. The plan was approved by the Rhode Island court and the insured was ordered dissolved after all insureds had been paid full value for their policies. The GTE Re Plan was objected to, on a theoretical basis, and the Providence County Superior Court issued a decision\(^4\) on a contract clause issue.

In 2020, the District Court of Oklahoma County approved Providence Washington Insurance Company’s (“PWIC”) IBT plan.\(^7\) The plan transferred all the insurance and reinsurance business underwritten by PWIC, a Rhode Island domestic insurer, to Yosemite Insurance Company. Later in 2020, the Oklahoma Insurance Commissioner issued an order authorizing Sentry Insurance a Mutual Company (“Sentry”), a Wisconsin-based insurer, to submit its IBT Plan to the District Court of Oklahoma County for approval.\(^8\) This IBT transfers a block of reinsurance business underwritten by Sentry to National Legacy Insurance Company, an insurer domiciled in Oklahoma and a subsidiary of Randall & Quilter Investment Holdings Ltd (NLIC). The Sentry transfer was approved by the Court in August of 2021.

Illinois completed a transaction under their CD statute in early 2020. The transaction was a transfer of risks with distinct characteristics into a single insurer within a holding company structure. All the transfers originated and ended within the same holding company. The Illinois Department of Insurance has indicated that it will issue a detailed regulation as experience develops with CD plans proposed and completed under the statute.

Section 4: Impact of IBTs and CDs to Personal Lines

A. Guarantee Association Issues

An important issue for corporate restructuring is the availability of guaranty association coverage in the event of the insolvency of the restructured insurer. In order to uphold the stated declaration that restructuring should not materially adversely affect consumers, guaranty association coverage should not be reduced, eliminated or otherwise changed by the restructuring. Each state guaranty association is a separate entity governed by the laws of that state, and those statutes will determine association coverage. Although most states pattern their laws after the NAIC model law, there could potentially be different results concerning guaranty association coverage depending on where the insured resides. Guaranty association coverage. It is possible that a corporate restructuring could result in the reduction, elimination or change in guaranty association coverage provided to a policyholder in the event of the restructured insurer’s insolvency if steps are not taken to prevent that result. The potential coverage issues are different.

\(^3\) C.A. No. PB 10-3777 (R.I. Super. Apr. 25, 2011)
\(^4\) State of Rhode Island Providence County Superior Court C.A. No. PB 10-3777
for life and health guaranty association coverage and property and casualty guaranty fund coverage. We
address them separately below.

**Transactions Involving Life or Health Insurance**

The Working Group received input from both the National Organization of Life and Health
Insurance Guaranty Associations (“NOLHGA”) and the National Conference of Insurance Guaranty Funds
(“NCIGF”). NOLHGA described how significant the concerns for insurance consumers of personal lines life and
health insurance business is particularly pronounced.

NOLHGA indicated that for there to be guaranty association coverage in the event of a life or
health insurer insolvency, there are three conditions that must be present. Those conditions are:

1. The consumer seeking protection must be an eligible person under the guaranty association
   statute; typically, this is achieved by being a resident of the guaranty association’s state
   at the time of the insurer’s liquidation;

2. The product must be a covered policy; and

3. The failed insurer for which protection is being sought must be a member insurer of the
   guaranty association of the state where the policyholder resides. To be a member insurer,
   the insurer must be licensed in that state, or have been licensed in the state to write the lines
   of business covered by the guaranty association.

In most states, coverage can be provided for an “orphan” policyholder of the insurer when the
coverage is issued but the policyholder has since moved to a state that is not a guaranty association
member. Those policies are covered under the state in which the insolvent insurer’s domestic
state. Orphan policyholders are policyholders who are residents of states where the guaranty association
cannot provide coverage because the insolvent insurer is domiciled. This provision is not a member insurer
due to not being licensed at the time required by the guaranty association act. The orphan policyholder
situation can arise when a policyholder purchases a policy in a state where the issuing company is licensed
(i.e., is a member of the guaranty association) but subsequently moves to a state where the issuing
insurance company was never licensed (i.e., is not a member of the guaranty association). The provision in
the NAIC Life and Health Insurance Guaranty Association Model Act, and the laws of most states, that
provides that orphan policies are covered by the guaranty association in the insolvent insurer's domestic
state is designed to plug the gap in these rare situations. Orphan coverage was not designed to provide
coverage to all policyholders regardless of domicile as might occur if

A key factor when considering a life or health IBT or CD transaction is whether the resulting
insurer in an IBT does not meet the requirements for guarantee association coverage. These issues can be or
will be addressed in legislative and regulatory manners including maintaining a certificate of authority in
each state, so the insurer is a guaranty association member insurer in each state. However, if the
same guaranty associations where the transferring insurer is domiciled or unable to be a member insurer, if
the resulting insurer is a member insurer of the same guaranty associations as the transferring insurer,
guaranty association coverage will be preserved and not changed for all policyholders. (Of course, specific
guaranty association coverage will be determined if when the resulting insurer is placed under an order of
liquidation with a finding of insolvency.) If the resulting insurer is not a member insurer of the same
guaranty associations as the transferring insurer, policyholders may lose guaranty association coverage or
be covered as orphans by the guaranty association in the insurer’s domestic state. Orphan coverage was not
designed to plug the gap in this situation. Shifting the coverage obligation to meet such requirements if the
domestic state guaranty association could impede the ability of a guaranty association coverage being
concentrated in that state.

To address these concerns with respect to complete restructuring of IBT and CD transactions
involving life or health insurance, restructuring statutes (or regulators reviewing proposed restructuring
transactions) should clearly provide that assuming or resulting insurers must be licensed so that
policyholders maintain eligibility for guaranty association coverage from the same guaranty association
that would have provided coverage immediately prior to a restructuring transaction. This means that the
resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been
licensed with respect to the policies being transferred.

**Transactions Involving Property and Casualty Insurance**

The Working Group received input from the National Conference of Insurance Guaranty Funds
(“NCIGF”) about the concerns for insurance consumers of personal lines property and casualty insurance
business.

One interpretation of the NAIC Property and Casualty Insurance Guaranty Association Model Act (Model # 540)\(^\text{27}\) is that based on the definitions of “Covered Claim,” “Member Insurer,”
“Insolvent Insurer,” and “Assumed Claim Transaction” an orphan policyholder could not be covered by
the state guaranty association.\(^\text{28}\) Consequently, there is a concern that no guaranty association
coverage would be provided if policies are transferred to a nonmember insurer.

Many many property and casualty guaranty fund statutes require that the policy be issued by the now-
insolvent insurer and that it must have been licensed either at the time of issue or when the insured event
occurred. These limitations, however, are designed to avoid coverage being provided when the policy at
issue did not “contribute” to the association, which would not exist in the case of an accessible policy later
transferred to a nonmember insurer. Moreover, the restrictions exist to prevent claims resulting from a
company regulated as a surplus lines or a similar structure to benefit from the protections afforded licensed
business when a licensed company is liquidated.

NCIGF’s position is that where there was guaranty association coverage before the IBT or CD,
state regulators should ensure that there is coverage after the IBT or CD. An IBT or CD should not reduce,
eliminate or in any way impact guaranty association coverage. An CD or IBT should not create,
exand, or in any way impact coverage. NCIGF suggested that possible technical gaps may exist in states
that have adopted the NAIC Property & Casualty Insurance Guaranty Association Model Act.\(^\text{29}\) These gaps
could include the definitions of Covered Claim, Member Insurer, Insolvent Insurer, and the Assumed
Claims Transaction found in Section 5 of the model law.

Fulfilling this intent may likely require property and casualty guaranty association fund statutes be amended in each of the states where the original insurer was a member of a guaranty association before
the transaction becomes final. NCIGF indicated that it had created a subcommittee to address this issue and

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\(^{27}\) Available at https://content.naic.org/sites/default/files/inline-files/MDL-540.pdf.
\(^{28}\) See NOHLGANOLHGA and NCIGF joint submission to NCOIL dated February 24, 2020 for more information. Available at
\(^{29}\) Property and Casualty Guaranty Association Model Act (Nat’l Ass’n of Ins. Comm’r’s 2009).
oversee a coordinated, national effort to enact the necessary changes in each state. Further discussion of this subcommittee’s work is discussed in the Recommendations section below.

B. Assumption Reinsurance

Existing assumption reinsurance statutes exist to provide policyholder disclosures and rights for rejection of a proposed novation of their policy. These statutes are primarily designed for the benefit of individual policyholder with regard to personal lines coverages, whether for automobile, homeowners, life insurance or long-term care insurance, in situations where the solvency of the insurer might be at risk. There are currently ten states that have enacted the NAIC Assumption Reinsurance Model Act.30

The Assumption Reinsurance Model Act was drafted by state insurance regulators and initially adopted by the NAIC on December 5, 1993. The effect of an assumption reinsurance transaction is to relieve the transferring insurer of all related insurance obligations and to make the assuming insurer directly liable to the policyholder for the transferred risks. Under these statutes, individual policyholders receive a notice of transfer and may reject or accept the transfer. If the policyholder does not respond, the policyholder is deemed to have given implied consent, and the novation of the contract will be affected. When a new agreement replaces an existing agreement, a novation has occurred. There is no judicial involvement under the Assumption Reinsurance Model Act.

Some stakeholders have questioned whether the existence of rights under the Assumption Reinsurance Model Act by implication prohibit an IBT or a CD. The argument is that the existence of the assumption reinsurance statute prohibits other statutory restructuring mechanisms without the policyholders express individual consent. Other stakeholders have suggested that these statutes coexist with restructuring mechanisms since the restructuring statutes are not addressing individual novations of policies. The argument is that the restructuring statutes address transfers of books of business not individual novation of policies and, therefore, are completely separate from assumption reinsurance statutes.

This is not an issue that can be resolved in this white paper. The issue has not yet been addressed by any court nor raised in the proceedings on restructurings. Therefore, while it is raised here for informational purposes, resolution of the issue is left unanswered for now and for the courts to determine in the future.

30 Assumption Reinsurance Model Act NAIC Model #803 (Adopted by Colorado, Georgia, Kansas, Maine, Missouri, Nebraska, North Carolina, Oregon, Rhode Island, and Vermont)
C. Separate Issues in Long-Term Care

Long-tail liabilities are naturally subject to greater reserve uncertainty and may impact the regulator’s willingness to consider the restructuring of certain lines of business. During the Working Group’s discussion, it was noted by a number of regulators that restructuring of certain lines of business, such as long-term care insurance, could be problematic since the specific line of business has presented significant challenges in determining appropriate reserving and capital required to support the business. The Working Group acknowledges that, regardless of whether some state laws would permit it, use of a corporate restructuring mechanism in certain lines, such as long-term care insurance, is likely to be subject to a great deal of opposition and higher capital requirements for the insurers involved.

The nature of long-term care insurance policyholders will make restructuring challenging especially with a transfer to a completely new insurer in a new holding company system. Long-term care insurance policyholders are individuals who may find it much more challenging to assert their rights in a court proceeding than a corporate entity would. This fact, along with the traditional inability of insurers to properly estimate future liabilities in this line of business, makes it a line of business that likely is not appropriate for restructuring mechanisms. This conclusion, however, could be refuted if the appropriate plan addresses these issues and provides benefit to the policyholders.

Section 5: Legal Impacts of IBT and CD Laws

A. How Other Jurisdictions Might Analyze IBT or CD Decisions from Other States

As previously discussed by others, a restructuring mechanism in one state will not provide finality unless the decision is recognized by other jurisdictions. The US Constitution includes the Full Faith and Credit Clause as well as the Privileges and Immunities Clause (also referred to as the doctrine of Comity) in Article IV. These clauses create methods of extending the effect of a restructuring mechanism beyond the state that issued the judgment and giving that state’s judgment effect in all other states in which the insurer does business.

Thus, the Privileges and Immunities Clause or the Full Faith and Credit Clause are two methods stemming from the US Constitution that provide for recognition of court orders from other states. We will briefly touch on both concepts but leave these non-core insurance topics to others to discuss in more depth.

The policyholder challenging the decision must first identify the property of which they are being deprived. Assuming the resulting insurer is sufficiently capitalized, a policyholder who has been reallocated to the resulting insurer, but alleges no additional harm, may have difficulty identifying the property interest of which they have been deprived. The determination on full faith and credit will likely rely upon the issues raised and considered in the Court of the domestic state.

The issue is not likely to be ripe until an insolvency occurs with the assuming insurer. At that point, if the assuming insurer is insolvent and the original insurer is still financially sound, will a court give full


32 The same analysis does not apply to jurisdictions outside the United States and is not addressed in this white paper.
faith and credit to the approval of the IBT or CD? This is an open question that is unlikely to be resolved until the specific factual scenario presents itself to the courts. The fact that this issue exists makes it even more important that only transactions with the greatest chance for success be subject to corporate restructuring process.

Comity is typically understood to be a courtesy provided between jurisdictions, not necessarily as a right but rather out of deference and good will. As such, comity might not require in this context that a state honor the decision of another state. This is an analysis to be conducted by the individual jurisdictions.

B. Impact of UK Part VII Transactions in the US

Although there has been limited experience in the US courts in approving commutations and IBTs, some US courts have had opportunities to review these types of issues because US insurers have been involved with UK-based commutations or transfers. Since the 2000 and 2005 revisions to UK laws, solvent schemes and Part VII transfers have been employed much more frequently in the UK. This has led to more frequent reviews by US courts of the underlying UK transactions. Some of the impact in the US is felt in bankruptcy courts, which often are implicated because US policyholders obtain coverage from UK-based insurers on a regular basis, while others involve non-bankruptcy situations, such as when a policyholder wants to submit a claim for payment but no longer has coverage.

There are several interesting cases that provide some guidance on these issues. Narragansett Electric Co. v. American Home Assurance Co. is one such case. In Narragansett Electric Co., the court reviewed claims by London-based insurer, Equitas, that the plaintiff had sued the wrong insurer on a claim that was alleged to have occurred more than sixty years earlier. Equitas argued that it had not assumed the obligations at issue. As the court summarized, “Equitas’s motion to dismiss raises the question whether this [Part VII] transfer of insurance obligations from Lloyd’s to Equitas is effective and enforceable under U.S. law.” First, the court decided that it was sitting in diversity jurisdiction and that the appropriate substantive law to apply was English. Next, the court discussed a prior District Court case where another Part VII transfer was discussed at length and not recognized as a foreign bankruptcy proceeding. In reaching a conclusion to reject the request for dismissal, the court relied on a letter sent by Equitas to US policyholders notifying them that Equitas was assuming the obligations of the original insurer. The court found that regardless of whether the Part VII had any effect the letter sent by Equitas to US policyholders notifying them that Equitas was assuming the obligations of the original insurer. The court found that regardless of whether the Part VII had any effect the letter sent by Equitas to US policyholders notifying them that Equitas was assuming the obligations of the original insurer. Equitas attempted to argue that the Part VII transfer did not state that it would become effective in the US, rather that it was only effective in certain countries of Europe. Nevertheless, the utility company alleged that it had not relied on the English High

Court Order executing the Part VII transfer, but rather relied on the notice letter it received as the evidence of obligation by the new named insurer.

Air & Liquid System Corp. v. Allianz Insurance Co., dealt with a discovery dispute as to whether a policyholder impacted by a Part VII transfer could later have access to the information that went into a UK’s independent expert’s report. Ultimately, the special master in the District Court allowed discovery to proceed with a deposition of the expert. Allianz Insurance Co. is an example of one way that Part VII transfers can be used to add complication to an insurance coverage dispute, embroiling all involved in later litigation. Allianz Insurance Co. also shows how the approval of such a transfer, even though well vetted originally, can later come under scrutiny in unintended or unforeseen locations.

Allianz Insurance Co. concerned General Star, which wrote policies for excess coverage outside the US for only three years, 1998–2000, and then was put into runoff and ceased writing new policies. By 2010, it had substantially wound down its business and decided to transfer its policies to a new insurer via a Part VII transfer. Both General Star (the transferor) and the transferee taking over the policies shared an ultimate parent company—Berkshire Hathaway. At issue here was whether the expert who opined on the Part VII transfer had properly included one particular US-based insured, Howden North America (“Howden”), and all three policies it had purchased from General Star. That insurance contract had been for excess coverage, and Howden had informed General Star of 13,500 potential asbestos related claims that were likely to exceed the initial layers of insurance, making it likely that the General Star excess policy would be required to pay out claims. The real issue in Allianz Insurance Co. seemed to be that the post-Part VII insurer was put into voluntary liquidation days after the Part VII transfer concluded, leading to questions about whether and how the independent expert had valued Howden’s potential asbestos claims.

In re Board of Directors of Hopewell International Insurance Ltd. involved a New York bankruptcy judge analyzed a solvent scheme of arrangement that occurred in Bermuda, and applied Bermuda law, rather than the requested Minnesota law. The court determined that, given the location of the petitioner’s assets, Respondents had failed to object to the solvent scheme as proposed when they had been provided notice, and that petitioner had been subjected to a foreign proceeding, it had jurisdiction. As such, the court enjoined the respondent from taking action against petitioner based on the underlying action. The court in Hopewell also recognized the Bermuda solvent scheme as one qualifying as a foreign proceeding under US Bankruptcy Code.

Section 6: Recommendations

A. Financial Standards Developed by Subgroup

38 Id. at *12. This interrelated nature is not unusual and is referred to as an intra-company transaction.
40 Written by then the Chief United States bankruptcy judge in the Southern District of New York Tina Brozman, this decision detailed relevant history behind the Bermuda schemes of arrangement, including the different methods available to companies. One arrangement involved a cut-off scheme, developed in 1995, in which companies have no more than five years to submit additional claims prior to a bar date. This scheme greatly reduced the time for a run-off to wind down its business.
41 Citing to 11 U.S.C. § 101(23) (2012). The court applied a standard that “a foreign proceeding is a foreign judicial or administrative process whose end is to liquidate the foreign estate, adjust its debts or effectuate its reorganization.” Id. at 49 (internal quotations omitted).
As reflected in this whitepaper, these restructuring mechanisms depend considerably upon the specific plan being proposed. Currently, each state with relevant statutes is being presented with plans for evaluation with no standard set of criteria under which to judge the financial underpinnings of the plan. The Working Group believes that trust in these mechanisms and protection of the policyholders who will be impacted by them, demands a standard set of financial principles under which to judge the transaction. As such, the Working Group created a subgroup to specifically address these financial issues.

The Restructuring Mechanism Subgroup (“Subgroup”) has been charged with the following initial work related to this White Paper:

Develop best practices to be used in considering the approval of proposed restructuring transactions, including, among other things, the expected level of reserves and capital expected after the transfer along with the adequacy of long-term liquidity needs. Also develop best practices to be used in monitoring the companies after the transaction is completed. Once completed, recommend to the Financial Regulation Standards and Accreditation (F) Committee for its consideration. Complete by the 2021 Summer National Meeting.42

Members of the Subgroup have studied and acknowledge that UK Part VII procedures set forth robust processes and that setting similar requirements should be applied to IBT and CDs. As of the date of this paper, the charge related to best practices has not been completed. The Subgroup will continue its work with the goal of developing financial best practices. Those practices will be exposed for comment and discussion prior to referral to other groups.

B. Guaranty Association Issues

As discussed above, when these restructuring mechanisms are applied to personal lines serious issues arise over the continuation of guaranty association coverage. A number of states—Connecticut, California, and Oklahoma—have enacted statutory solutions to these issues. In addition, NCIGF has provided proposed statutory language. The Working Group would suggest that these issues, and the potential solutions, be referred to the Receivership Task Force for consideration to include language in the Guaranty Association Model Act.

On the life and health side, as noted above, restructuring statutes (or regulators reviewing proposed restructuring transactions) should clearly provide that assuming or resulting insurers must be licensed so that policyholders maintain eligibility for life and health guaranty association coverage from the same guaranty association that would have provided coverage immediately prior to a restructuring transaction. This means that the resulting insurer must be licensed in all states where the transferring insurer was licensed or had ever been licensed with respect to the policies being transferred.

On the property and casualty side, amendments to the guaranty fund statutes likely will be necessary. A number of states—California, Illinois, and Oklahoma—have enacted statutory solutions to the property and casualty guaranty association issues similar to what NCIGF has suggested to the working group. In addition, NCIGF has provided proposed statutory language for other states to consider. The Working Group would suggest that these issues, and the potential solutions, be referred to the Receivership

42 Charges were adopted by the Financial Condition (E) Committee Oct. 27, 2020 (see NAIC Fall National Meeting Minutes for the Financial Condition (E) Committee-Attachment Two).
and Insolvency Task Force for consideration. Specifically, the Working Group recommends that the language proposed by NCIGF be included in the NAIC Property and Casualty Insurance Guaranty Association Model Act. Regulators, guaranty funds and other appropriate industry stakeholders should work cooperatively to implement this statutory remedy with all deliberate speed.

Inclusion in the model, of course, only provides a roadmap for a state. The Working Group, therefore, suggests that, once appropriate language has been drafted, a serious effort be undertaken to obtain changes to the statutes in the various states to address this issue. Until that is accomplished, regulators should very carefully consider how plans presented address the property and casualty guaranty association issues to assure that consumers are not harmed by the transaction.

C. Statutory Minimums

During the Working Group hearing, stakeholders made a number of suggestions as to provisions which should be required to be included in IBT and CD statutes. Those include:

1. Requirement of court approval must be required for all restructuring mechanisms. Currently the IBT statutes (except for Vermont) require court approval, but the CD statutes generally do not.

2. Requirement of the use of an independent expert to assist the state in both IBT and CD transactions, even though none of the states require this independent expert assistance for a CD.

3. Requirement of a notice to stakeholders, a public hearing, robust regulatory process, and an opportunity to submit written comments are necessary for all policyholders, reinsurers, and guaranty associations.

None of the restructuring mechanism are based on an NAIC model. While the Rhode Island, Oklahoma and Arkansas statutes are similar and are based on the Part VII processes in the UK, all CD processes are different and drafted by the legislatures of the states which enacted the statutes. Each of these recommendations is designed to address possible impairment of the financial position of the policyholders of the companies involved in the IBT and CD. As some commenters indicated, each of these suggestions would be beneficial in some transaction. Other transactions, however, may not need all of these provisions. For example, an intra holding company transaction may not need full faith and credit. While independent experts can be of value, the mere fact that someone is employed by an insurance department does not mean that their skill set is not sufficient for certain transactions. Depending upon the transaction, department staff with a deep understanding of the insurer might provide more protection for consumers than a newly hired individual without a history with the insurer. Thus far, none of the transactions have been undertaken without a robust regulatory process; however, there would be concern from other regulators if this quality of regulatory process was not in place.

D. Impact of Licensing Statutes

Insurers formed for the purpose of effectuating restructuring mechanisms may, in the right transactions, provide value to consumers in the efficient management of runoff liabilities. However, these newly formed companies have difficulty getting licensed in the various states either because of
“seasoning” issues or because they are not writing ongoing business so the state may be hesitant to grant a license. Lack of licensure can provide a lack of regulatory control which can lead to actions which harm consumers. The Working Group, therefore, recommends that the appropriate committee look at licensing standards consider whether any changes should be made to the licensure process for runoff companies resulting from restructuring transactions of runoff blocks. A streamlined process that still ensures appropriate regulatory oversight (and any licensure necessary to preserve guaranty association coverage) may wish to adopt be appropriate in limited circumstances.

Commented [A5]: If possible, we suggest that the appropriate committee be identified here.
NATIONAL WORKERS COMPENSATION
REINSURANCE ASSOCIATION NFP

December 1, 2021

The Honorable Elizabeth Kelleher Dwyer
State of Rhode Island Department of Business
Regulation -- Division of Insurance
1511 Pontiac Avenue, Bldg. #69-2
Cranston, Rhode Island 02920
elizabeth.dwyer@dbr.ri.gov

The Honorable Glen Mulready
Oklahoma Insurance Department
400 NE 50th Street
Oklahoma City, OK 73105-1816
glen.mulready@oid.ok.gov

Re: NAIC Restructuring Mechanisms (E) Working Group
Workers Compensation Residual Market Considerations in Restructuring Transactions

Dear Superintendent Dwyer and Commissioner Mulready:

On behalf of the NWCRAs Board of Directors, we reiterate the concerns and comments included in my prior letter dated July 14, 2021 (copy attached), which do not yet appear to be addressed in the exposure draft of the Working Group’s white paper. However, we also recognize that several NWCRAs representatives have been invited to participate in the December 6 meeting of the Working Group and hope our concerns and comments on the draft white paper will be discussed for consideration at that meeting. The NWCRAs Board concern on avoiding restructuring transactions creating uncertainty with regard to NWCRAs member company obligations. We appreciate the invitation and opportunity to discuss those concerns and address any questions the working Group might have on these issues.

For your information, the individuals planning to participate as NWCRAs representatives are Gerald Chiddick (NWCRAs Board Chair), Rowe Snider (Board counsel), and Cliff Merritt and Michael Kahlowsky (NCCI as NWCRAs Administrator). We look forward to the discussion.

Very truly yours,

Gerald Chiddick
NWCRAs Board Chair

CC: Cliff Merritt (NCCI -- Senior Division Executive, Residual Markets)
Brian Mourer (NCCI -- Director of Plan Administration)
Michael Kahlowsky (NCCI-Director of Reinsurance)
Rowe W. Snider (Locke Lord LLP -- NWCRAs Counsel)
July 14, 2021

The Honorable Elizabeth Kelleher Dwyer  
State of Rhode Island Department of Business  
Regulation -- Division of Insurance  
1511 Pontiac Avenue, Bldg. #69-2  
Cranston, Rhode Island 02920  
elizabeth.dwyer@dbr.ri.gov

The Honorable Glen Mulready  
Oklahoma Insurance Department  
400 NE 50th Street  
Oklahoma City, OK 73105-1816  
glen.mulready@oid.ok.gov

Re:  NAIC Restructuring Mechanisms (E) Working Group  
Workers Compensation Residual Market Considerations in Restructuring Transactions

Dear Superintendent Dwyer and Commissioner Mulready:

I am writing to you in my capacity as Chair of the Board of Directors (the “Board”) of the National Workers Compensation Reinsurance Association NFP (“NWCRA”), which is an industry organization that manages the reinsurance mechanism presently supporting the workers compensation residual market in 23 states. That residual market reinsurance mechanism was affected by the initial Insurance Business Transfer (“IBT”) transaction completed last October in Oklahoma. The transferor in the Oklahoma IBT, Providence Washington Insurance Company (“PWIC”), was a participant in the residual market reinsurance mechanism and its workers compensation policies were transferred to Yosemite Insurance Company (“Yosemite”). As explained below, the Board understands that the transaction included the transfer of PWIC’s residual market reinsurance obligations to Yosemite. Further, based upon its review of this initial IBT transaction, the NWCRA Board has developed some suggestions related to residual market obligations which we respectfully submit for the Working Group’s consideration. The Board believes that these suggestions, if included in the Working Group’s forthcoming White Paper, could improve how workers compensation residual market obligations are analyzed and treated in the review and approval process for IBTs and Company Divisions (together, “Restructuring Transactions”).\(^1\) The same concepts applicable to the NWCRA states may also be applicable to the workers compensation residual market mechanisms in other states, particularly those using a similar reinsurance mechanism to facilitate the residual market.

\(^1\) While this letter primarily addresses IBT transactions in reaction to the Oklahoma IBT, the Board believes that the concepts and suggestions discussed in this letter are also applicable to company divisions under statutes like those enacted in Illinois and Connecticut, for example.
Background Discussion

Before turning to the Oklahoma IBT and our suggestions, some background regarding the NWCRA’s workers compensation residual market may be useful context for the Working Group.

The Workers Compensation Residual Market in NWCRA states.

Given the mandatory nature of workers compensation insurance for most employers in almost all states, most states provide for a "residual market" for difficult-to-place employers so they may comply with the law by obtaining workers compensation insurance. In the NWCRA states, the workers compensation residual market is implemented through a statutorily-authorized Workers Compensation Insurance Plan ("WCIP" or "Plan"). The Plan is a filed program established and maintained by the National Council on Compensation Insurance ("NCCI") and approved by each state’s insurance regulator. The Plan provides a process through which eligible employers who are unable to secure such coverage through ordinary means, i.e., in the voluntary market, may obtain workers compensation insurance. The Plan is also known as the "involuntary market" or the "assigned risk market." (The latter term applies because involuntary market employers are assigned to a specific insurer, which issues them a workers compensation policy.) In general, all admitted workers compensation insurers in a state must participate in that state’s Plan, either through membership in the NWCRA and its reinsurance mechanism or, in states where permitted, as Direct Assignment Carriers.  

National Workers Compensation Reinsurance Pooling Mechanism

The National Workers Compensation Reinsurance Pooling Mechanism ("NWCRP" or "residual market reinsurance mechanism") is a contractual quota share reinsurance mechanism that affords participating workers compensation insurers a means for complying with state Plan requirements by the participating insurer's sharing in the operating results of certain involuntary market policies written pursuant to state insurance Plans. Through the NWCRP, participating insurers reinsure certain servicing carriers, who issue the involuntary market policies to eligible employers who apply through the Plan. By electing to participate in this residual market reinsurance mechanism, participating voluntary market insurers in a state each share an equitable proportion of the residual market results in the state with all other participants based upon each insurer’s share of the state’s calendar year direct written premium, avoiding random and variable burden of each insurer assuming and absorbing the results of individual assigned risk policies.

The NWCRP, as a quota share reinsurance mechanism, has been in existence since 1970. As noted above, the participants’ quota shares are calculated on a policy year basis in each NWCRA state. Consequently, the NWCRP is comprised of approximately 1500 individual state residual market policy year quota share reinsurance calculations, each of which is adjusted quarterly. Overall operating results, including remittance of involuntary market premium minus servicing carrier allowances and indemnity owed reinsured servicing carriers for paid losses, are netted quarterly. NCCI, as administrator of the NWCRP, calculates statements of net account balances.

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2 Not all NWCRA states allow Plan participants to opt to be a Direct Assignment Carrier, rather than participating in the residual market reinsurance mechanism. This letter does not address the potential impact Restructuring Transactions may have, if any, on Direct Assignment Carriers.

3 While the NWCRA presently reinsures the residual market in 23 states, that number has varied over time. There are presently open reinsured policy years in a total of 41 states.
of the participating companies and servicing carriers and settles the cash flow of such accounts quarterly, with participating insurers retaining liability for unearned premium and unpaid loss reserves. At year-end 2020, the total amount of reinsured residual market liabilities within the NWCRP exceeds $4 Billion.

It is important for present purposes to emphasize that the NWCRP is a pass-through reinsurance mechanism, so in addition to members’ proportional assumption of the reinsurance liabilities, the related assets, intended to cover the reinsurance obligations, are also almost entirely distributed to the participating members. Aside from a relatively small “working fund” advanced by participating companies to provide liquidity and cover expenses between quarterly settlements, the NWCRP reinsurance mechanism distributes proportionately all assets to participating companies. Accordingly, any restructuring transaction involving an NWCRP participating company and transferring or allocating policies written in a NWCRA state will need to evaluate not only any affected residual market reinsurance obligations, but should not separate those obligations from the associated assets held by the participating company.

*The National Workers Compensation Reinsurance Association NFP*

Insurance companies participate in the NWCRP residual market reinsurance mechanism as members of the National Workers Compensation Reinsurance Association NFP (“NWCRA”), which is organized as a not-for-profit corporation. The NWCRA is responsible for all policymaking and oversight functions for the NWCRP residual market reinsurance mechanism. The NWCRA operates that mechanism pursuant to the NWCRA Bylaws under the direction of the NWCRA’s Board of Directors and consistent with quota share reinsurance agreements between the servicing carrier and the participating members. The NWCRA contracts with NCCI for operational and managerial support, as well as for administration of the residual market reinsurance mechanism (the “NWCRP Administrator”).

*The NWCRA and the Initial Oklahoma IBT*

At the time the initial Oklahoma IBT transaction was approved, PWIC was a member of the NWCRA having residual market obligations in more than twenty states and totaling approximately $2.3 Million. These obligations include unpaid loss reserves and thus present exposure capable of adverse development.

Based upon non-sealed, available court records and a limited investigation by Board’s counsel, the Board believes that PWIC’s residual market obligations were not specifically analyzed in the review of the transaction. There was a suggestion in at least one public discussion of the transaction that these residual market obligations were considered not to be material to the analysis. The Board, of course, recognizes that it has limited insight into the review process and there are sealed court filings, so there may be relevant information and aspects of the analysis of which we are not aware.

The Board was unable to confirm that NCCI, in its capacity as NWCRP Administrator, received notice of the proposed IBT. Nor was the NWCRP Administrator contacted to verify PWIC’s residual market obligations or their amount. The NWCRP Administrator did receive a copy of the October 15, 2020, Judgment and Order of Approval (the “Order”) implementing the IBT. The Order, however, contains no express reference to or direction regarding PWIC’s residual market

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obligations, which PWIC had assumed as a result of the “subject business” that was being transferred to Yosemite in the IBT.

Given our understanding that PWIC’s entire book of workers compensation policies were included in the “subject business” being transferred to Yosemite, the NWCRP Administrator concluded that the intention of the IBT was that all of PWIC’s residual market reinsurance obligations were also transferred to Yosemite. This conclusion seems further supported by the language in paragraph 46 of the Order, which states as a conclusion of law that Yosemite will be treated as the “original insurer” from inception of the transferred PWIC policies for not only with regard to “contractual rights, obligations, and liabilities, but also to seamless application of regulatory laws applicable to the Subject Business…” as if Yosemite has issued the transferred policies initially. Nowhere in the Order was transfer of these residual market obligations expressly addressed. Because Yosemite was already a member of the NWCRA and had executed the appropriate membership documents, NCCI could readily transfer PWIC’s outstanding residual market obligations to Yosemite in the NWCRP records. At this point, no NWCRP operational issues have arisen from the Oklahoma IBT, but we note that it was an intra-group transfer, which may have decreased the chances of any operational issue arising. If the IBT had transferred residual market obligations to a non-affiliated insurer without being explicitly addressed, operational issues with billing and payment of quarterly settlement balances would have been more likely to arise.

Suggestions for consideration of Workers Compensation Residual Market Obligations in the Review and Approval of proposed Restructuring Transactions.

The NWCRA Board, as part of its managerial responsibilities, followed and has discussed the initial Oklahoma IBT transaction, given it involved PWIC as a member company with residual market obligations. Further, aware of the increasing number of states that have enacted or may enact statutes authorizing Restructuring Transactions, the Board has consulted with its counsel and developed some suggestions related to the NWCRA and the residual market for the Working Group’s consideration in conjunction with the White Paper it is drafting. We respectfully suggest that these suggestions may be appropriate for the Working Group to incorporate in some way in the White Paper.

1. Identify and verify any Residual Market Reinsurance Obligations affected by a proposed Restructuring Transaction.

We suggest that when a regulator is reviewing a proposed Restructuring Transaction involving workers compensation policies, the regulator should be certain that the review process has specifically identified what residual market obligations may be affected by the Restructuring Transaction. The existence of such obligations may need to be verified, which, in the case of NWCRA states, an appropriate representative of the regulator could contact the NWCRP Administrator for such verification. Almost all insurers that have written workers compensation insurance in one of the NWCRA states at any time since 1970 will have incurred residual market reinsurance obligations for various policy years. In the first instance, the applicant insurer should be able to provide information about the existence of any such residual market obligations and whether those obligations are potentially affected by the proposed Restructuring Transaction. If there is any doubt or uncertainty about these obligations or what states and policy years may be affected, it may be prudent for the reviewing regulator (or his/her appropriate representative) to
contact the NWCRA Administrator to verify the nature and extent of the residual market obligations that may be affected.

2. Where an applicant’s Residual Market Obligations are affected, verify that those Residual Market Obligations are accurately stated in the applicant’s financial statements and in the application documents.

Given the nature of the NWCRP’s quota share reinsurance mechanism, each NWCRA member participating insurer has individually assumed its proportionate share of the residual market reinsurance obligations as its own liability. NCCI’s policies and procedures, as NWCRP Administrator, provide all NWCRA member insurers with sufficient information for each member insurer to appropriately record the member’s share of the residual market reinsurance obligations on its financial statements. That being said, the NWCRA Board has no knowledge of each member insurer’s actual practices in accounting for its participation in the NWCRP residual market reinsurance mechanism. Accordingly, it may be prudent to have the reviewing regulator (or his/her appropriately credentialed representative) contact the NWCRP Administrator to verify that the residual market reinsurance obligations affected by the transaction are accurately stated as they are considered in the review process.

3. Ensure that both Residual Market Obligations and associated assets are considered as part of the evaluation process and are appropriately transferred or allocated in Restructuring Transactions.

As noted above, in the NWCRP residual market reinsurance mechanism, both reinsurance obligations and associated assets are distributed to participating member insurers. If a proposed Restructuring Transaction affects residual market reinsurance obligations, the reviewing regulator should make certain that both residual market reinsurance obligations and appropriate related assets are taken into consideration in the evaluation process. Each NWCRA member insurer has not only residual market reinsurance obligations, but also holds related assets (basically, a share of residual market insurance premiums) distributed to the member insurer at approximately the same time the reinsurance obligations were originally assumed. Accordingly, appropriate consideration should be given to the allocation/transfer of both the obligations and related assets in the effectuation of any Restructuring Transaction.

4. In approving any Restructuring Transaction affecting the Residual Market Reinsurance Obligations, the approval orders or judgments should provide clear and specific guidance regarding the disposition of the affected residual market obligations.

Clarity and certainty in the administration of residual market mechanisms benefits all stakeholders. Given the nature of Restructuring Transactions, the NWCRP Board understands that, generally, outstanding residual market reinsurance obligations would be transferred or allocated in a fashion that follows responsibility for the voluntary market policies that generated the direct written premium on the basis of which those residual market reinsurance obligations originally arose as quota share obligations. As noted above, based upon the IBT transferring all PWIC’s workers compensation policies and, further, the Order “deeming” Yosemite to have been the original insurer of the transferred policies for regulatory purposes, PWIC’s residual market obligations have been transferred to Yosemite by the IBT. An explicit direction to make this transfer would have removed any uncertainty for all stakeholders. Additional direction and more
specific communications may be required if some other result were intended in other Restructuring Transactions, or if only a portion of an applicant's workers compensation book is being transferred or allocated to the transferee insurer while other blocks of workers compensation business remain with the applicant transferor insurer. To make the point in stark practical terms, NCCI, as NWCRA Administrator of the NWCRP reinsurance mechanism, needs to know with certainty the insurer to whom it sends quarterly reports and from whom it will collect reinsurance obligations when a net amount is due and owing to the residual market reinsurance mechanism.

Conclusion

The Board appreciates the Working Group’s consideration of our suggestions and hopes these prove helpful. Should you have any questions or wish to discuss any of the suggestions, please feel free to contact me (gerald.chiddick@zurichna.com) or Cliff Merritt (cliff_merritt@ncci.com) and/or counsel (rsnider@lockelord.com).

Very truly yours,

Gerald Chiddick
NWCRA Board Chair

CC:  Doug Stolte (Subgroup Co-Chair)
     David Smith (Subgroup Co-Chair)
     Dan Daveline (NAIC Staff)
     Casey McGraw (NAIC Staff)
     Robin Marcotte (NAIC Staff)
     Cliff Merritt (NCCI -- Senior Division Executive, Residual Markets)
     Brian Mourer (NCCI – Director of Plan Administration)
     Rowe W. Snider ( Locke Lord LLP -- NWCRA Counsel)
The Risk-Focused Surveillance (E) Working Group of the Financial Condition (E) Committee met Nov. 9, 2021. The following Working Group members participated: Justin Schrader, Chair (NE); Amy Malm, Vice Chair (WI); Blase Abreo and Sheila Travis (AL); Susan Bernard (CA); William Arfanis and Kathy Belfi (CT); Carolyn Morgan and Virginia Christy (FL); Daniel Mathis (IA); Cindy Andersen and Eric Moser (IL); Ray Eft (IN); Stewart Guerin (LA); Dmitriy Valekha (MD); Vanessa Sullivan (ME); Judy Weaver (MI); Debbie Doggett (MO); Jackie Obusek and monique smith (NC); Patricia Gosselin (NH); Mark McLeod (NY); Dwight Radel and Tracy Snow (OH); Eli Snowbarger (OK); Melissa Greiner and Kimberly Rankin (PA); Jack Broccoli and John Tudino (RI); Johanna Nickelson (SD); Jake Garn (UT); Greg Chew, David Smith, and Doug Stolte (VA); Dan Petterson (VT); and John Jacobson (WA).

1. Discussed Comments Received on the Exposure of Affiliated Services Guidance

Mr. Schrader stated that the first agenda item for the call is to discuss comments received during the exposure of proposed revisions to the NAIC’s Financial Analysis Handbook (Analysis Handbook) and Financial Condition Examiners Handbook (Exam Handbook) to enhance guidance related to the review of affiliated service agreements. This issue was first brought to the Working Group based on discussions held during a meeting of the Chief Financial Regulator Forum in November 2020. During that meeting, the Forum discussed the growing prevalence of market-based expense allocations in affiliated service agreements and noted a need for some additional guidance or best practices in reviewing these agreements. Because it is important to ensure consistency and communication across the analysis and examination functions in reviewing and monitoring the impact of affiliated service agreements, the issue was referred to the Working Group, as opposed to being sent to the individual handbook groups.

Mr. Schrader stated that the referral provided some detail on existing guidance included in the Analysis Handbook on this topic. Such guidance already states, “compensation bases other than actual cost should be closely evaluated” and “insurers should not use related-party transactions as a market for transferring profits of the insurance company to an affiliate or related party.” However, the referral indicates that additional guidance, including best practices or illustrations to help analysts apply these standards, could be beneficial. In addition, the referral states that the Exam Handbook does not currently include any guidance on reviewing market-based expense allocations and only provides general guidance on reviewing affiliated service agreements.

Mr. Schrader stated that the referral was received by the Working Group earlier this year, and several members volunteered to develop some initial proposed guidance for the Working Group to consider. Volunteer states participating on the project include Connecticut, Idaho, Maine, North Carolina, Pennsylvania, Virginia, and Wisconsin. After being formed, the volunteer group met multiple times over a period of months to discuss the issues and develop proposed Analysis and Exam Handbook revisions for consideration, which were subsequently released for a 60-day public comment period that ended Oct. 29.

Ms. Malm provided an overview of the proposed revisions to both the Analysis Handbook and the Exam Handbook to enhance guidance related to the regulatory review of affiliated service agreements. Many of the changes to the Analysis Handbook are included in the Form D review procedures and related analyst reference guide. Ms. Malm stated that several of the changes were proposed to incorporate recent amendments to the Insurance Holding Company System Regulatory Act (#440) that were adopted by the NAIC in August 2021. Other changes were proposed to place greater emphasis on fair and reasonable considerations in reviewing affiliated services agreements, particularly those whose compensation is market-based. Changes to other sections of the Analysis Handbook include enhancements to ongoing operational risk review to monitor ongoing impacts of affiliated services and recommended discussion of affiliated service agreements in exam planning meetings. For the Exam Handbook, changes are proposed to three sections of guidance. General background information on affiliated services transactions is proposed for inclusion in the narrative guidance; revisions to possible risks, controls, and test procedures to be performed related to affiliated service agreements are included in the Related Party Exam Repository; and a discussion of affiliated service agreements was added to Exhibit D – Planning Meeting with the Financial Analyst.

Mr. Schrader stated that comment letters were received during the exposure period from the Hawaii Insurance Division, the Ohio Department of Insurance, the Medicaid Health Plans of America (MHPA), the Association for Behavioral Health and Wellness (ABHW), and a consolidated group of various other interested parties.
Mr. Bruggeman provided an overview of the Ohio comments on maintaining the importance of the Form D review and approval process by being careful not to discount that approval and constantly reevaluate it during ongoing examination activities. Instead, the focus of the exam should be in verifying that the services are following the approved terms and conditions and operating as intended. Mr. Bruggeman also discussed recommendations related to increased focus on market-based agreements and removing or not requiring language regarding a notice to the insurer that the agreement is subject to ongoing verification.

Keith Bell (Travelers) provided an overview of the comments submitted by a joint group of interested parties. He stated that any review of an approved service agreement after the fact should be limited to those agreements that are material and have the potential to result in a solvency or compliance concern. Such a review should be focused on whether the profit included in a market-based agreement was negotiated at arms-length, and he stated that companies often conduct detailed transfer pricing analysis before finalizing such transactions, which state insurance regulators may be able to utilize and leverage. In addition, any subsequent review conducted by the department should be initiated by and coordinated with the assigned financial analyst. Mr. Bell also stated that another comment in the letter was focused on clarifying language in the Exam Handbook regarding related party versus affiliate in referring to transactions and agreements. Finally, he encouraged the Working Group to allow interested parties to assist in any ongoing redrafting efforts.

Joe Zolecki (Blue Cross Blue Shield Association—BCBSA) thanked the Working Group for providing a 60-day exposure period at the request of interested parties to allow more time to review and accumulate comments. He stated that the Form D review guidance is viewed by the industry as a significant issue. As such, he asked the Working Group to defer adoption of any updated guidance until after the issues raised in the comment letter can be thoroughly discussed and addressed, and he requested that a collaborative drafting group of state insurance regulators and interested parties be formed to work on the project.

Ms. Weaver stated that limiting a review of affiliated party agreements to those that are material could be problematic, as subsequent agreements could be based on the terms of the initial, non-material agreement. Mr. McLeod asked the interested parties for their definition of material when it comes to affiliated services agreements. Mr. Bell stated that materiality considerations for affiliated service agreements should focus on the dollar impact of the services rendered under the agreement. He stated that with that in mind, existing definitions for materiality in NAIC guidance can be utilized to make that determination. Mr. Zolecki added that the financial analysis process has become much more risk-focused in nature in recent years, which should allow the analyst to direct any substantive review of affiliated service agreements on an ongoing basis.

Ms. Belfi stated that limiting the ongoing review of affiliated service agreements based upon materiality can become a slippery slope, as there is a lot of variation from one agreement to another. As such, state insurance regulators should be able to make their own determinations about which agreements are subject to ongoing review. Ms. Belfi also stated that the goal of developing additional guidance in this area is to promote more uniformity in the review and approval process across states, which would be beneficial to the industry. Therefore, if the industry can contribute to this process by presenting a methodology for evaluating the fairness and reasonableness of contract terms that is used consistently across the industry, it would be very valuable.

Mr. Schrader stated his agreement with the goal of driving more uniformity and consistency in state review, approval, and ongoing monitoring of affiliated service agreements, as they often use similar terms across states. He also stated his concerns with a strict materiality threshold that limits regulatory review options and his preference for listing materiality as a consideration. Mr. Bell stated that any materiality considerations applied to affiliated service agreements should be both qualitative and quantitative in nature to allow adequate flexibility.

Mr. Stolte stated that affiliated service agreements incorporating market-based compensation are generally not very transparent and are difficult to review and approve. This is often because rates are based on public sources of information on third-party rates and profits that may not be relevant to the services being rendered by the affiliate. In addition, it can be very difficult to unwind or revoke an agreement after it has been approved by the department, even if concerns are noted in an examination. Therefore, states should take care to ensure that the initial approval verifies that terms are fair and reasonable and are not functioning as an unapproved dividend to pull profits out of the insurer.

Mr. Schrader stated that based on the comments received and discussions held, the proposed guidance could benefit from additional clarifications. He stated his preference for asking the existing drafting group to work with volunteers from the interested parties to develop clarifications using the current draft as a starting point. Ms. Malm stated her agreement with this proposal. Ms. Weaver added her agreement with the proposal, and she recommended that the drafting group also research the legal process and authority across states to revoke regulatory approval of a Form D filing. Mr. Schrader stated his agreement.
with this recommendation, and he asked NAIC staff to work with the drafting group and interested party volunteers to schedule a call to move forward on this project in early 2022.

2. **Adopted Updated Salary Ranges and Rates**

Mr. Schrader said the second item on the agenda is to consider adoption of updated salary ranges for analysts and examiners and legacy per diem rates for examiners. This task is the responsibility of the Working Group based on its charge to “[c]ontinually maintain and update standardized job descriptions/requirements and salary range recommendations for common solvency monitoring positions to assist insurance departments in attracting and maintaining suitable staff.”

Mr. Schrader stated that the recommended salary ranges for analysts and examiners were first added to NAIC handbooks in 2020 based on the research and recommendations of the Working Group. At that time, the Working Group committed to reviewing and updating the ranges as needed, with a minimum review period of every other year. In addition, legacy per diem examiner rates continue to be published in the Exam Handbook, which require annual review and updates.

Mr. Schrader stated that NAIC staff were asked to utilize existing industry resources to review general changes in salary rates over the last two years, as well as changes in the Consumer Price Index over the last year, to recommend updates to both the salary ranges and legacy per diem rates in the handbooks.

Bailey Henning (NAIC) presented the results of NAIC staff research in this area. NAIC staff obtained and reviewed the Robert Half Salary Guides for 2019–2021, which showed modest annual increases from 2019 to 2020 (2–4%), and minimal increases from 2020 to 2021 (1% or less). The total change for the period ranged from 4–8% depending on position and seniority. To recognize this variation in salary increases over the past two years, NAIC staff recommended adjusting the low end of the analyst/examiner salary ranges by 3% and the high end of the salary ranges by 6%.

Ms. Henning also summarized the work performed to recommend updates to the legacy per diem rate in the Exam Handbook. Based upon the current Consumer Price Index (CPI) data available (July 2020 – July 2021), the estimated annual change in the CPI was approximately 5.37%. However, economic experts have suggested that the current level of inflation, which is a key factor in the CPI, is primarily driven by temporary supply chain disruptions due to the ongoing impact of the COVID-19 pandemic and related economic conditions. As such, NAIC staff recommended a slightly lower increase of 4.5% to base per diem salary rates in all position classifications.

Mr. Eft made a motion, seconded by Ms. Bernard, to adopt the proposed salary ranges and per diem rates (Attachment Eight-A). The motion passed unanimously.

3. **Discussed Referral Received from Chief Financial Regulator Forum**

Mr. Schrader stated that the third agenda item is to discuss a referral that the Working Group recently received from the Chief Financial Regulator Forum resulting from discussions held in August. On that call, financial regulators discussed the need to update the standardized job descriptions for analyst and examiner positions maintained by the Working Group. The referral recommends that the job descriptions be updated to incorporate additional information on relevant educational backgrounds, as well as additional duties associated with new areas of financial regulation.

Mr. Schrader suggested the formation of a volunteer drafting group to review and propose updates to the job descriptions for Working Group consideration. Ms. Belfi and Ms. Rankin both offered their support for the recommendation, and they discussed the need to keep the job descriptions up to date to assist states in attracting and maintaining qualified staff. Mr. Schrader encouraged those states interested in volunteering for the project to contact NAIC staff.

4. **Discussed Other Matters**

Mr. Schrader stated that the Working Group has continued to oversee the NAIC’s Peer Review Project in 2021 by holding two virtual sessions in light of the ongoing pandemic. Twelve states participated in a virtual session for financial analysts in May, with six states participating in a virtual session for financial examiners in October. For 2022, the Working Group is hoping that in-person sessions can be held during the second half of the year. However, the Working Group is planning to schedule another virtual analysis session for January or February 2022 to take advantage of reduced workloads for financial analysts during this time of year.
Ms. Greiner asked whether another Own Risk and Solvency Assessment (ORSA) peer review session would be scheduled for 2022. Mr. Schrader stated that the Working Group is hoping to schedule another ORSA session in 2022, and those states previously scheduled to participate in the 2020 session that was cancelled would be given priority treatment for registration.

Having no further business, the Risk-Focused Surveillance (E) Working Group adjourned.
MEMORANDUM

TO: Risk-Focused Surveillance (E) Working Group
FROM: NAIC Staff
DATE: November 9, 2021
RE: Recommended Increases to Financial Analyst and Examiner Salary Range Guidelines and Financial Examiner Per Diem Rates

The Risk-Focused Surveillance (E) Working Group is charged with maintaining and updating salary range guidelines for financial analysts and financial examiners published in the Financial Analysis Handbook and Financial Condition Examiners Handbook, respectively. The Working Group expects to consider updates to the salary ranges every two years, with the next salary survey to be conducted during 2023 and resulting recommendations to be considered for inclusion in the 2024 Handbooks. Additionally, as several states currently base examiner compensation on the salary and per diem guidelines contained in Section 1 – II (D) of the Financial Condition Examiners Handbook the Working Group will continue to ensure those rates are updated. The Working Group expects to update per diem rates annually. This memo outlines the recommended increases to the salary ranges and per diem rates, along with the methodology utilized to reach these recommendations.

Salary Range Guidelines
In 2019 the Working Group adopted salary range guidelines that were developed in recognition of the importance of compensation, particularly as it relates to the ability of an Insurance Department to attract and retain well-qualified employees. These guidelines, which were first published in the 2020 editions of the Financial Analysis Handbook and Financial Condition Examiners Handbook, were based on an in-depth salary survey that collected and analyzed salary data for state insurance regulators, banking regulators, and other related position in the financial services sector (e.g., internal and external auditors, etc.). The Working Group reviewed a high-level analysis of salary data prepared by NAIC staff which showed that increases to comparable salaries were not material. Therefore, the Working Group determined that a full salary survey is not necessary at this time, and instead recommended applying a flat rate adjustment to the existing salary ranges.

NAIC staff obtained and reviewed the Robert Half Salary guides for 2019-2021 which showed modest annual increases from 2019 to 2020 (2% - 4%), and minimal increases from 2020-2021 (1% or less). The total change for the period since the last salary survey ranges from 4% - 8% depending on position and seniority. To recognize this variation in salary increases, NAIC staff recommend adjusting the low end of the salary ranges by 3% and the high end of the salary ranges by 6%, as shown in the table below.

<table>
<thead>
<tr>
<th>Positions (Analyst &amp; Examiner)</th>
<th>Current Salary Range</th>
<th>Recommended Increase</th>
<th>Proposed Salary Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low End / High End</td>
<td>Low End / High End</td>
<td>Low End / High End</td>
</tr>
<tr>
<td>Financial Analyst/Examiner</td>
<td>$46,000 / $75,000</td>
<td>$47,380 / $79,500</td>
<td></td>
</tr>
<tr>
<td>Senior Financial Analyst/Examiner</td>
<td>$57,000 / $90,000</td>
<td>$58,710 / $95,400</td>
<td></td>
</tr>
<tr>
<td>Supervisor/Assistant Chief Analyst/Examiner</td>
<td>$80,000 / $130,000</td>
<td>$82,400 / $137,800</td>
<td></td>
</tr>
<tr>
<td>Chief Analyst/Examiner</td>
<td>$92,000 / $150,000</td>
<td>$94,760 / $159,000</td>
<td></td>
</tr>
</tbody>
</table>

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Salary and Per Diem Guidelines

The per diem guidelines are based off the Consumer Price Index (CPI). The Consumer Price Index, as defined by the U.S. Bureau of Labor Statistics (BLS), is a measure of the average change in prices of goods and services purchased by households over time. The CPI is based on prices of food, clothing, shelter, fuels, transportation fares, charges for doctors’ and dentists’ services, drugs, and other goods and services purchased for day-to-day living. In 2008, regulators determined that because the CPI takes into consideration most costs incurred by the average household, it is reasonable that an increase in salary should be within the same parameters as the increase in the cost of living. In years in which the CPI does not accurately reflect market conditions, additional work—including surveys and salary studies—may be completed to ensure proper salary suggestions.

Based upon the current CPI data available (July 2020–July 2021), the estimated annual change in CPI is approximately 5.37%. Multiple economic experts continue to suggest that the current level of inflation, which is a key factor in the CPI, is primarily driven by temporary supply chain disruptions due to the ongoing impact of the COVID-19 pandemic and related economic conditions. As such, we recommend a slightly lower increase of 4.5% to base salary rates in all position classifications shown below.

The following data table shows the average annual salary increases adopted in the previous five years as compared to the CPI, as well as the proposed increase for the following year. The information “as published by BLS” compares the CPI as of July of each year, consistent with the analysis performed in past years. As shown below, the rates suggested by the NAIC have been consistently comparable to those published by the BLS, regardless of method used.

<table>
<thead>
<tr>
<th>Classification</th>
<th>2020 Daily Rates</th>
<th>Suggested Increase</th>
<th>2021 Daily Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Company Examiner, AFE*</td>
<td>$ 339</td>
<td>4.50%</td>
<td>$ 354</td>
</tr>
<tr>
<td>Automated Examination Specialist, AFE</td>
<td>$ 415</td>
<td>4.50%</td>
<td>$ 434</td>
</tr>
<tr>
<td>(no AES**)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Insurance Examiner, CFE***</td>
<td>$ 415</td>
<td>4.50%</td>
<td>$ 434</td>
</tr>
<tr>
<td>Automated Examination Specialist, AES</td>
<td>$ 467</td>
<td>4.50%</td>
<td>$ 488</td>
</tr>
<tr>
<td>Automated Examination Specialist, CFE</td>
<td>$ 467</td>
<td>4.50%</td>
<td>$ 488</td>
</tr>
<tr>
<td>(no AES)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance Examiner In-Charge, CFE</td>
<td>$ 500</td>
<td>4.50%</td>
<td>$ 523</td>
</tr>
<tr>
<td>Supervising or Administrative Examiner</td>
<td>$ 530</td>
<td>4.50%</td>
<td>$ 554</td>
</tr>
</tbody>
</table>

* Accredited Financial Examiner
** Automated Examination Specialist
*** Certified Financial Examiner
Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation

Mutual Recognition of Jurisdictions (E) Working Group
Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation

1. **Group Capital Calculation.** On December 9, 2020, the NAIC adopted revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). These revisions implement the Group Capital Calculation (GCC) filing requirements for insurance groups at the level of the ultimate controlling person for the purposes of evaluating solvency at the group level. The revisions specifically provide that the requirement to file the NAIC’s GCC applies to U.S.-based groups, while a group headquartered outside the U.S. is exempt from the GCC (subject to limited exceptions) if its group-wide supervisor “recognizes and accepts” the GCC for U.S. groups doing business in that jurisdiction. Likewise, a U.S. group subject to a group capital calculation specified by the Federal Reserve Board is exempt from the GCC. This process codifies the concepts of mutual recognition and one group/one group-wide supervisor.

2. **NAIC Listing Process.** Section 4L(2) of Model #440 provides two ways a non-U.S. jurisdiction may meet the standards for its insurance groups to be exempt from the GCC:

   (a) If the jurisdiction has been determined to be a Reciprocal Jurisdiction for purposes of credit for reinsurance, which includes a requirement that the jurisdiction “recognizes the U.S. state regulatory approach to group supervision and group capital”; or

   (b) If the jurisdiction has otherwise been determined to recognize and accept the GCC by procedures specified in regulation.

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

3. **Covered Agreements.** The “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” was

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

2 Model #440. § 4L(2)(c).
signed on September 22, 2017. On December 18, 2018, a similar Covered Agreement was signed with the United Kingdom (UK) (collectively “Covered Agreements”). The Covered Agreements include, inter alia, the elimination of reinsurance collateral requirements for certain reinsurers licensed and domiciled in participating jurisdictions, and limit the worldwide application of prudential group insurance measures on insurance groups based in participating jurisdictions. In relevant part, the Covered Agreements provide that U.S. insurers and reinsurers can operate in the EU and UK without subjecting the U.S. parent to the host jurisdiction’s group-level governance, solvency and capital, and reporting requirements, and also provide the same protections for EU and UK insurers and reinsurers operating in the U.S. However, the Covered Agreements only exempt U.S., EU and UK insurance groups from each other’s worldwide group capital requirements if the home supervisor performs worldwide group capital assessments on its own insurance groups and has the authority to impose preventive and corrective measures.

4. Reciprocal Jurisdictions. In response to the Covered Agreements, the NAIC also amended the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) to provide that jurisdictions that are subject to in-force covered agreements are considered to be “Reciprocal Jurisdictions,” and large, financially strong reinsurers that are based in those jurisdictions are not required to post reinsurance collateral. In addition, a “Qualified Jurisdiction” under Section 2E of Model #785 may become a Reciprocal Jurisdiction if, among other requirements, it “recognizes the U.S. state regulatory approach to group supervision and group capital.” By the terms of the Covered Agreements, insurance groups based in EU Member States and the UK are entitled to exemption from the extraterritorial application of the U.S. GCC, and Section 4L(2)(c) of Model #440 recognizes that other Reciprocal Jurisdictions, which have made the same commitment, are entitled to the same treatment.

5. Other Jurisdictions that Recognize and Accept. In addition, because most of the requirements for Reciprocal Jurisdiction status are not relevant to group capital and group supervision, Section 4L(2)(d) of Model #440 provides an alternative pathway for the exemption. The ultimate controlling person of an insurance holding company system whose non-U.S. group-wide supervisor is not in a Reciprocal Jurisdiction is exempted from filing the GCC as long as the jurisdiction of its group-wide supervisor “recognizes and accepts” the GCC, as specified by the commissioner in regulation. Section 21D of Model #450 provides that a non-U.S. jurisdiction is considered to “recognize and accept” the GCC if it satisfies all of the following criteria:

   (a) The non-U.S. jurisdiction recognizes the U.S. state regulatory approach to group supervision and group capital, by providing confirmation by a competent regulatory authority, in such jurisdiction, that insurers and insurance groups whose lead state is accredited by the NAIC under the NAIC Accreditation Program shall be subject only
to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction;

(b) Where no U.S. insurance groups operate in the non-U.S. jurisdiction, that non-U.S. jurisdiction indicates formally in writing to the lead state with a copy to the International Association of Insurance Supervisors that the group capital calculation is an acceptable international capital standard. This will serve as the documentation otherwise required in Section 21D(1)(a);

(c) The non-U.S. jurisdiction provides confirmation by a competent regulatory authority in such jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner in accordance with a memorandum of understanding or similar document between the commissioner and such jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC. The commissioner shall determine, in consultation with the NAIC Committee Process, if the requirements of the information sharing agreements are in force;

(d) Notwithstanding these exemptions, Section 4L(2)(e) of Model #440 provides that a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system from a Reciprocal Jurisdiction or “Recognize and Accept” Jurisdiction where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the commissioner for prudent oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. Section 21E(1) of Model #450 then provides that to assist with a determination under Section 4L(2)(e) of Model #440, the list will also identify whether a jurisdiction that is exempted under either Sections 4L(2)(c) or 4L(2)(d) requires a group capital filing for any U.S.-based insurance group’s operations in that non-U.S. jurisdiction.

6. Mutual Recognition of Jurisdictions (E) Working Group. On March 8, 2021, the Financial Condition (E) Committee repositioned the Qualified Jurisdiction (E) Working Group to report directly to the Committee and revised the name of the group to the Mutual Recognition of Jurisdictions (E) Working Group. The Working Group received the additional charge of developing a process for evaluating jurisdictions that meet the NAIC requirements for recognizing and accepting the GCC (“Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation,” or “Recognize and Accept” Process). A separate
process exists for evaluating Qualified and Reciprocal Jurisdictions (“Process for Evaluating Qualified and Reciprocal Jurisdictions”), and it is intended that the “Recognize and Accept” Process will closely mirror this process. The Committee charged this Working Group with developing and implementing the “Recognize and Accept” Process due to this Working Group’s experience and expertise in evaluating the insurance regulatory systems of non-U.S. jurisdictions and their recognition of U.S. group-wide supervision.

7. **List of Jurisdictions that Recognize and Accept the GCC.** The Mutual Recognition of Jurisdictions (E) Working Group will evaluate non-U.S. jurisdictions in accordance with this “Recognize and Accept” Process. A list of “Recognize and Accept” Jurisdictions is published through the NAIC committee process (“NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation”; “‘Recognize and Accept’ List”; or “List”). The creation of the List does not constitute a delegation of regulatory authority to the NAIC. Although a state must consider this List under Section 21E(3) of Model #450 in its determination of whether a non-U.S. insurance group is exempt from filing an annual GCC, the List is not binding and the ultimate authority to designate a “Recognize and Accept” Jurisdiction resides solely in each state.

   (a) The List will include all Reciprocal Jurisdictions that recognize the U.S. state regulatory approach to group supervision and group capital. [See discussion in paragraph 9.]

   (b) The evaluation of non-U.S. jurisdictions that are non-Reciprocal Jurisdictions as “Recognize and Accept” Jurisdictions will be conducted in accordance with the provisions of Section 4L(2) of Model #440 and Section 21 of Model #450, and any other relevant guidance developed by the NAIC. [see discussion in paragraphs 10 and 11.]

   (c) As specified in Section 21E(1) of Model #450, the List will also identify which “Recognize and Accept” Jurisdictions require a group capital filing for a U.S.-based insurance group’s operations in that jurisdiction. [See discussion of Subgroup Capital Calculation in paragraph 13.]

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

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

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

(a) **Initiation of Evaluation.** Formal notification of the Mutual Recognition of Jurisdictions (E) Working Group’s intent to initiate the evaluation process will be sent by the NAIC to the supervisory authority in the jurisdiction selected. The process of evaluation and all related documentation are private and confidential matters between the NAIC and the applicant jurisdiction, unless otherwise provided in this document. Upon receipt of confirmation by a competent regulatory authority of the non-U.S. jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group:

i. Will direct NAIC staff and/or outside consultants with the appropriate knowledge, experience and expertise to review the materials received from the jurisdiction. Upon completing its review of the evaluation materials, the internal reviewer(s) will report initial findings to the Mutual Recognition of Jurisdictions (E) Working Group, including any significant issues or concerns identified. This report will be included as part of the official documentation of the evaluation. Copies of the initial findings may also be made available to the Federal Insurance Office (FIO) and other relevant federal authorities subject to appropriate confidentiality and information-sharing agreements being in place.

ii. Will issue public notice on the NAIC website inviting public comments with respect to consideration of the jurisdiction as a “Recognize and Accept” Jurisdiction.

iii. Will consider public comments from state regulators, U.S. insurance groups, and any other interested parties.

iv. May review other public materials deemed relevant to making a determination.

v. Will invite each non-U.S. jurisdiction, or its designee, to provide any additional information it deems relevant to making a determination.

vi. Relevant U.S. state and federal authorities will be notified of the Mutual Recognition of Jurisdictions (E) Working Group’s decision to evaluate a
jurisdiction.

(b) Preliminary Evaluation Report. NAIC staff will prepare a Preliminary Evaluation Report for review by the Mutual Recognition of Jurisdictions (E) Working Group. The report will contain a recommendation as to whether the NAIC should recognize the jurisdiction as a “Recognize and Accept” Jurisdiction. Upon review by the Working Group, the results of the Preliminary Evaluation Report will be immediately communicated in written form to the supervisory authority of the jurisdiction under review. At that time, a copy of the Preliminary Evaluation Report will also be shared with the Group Capital Calculation (E) Working Group in regulator-to-regulator session. The Group Capital Calculation (E) Working Group will also be kept advised of any new developments in the evaluation of this jurisdiction.

(c) Final Evaluation Report. Upon receipt of the Preliminary Evaluation Report, the supervisory authority will have an opportunity to respond to the initial findings and determination. The Mutual Recognition of Jurisdictions (E) Working Group will consider any response, and will proceed to prepare its Final Evaluation Report. The Working Group will consider the Final Evaluation Report for approval in regulator-to-regulator session.

(d) Summary of Findings and Determination. Upon approval of the Final Evaluation Report, the Mutual Recognition of Jurisdictions (E) Working Group will issue a public statement and a summary of its findings with respect to its determination. At this time, the Working Group will release the Summary of Findings and Determination for public comment. Once the Working Group has finally adopted the Summary of Findings and Determination in open session after opportunity for public comment, it will submit the summary of its findings and its recommendation to the Financial Condition (E) Committee at an open meeting. Upon approval by the Committee, the summary and recommendation will be submitted to the Executive (EX) Committee and Plenary, as well as to the Federal Insurance Office (FIO), United States Trade Representative (USTR) and other relevant federal authorities for informational purposes. Upon approval as a “Recognize and Accept” Jurisdiction by the Executive (EX) Committee and Plenary, the jurisdiction will be added to the NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation.

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

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

(a) The Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm that to the best of its determination the representations in the written confirmation are true and accurate.

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

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

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

(a) The Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm that, to the best of its determination, the representations in the written confirmation are true and accurate.

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

(c) NAIC staff will work with the Mutual Recognition of Jurisdictions (E) Working Group and the applicant jurisdiction to prepare an acceptable confirmation letter for this purpose.

12. Memorandum of Understanding.

Section 21D(2) of Model #450 requires a non-Reciprocal Jurisdiction that “recognizes and accepts” the GCC to provide confirmation by a competent regulatory authority that information regarding insurers, and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state commissioner of any U.S.-based insurance group doing business in that jurisdiction, in accordance with a memorandum of understanding or similar document between the commissioner and the jurisdiction. Acceptable MOUs include, but are not limited to, the International Association of Insurance Supervisors Multilateral Memorandum of Understanding (“IAIS MMoU”) or other multilateral memoranda of understanding coordinated by the NAIC. The Mutual Recognition of Jurisdictions (E) Working Group will review such memoranda of understanding and include an opinion in the Summary of Findings and Determination as to whether the jurisdiction has met this condition to be included on the “Recognize and Accept” List.

(a) The lead state will act as a conduit for information between the “Recognize and Accept” Jurisdiction and other states that have an insurer from that jurisdiction, and will share information with these states consistent with the terms governing the further sharing of
information included in the applicable MOU, and pursuant to the NAIC Master Information Sharing and Confidentiality Agreement. The jurisdiction must also confirm in writing that it is willing to permit this lead state to act as the contact for purposes of sharing information concerning all insurers within the group.

(b) If a jurisdiction has not been approved by the IAIS as a signatory to the MMoU, it must either (1) enter into an MOU with the lead state, or (2) enter into an MOU with a state that has agreed to serve as a single point of contact for multiple lead states, similar to the procedure for sharing information under the Process for Evaluating Qualified and Reciprocal Jurisdictions. The MOU must also provide for appropriate confidentiality safeguards with respect to the information shared among the jurisdictions.

(c) The same requirements and procedures will apply to a Reciprocal Jurisdiction that is subject to a case-by-case “recognize and accept” review, unless the necessary information-sharing procedures are already specified in the applicable covered agreement.

13. Prudential Oversight and Solvency Monitoring. Section 4L(2)(e) of Model #440 directs a lead state commissioner to require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system based in a “Recognize and Accept” Jurisdiction if, after any necessary consultation with other supervisors or officials, the commissioner deems such a “subgroup” calculation to be appropriate for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace. Section 21E(1) of Model #450 provides that to assist with such a determination, the “Recognize and Accept” List will also identify whether a listed jurisdiction requires a group capital filing for any U.S. based insurance group’s operations in that jurisdiction. As part of Paragraph 8, Procedure for Evaluation of Non-U.S. Jurisdiction, the Mutual Recognition of Jurisdictions (E) Working Group will perform a due diligence review of available public and confidential documents to confirm whether or not any “Recognize and Accept” Jurisdiction requires a subgroup group capital filing for a U.S.-based insurance group’s operations, and a discussion and findings on this review will be included in the Preliminary Evaluation Report, Final Evaluation Report and Summary of Findings and Determination. If the Working Group has evidence indicating that a jurisdiction requires a subgroup group capital filing for any U.S.-based insurance group’s operations in that jurisdiction, it will attempt to obtain written confirmation of the existence and scope of any such requirement from a competent regulatory authority in that jurisdiction, but it is recognized that such a confirmation is not an essential element of the Working Group’s determination. The NAIC will identify such jurisdictions on the “Recognize and Accept” List, and may include an explanatory note in cases where a simple “Yes” or “No” response does not adequately describe the jurisdiction’s requirements. States may rely on this List when making determinations under Section 4L(2)(e) of Model #440.
14. **Process for Periodic Evaluation.** The process for determining whether a non-U.S. jurisdiction is a “Recognize and Accept” Jurisdiction is ongoing and subject to periodic review. The Mutual Recognition of Jurisdictions (E) Working Group will perform a yearly review of the NAIC List of Jurisdictions that Recognize and Accept the Group Capital Calculation to determine whether there have been any significant changes over the prior year that might affect inclusion on the List. This yearly review shall follow such abbreviated process as may be determined by the Working Group to be appropriate.

(a) Upon determination by a lead state commissioner that a non-U.S. jurisdiction no longer meets one or more of the requirements to “recognize and accept” the GCC, the lead state commissioner may provide a recommendation to the Working Group that the jurisdiction be removed from the “Recognize and Accept” List. Upon review and after consultation with the “Recognize and Accept” Jurisdiction, the Working Group may remove the jurisdiction from the List, which must then be confirmed by the Financial Condition (E) Committee and the NAIC Executive (EX) Committee and Plenary.

(b) Upon determination by a lead state commissioner that a non-U.S. jurisdiction requires a group capital filing for any U.S. based insurance group’s operations in that non-U.S. jurisdiction, the lead state commissioner may provide a recommendation to the Working Group that the non-U.S. jurisdiction be identified as such on the “Recognize and Accept” List. Upon receipt of any such notice, the Mutual Recognition of Jurisdictions (E) Working Group will also consider whether it is necessary to re-evaluate the jurisdiction’s “Recognize and Accept” status.

(c) The Mutual Recognition of Jurisdictions (E) Working Group will also give due consideration to any notice from a U.S.-based insurance group that it has been required to perform a group capital calculation, at either the group-wide or subgroup level, in a jurisdiction on the “Recognize and Accept” List.

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

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

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

As the competent regulatory authority for [non-U.S. Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories the following:

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

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

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

As the competent regulatory authority and lead insurance regulatory supervisor for [non-U.S. Jurisdiction], I hereby confirm to the National Association of Insurance Commissioners (NAIC) and the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories, with a copy to the International Association of Insurance Supervisors (IAIS), the following:

- [Non-U.S. Jurisdiction] recognizes the Group Capital Calculation as defined under Section 4L(2) of the NAIC Insurance Holding Company System Regulatory Act (#440) as an acceptable international capital standard.

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

- [Non-U.S. Jurisdiction] will immediately notify the NAIC upon any changes to the assurances provided in this letter.

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

Reinsurance Financial Analysis (E) Working Group
ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers (“ReFAWG Review Process”)

1. ReFAWG Review Process

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

a. In November 2011, the NAIC adopted revisions to its Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) which reduce the prior reinsurance collateral requirements for non-U.S. licensed reinsurers that are licensed and domiciled in Qualified Jurisdictions and establish a certification process for reinsurers under which a Certified Reinsurer is eligible for collateral reduction with respect to contracts entered into or renewed subsequent to certification. The authority to issue individual ratings of certified reinsurers is reserved to the NAIC member jurisdictions under their respective statutes and regulations. While this forum is intended to strengthen state regulation and prevent regulatory arbitrage, it is not within the authority of the Working Group to assign collateral requirements for individual reinsurers.

b. On June 25, 2019, the NAIC adopted further revisions to the models, which implement the reinsurance collateral provisions of the Covered Agreements with the European Union (EU) and the United Kingdom (UK). The revisions eliminate reinsurance collateral requirements and local presence requirements for EU and UK reinsurers that maintain a minimum amount of own-funds equivalent to $250 million USD and a solvency capital requirement (SCR) of 100% under Solvency II. The revisions also incorporate the “Reciprocal Jurisdiction” concept. Reciprocal Jurisdiction status is afforded to (1) jurisdictions subject to an in-force Covered Agreement within the U.S.; (2) accredited U.S. jurisdictions; and (3) Qualified Jurisdictions if they meet certain requirements in the credit for reinsurance models. ReFAWG has also been given additional responsibilities with respect to these “Reciprocal Jurisdiction Reinsurers.” ReFAWG will coordinate its efforts with the Mutual Recognition of Jurisdictions (E) Working Group (formerly known as the Qualified Jurisdictions (E) Working Group).

c. Issues upon which the Working Group may provide advisory support and assistance include but are not limited to:

   i. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for
reinsurance collateral reduction and qualified jurisdictions should strengthen state
regulation and prevent regulatory arbitrage.

ii. Provide a forum for discussion, among NAIC jurisdictions, of reinsurance issues related to
specific companies, entities or individuals.

iii. Support, encourage, promote and coordinate multi-state efforts in addressing issues related
to certified reinsurers, including but not limited to multi-state recognition of certified
reinsurers.

iv. Provide analytical expertise and support to the states with respect to certified reinsurers
and applicants for certification.

v. Interact with domiciliary regulators of ceding insurers and certifying states to assist and
advise on the most appropriate regulatory strategies, methods and actions with respect to
certified reinsurers.

vi. Provide advisory support with respect to issues related to the determination of qualified
jurisdictions.

vii. Ensure the public passporting website remains current.

viii. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective
approaches for the financial solvency surveillance to assist the states in their work to
protect the interests of policyholders.

2. Lead States and Passporting Process

a. A reinsurer seeking recognition as either a Certified Reinsurer or a Reciprocal Jurisdiction
Reinsurer must submit certain information to each state in which it seeks such recognition. A
reinsurer may decide to make a filing with a Lead State and use the NAIC Passporting process to
facilitate multi-state recognition or a reinsurer may decide to submit the information to each state
as a separate application. Under the ReFAWG Review Process, ReFAWG will assist the states with
the initial review of this information and provide guidance to the states in making their review of
the reinsurer to determine whether it has met the regulatory requirements to be recognized as a
Certified Reinsurer and/or a Reciprocal Jurisdiction Reinsurer.

b. Passporting for Certified Reinsurers - In addition to this assistance to individual states,
ReFAWG will also assist with a passporting process for the states. “Passporting” refers to the
process under which a state has the discretion to defer to the certification of a reinsurer (and the
rating assigned to that certified reinsurer) by another state. Under this process, a reinsurer will apply
to an initial state for certification, referred to as the “Lead State,” which will begin its analysis of
the reinsurer and notify ReFAWG of the application. The Lead State will complete its initial
analysis and will submit filing information and other documentation to ReFAWG for a peer review.
Upon completion of the confidential peer review process, ReFAWG will make its recommendation
concerning both the certified status of the reinsurer and its rating. The Lead State then makes the
final determination regarding certification, upon which the Lead State notifies ReFAWG and the
certified reinsurer is eligible to apply for passporting into other states. States are encouraged to
utilize the passporting process to reduce the amount of documentation filed with the states and
reduce duplicate filings.
c. **Passporting for Reciprocal Jurisdiction Reinsurers** - A similar Passporting Process is in place with respect to Reciprocal Jurisdiction Reinsurers as outlined in Sections 5 and 6 below. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination with respect to compliance with this section. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings.

d. **Discretion to Defer to Lead State** - If an NAIC accredited jurisdiction has determined that the conditions set forth for recognition as a Reciprocal Jurisdiction Reinsurer have been met, the commissioner of any other state has the discretion to defer to that jurisdiction’s determination and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit. The commissioner may accept financial documentation filed with the Lead State or with the NAIC and is encouraged to support a uniform submission and approval process among the states of the NAIC. ReFAWG and the Mutual Recognition of Jurisdictions (E) Working Group will coordinate efforts to obtain financial information regarding both Certified Reinsurers and Reciprocal Jurisdiction Reinsurers and disseminate it to the states.

e. **Communication with ReFAWG** - The ReFAWG Review Process is designed to facilitate communication of relevant information with respect to individual reinsurers or reinsurance related issues by allowing interested state insurance regulators the opportunity to monitor the ReFAWG meetings and discussion. It should be noted that the process for engaging ReFAWG in the consideration of an application is intended to be flexible. Specific circumstances may necessitate discussion between ReFAWG and any states that have received any application in order to determine an appropriate lead state on a case-by-case basis.

f. **Change of Lead State** - The Lead State for a Certified Reinsurer and/or a Reciprocal Jurisdiction Reinsurer may change based upon mutual agreement between the current lead state and any other state where the reinsurer is recognized, with input to be provided by ReFAWG. Upon a change in lead state, NAIC staff will provide timely notification to all states. In order to facilitate a change of lead state from one state to another, both states should discuss the rationale for the change during a regulator-only ReFAWG meeting. NAIC Staff will update the lead state and note such change on NAIC systems and send notice to ReFAWG and interested regulators.

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

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

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

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

a. **Qualified Jurisdiction** - The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction. The applicant must be in good standing and provide a copy of the certificate of authority or license to transact insurance and/or reinsurance business.

b. **Capital and Surplus** - The assuming insurer must maintain capital and surplus of no less than $250,000,000 as reported within its audited financial statement. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

c. **Financial Strength Ratings** - The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. The applicant must provide the rating agency report. If the rating is a group rating, the rationale for the group rating must be provided. Initial or Affirmed financial strength rating dates must be within 15 months of the application date/renewal filing date. Acceptable rating agencies include: A.M. Best, Fitch Ratings, Moody’s, Standard & Poor’s or any other Nationally Recognized Statistical Rating Organization by the SEC. Kroll is not recognized as an acceptable rating organization in Model #786 but has been recognized as an acceptable rating organization by the Reinsurance (E) Task Force.
d. The following table outlines the necessary ratings needed to meet a secure level:

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Collateral Required</th>
<th>A.M. Best</th>
<th>Standard &amp; Poor’s</th>
<th>Moody’s</th>
<th>Fitch</th>
<th>Kroll</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure – 1</td>
<td>0%</td>
<td>A++</td>
<td>AAA</td>
<td>Aaa</td>
<td>AAA</td>
<td>AAA</td>
</tr>
<tr>
<td>Secure – 2</td>
<td>10%</td>
<td>A+</td>
<td>AA+, AA, AA-</td>
<td>Aa1, Aa2, Aa3</td>
<td>AA+, AA, AA-</td>
<td>AA+, AA, AA-</td>
</tr>
<tr>
<td>Secure – 3</td>
<td>20%</td>
<td>A</td>
<td>A+, A</td>
<td>A1, A2</td>
<td>A+, A</td>
<td>A+, A</td>
</tr>
<tr>
<td>Secure – 4</td>
<td>50%</td>
<td>A-</td>
<td>A-</td>
<td>A3</td>
<td>A-</td>
<td>A-</td>
</tr>
<tr>
<td>Secure – 5</td>
<td>75%</td>
<td>B++, B+</td>
<td>BBB+, BBB, BBB-</td>
<td>Baa1, Baa2, Baa3</td>
<td>BBB+, BBB, BBB-</td>
<td>BBB+, BBB, BBB-</td>
</tr>
</tbody>
</table>

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

i. For reasons set forth in the rating agency report or its published ratings standards or guidelines, the rating agency utilizes the group rating as a consequence of finding that the company had sufficient interconnectivity with the group;

ii. For reasons set forth in the rating agency report or its published ratings standards or guidelines, the rating agency enhances the group rating due to the subsidiary’s potential benefit of capital support from one or more affiliated companies;

iii. The group rating was utilized because the subsidiary derives benefit from its inclusion within a financially strong and well-capitalized insurance group;
iv. The lead state has contacted the rating agency and was provided a written explanation for the use of the group rating;

v. Other factors deemed appropriate by the Reinsurance Financial Analysis (E) Working Group; or

vi. To assist the Lead State in the assessment of the appropriateness of the use of a group rating, applicants are encouraged to provide their rational for the use of a group rating.

f. Changes in Ratings

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

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

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

g. Schedule F/S (Ceded Reinsurance) – Applicants domiciled in the U.S. must provide the most recent NAIC Annual Statement Blank Schedule F (property/casualty) and/or Schedule S (life and
health). Applicants domiciled outside the U.S. must provide Form CR-F (property/casualty) and/or Form CR-S (life and health), completed in accordance with the instructions.

h. **Disputed and/or Overdue Reinsurance Claims** - The applicant must provide a detailed explanation regarding reinsurance obligations to U.S. cedents that are in dispute and/or more than 90 days past due that exceed 5% of its total reinsurance obligations to U.S. cedents as of the end of its prior financial reporting year or reinsurance obligations to any of the top 10 U.S. cedents (based on the amount of outstanding reinsurance obligations as of the end of its prior financial reporting year) that are in dispute and/or more than 90 days past due exceed 10% of its reinsurance obligations to that U.S. cedent. The applicant must then provide a description of its business practices in dealing with U.S. ceding insurers and a statement that the applicant commits to comply with all contractual requirements applicable to reinsurance contracts with U.S. ceding insurers.

i. **Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer** - The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. Use of multi-beneficiary trust must include: (1) approval from the domiciliary regulator; (2) the form of the trust that will be used as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant’s certified reinsurer status (if applicable).

j. **Regulatory Actions** – The applicant must provide a description of any regulatory actions taken against the applicant. Include details on all regulatory actions, fines, and penalties. Further, a description of any changes in with respect to the provisions of the applicant’s domiciliary license should be provided.

k. **Audited Financial Report and Actuarial Opinion** – As filed with its non-U.S. jurisdiction supervisor, with a translation into English, the applicant must file audited financial statement for the current and prior year and an actuarial opinion (must be stand-alone, or the functional equivalent under the Supervisor’s applicable Actuarial Function Holder Regime).

l. **Solvent Schemes of Arrangement** - The applicant must provide a description of any past, present, or proposed future participation in any solvent scheme of arrangement, or similar procedure, involving U.S. ceding insurers.

m. **Form CR-1** - The applicant must provide a state lead state specific Form CR-1, which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form.

n. **Other Requirements** - The applicant must commit to comply with other reasonable requirements deemed necessary for certification by the certifying state. Further, the applicant must provide a statement that it agrees to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.

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

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

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

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

a. **Qualified Jurisdiction** - The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction.

b. **Verification of Certification Issued by an NAIC Accredited Jurisdiction** – The applicant must provide a copy of the approval letter or other documentation provided to the applicant by the NAIC accredited jurisdiction. The letter should include the state, rating and collateral percentage assigned, effective date, lines of business, and the applicant’s statement on compliance. ReFAWG may also verify a certification issued by an NAIC accredited jurisdiction through its internal processes.

c. **Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer** - The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. Use of multi-beneficiary trust must include: (1) approval from the domiciliary regulator; (2) the form of the trust that will be used as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant’s certified reinsurer status (if applicable).

d. **Form CR-1** - The applicant must provide a state lead state specific Form CR-1, which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form.

e. **Other Requirements** - The applicant must commit to comply with other reasonable requirements deemed necessary for certification by the certifying state. Further, they must provide a statement that they agree to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.

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

**Annual Verification of Minimum Standards:**

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

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

a. **Status of Reciprocal Jurisdiction** - The assuming insurer must be licensed to write reinsurance by, and have its head office or be domiciled in, a Reciprocal Jurisdiction that is listed on the *NAIC List of Reciprocal Jurisdictions*. A “Reciprocal Jurisdiction” is a jurisdiction, as designated by the commissioner, that meets one of the following: (1) a non-U.S. jurisdiction that is subject to an in-force Covered Agreement with the United States; (2) a U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Standards and Accreditation Program; or (3) a Qualified Jurisdiction that has been determined by the commissioner to meet all applicable requirements to be a Reciprocal Jurisdiction. The Reciprocal Jurisdiction Reinsurer should identify which type of jurisdiction it is domiciled in and provide any documentation to confirm this status if requested by the commissioner.

b. **Minimum Capital and Surplus** - The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction: no less than $250,000,000 (USD); or if the assuming insurer is an association, including incorporated and individual unincorporated underwriters: minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least $250,000,000 (USD); and a central fund containing a balance of the equivalent of at least $250,000,000 (USD). The assuming insurer’s supervisory authority must confirm to the Lead State commissioner on an annual basis according to the methodology of its domiciliary jurisdiction that the assuming insurer satisfies this requirement. The Mutual Recognition of Jurisdictions (E) Working Group will coordinate the confirmations of the domiciliary jurisdictions with ReFAWG with respect to individual Reciprocal Jurisdiction Reinsurers.

c. **Minimum Solvency or Capital Ratio** - The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio: The ratio specified in the applicable in-force
Covered Agreement where the assuming insurer has its head office or is domiciled; or if the assuming insurer is domiciled in an accredited state, a risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, calculated in accordance with the formula developed by the NAIC; or if the assuming insurer is domiciled in a Reciprocal Jurisdiction that is a Qualified Jurisdiction, such solvency or capital ratio as the commissioner determines to be an effective measure of solvency. The assuming insurer’s supervisory authority must confirm to the Lead State commissioner on an annual basis that the assuming insurer complies with this requirement. The Mutual Recognition of Jurisdictions (E) Working Group will coordinate the confirmations of the domiciliary jurisdictions with ReFAWG with respect to individual Reciprocal Jurisdiction Reinsurers.

d. **Form RJ-1** - The assuming insurer must provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.

e. **Audited Financial Report** - The assuming insurer’s annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report as provided under Section 9C(5)(a) of Model #786.

f. **Solvency and Financial Condition Report or Actuarial Opinion** – The applicant must submit a solvency and financial condition report or actuarial opinion, if filed with the assuming insurer’s supervisor as provided under Section 9C(5)(b) of Model #786.

g. **Overdue Reinsurance Claims** – The applicant must submit a list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States as provided under Section 9C(5)(c) of Model #786. The commissioner shall request the reinsurer to provide the information required to demonstrate the reinsurer’s practice of prompt payment of claims under its reinsurance agreements prior to entry into a reinsurance agreement, and annually thereafter, in order to demonstrate compliance with Section 9C(6) of Model #786.

h. **Assumed and Ceded Reinsurance Schedules** – The applicant must submit information regarding the assuming insurer’s assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer as provided under Section 9C(5)(d) of Model #786. Applicants domiciled in the U.S. must provide the most recent NAIC Annual Statement Blank Schedule F (property/casualty) and/or Schedule S (life and health). Applicants domiciled outside the U.S. may provide this information using Form CR-F (property/casualty) and/or Form CR-S (life and health), which ReFAWG considers sufficient to meet this requirement.

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

6. Reciprocal Jurisdiction Process – Passporting States

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

a. Form RJ-1 - The assuming insurer must provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.

b. Verification of Determination Issued by an NAIC Accredited Jurisdiction – The applicant must provide a copy of the approval letter or other documentation provided to the applicant by the NAIC accredited jurisdiction. The letter should include the state, effective date, and lines of business.

7. NAIC Staff Review of Certified and Reciprocal Jurisdiction Reinsurers

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

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

8. Process for Ongoing Monitoring of Reinsurers

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

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

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

   a. Under Section 8A(5) Model #786, credit for reinsurance shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer with respect to Certified Reinsurers. Under Section 2F(7) of the Credit for Reinsurance Model Law (#785), credit shall be taken with respect to Reciprocal Jurisdiction Reinsurers only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements to be designated a Reciprocal Jurisdiction Reinsurer, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.

   b. It is expected that certain assuming insurers may be considered to be Certified Reinsurers for purposes of in-force business or business with existing liabilities and Reciprocal Jurisdiction Reinsurers with respect to reinsurance agreements entered into, amended, or renewed on or after the effective date. In addition, these same reinsurers may also have certain blocks of business that are fully collateralized under the prior provisions of Model #785 and Model #786. The NAIC Blanks have been amended to reflect the status of these reinsurers with respect to each type of insurance assumed.

   c. With respect to those reinsurers that are currently Certified Reinsurers but are seeking recognition by ReFAWG as Reciprocal Jurisdiction Reinsurers for passporting purposes, the same process as outlined in paragraphs 3-6 of this ReFAWG Review Process must be followed. A Form RJ-1 must be filed with each state in which the reinsurer seeks recognition as a Reciprocal Jurisdiction Reinsurer, and the reinsurer must meet all other applicable requirements. However, states may share this information with other states through the NAIC and the ReFAWG Review Process, and previously filed information used in the review of the reinsurer as a Certified Reinsurer may also be utilized in its review as a Reciprocal Jurisdiction Reinsurer. For example, a Reciprocal Jurisdiction Reinsurer may cross reference information/documentation that has been filed with respect to its status as a Certified Reinsurer, so that it is not necessary to file duplicative documents. ReFAWG will take full advantage of the passporting process, with the intent of reducing the amount of documentation filed with the states and reduce duplicate filings.

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

11. Commissioner Shall Create and Publish Lists

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

To the NAIC Climate and Resiliency Task Force

December 9, 2021

2022 Charges

CEJ writes to recommend an additional charge Financial Condition (E) Committee for 2022.

Impacts of Insurer Investments on Communities of Color

We propose a charge for the Financial Condition (E) Committee e to engage on race and insurance. Attached is our letter to the Committee on Race urging their endorsement of charges related to race and insurance to subject matter committees, task forces and working groups.

Despite powerful statements1 made in connection with the establishment of the Committee on Race regarding the importance and urgency of addressing issues of race in insurance in July 2020, the Committee has progressed very slowly with little progress or concrete actions. One notable exception is the work of the health work stream’s efforts to develop principles for data collection to facilitate analysis of racially-biased outcomes in health insurance.

While we endorse the role of the Committee on Race as a coordinating body for the NAIC’s efforts to address systemic racism in insurance, placing all work on race and insurance has been limited to the activities of the Committee. This has proven to be an unproductive approach for at least two reasons.

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1 “It is the duty of the insurance sector to address racial inequality while promoting diversity in the insurance sector. We welcome the public commitments of industry leaders to address these issues and I am excited by the strong and personal commitment of my fellow commissioners to take action on these important subjects. If not us, who? If not now, when?” NAIC President Ray Farmer

“Our regulatory system and insurance in general is a reflection of the society it aims to protect, and while state insurance regulators have worked to eliminate overt discrimination and racism, we all have been increasingly aware that unconscious bias can be just as damaging to society,” said NAIC CEO, Mike Consedine.

At https://content.naic.org/article/news_release_naic_announces_special_committee_race_and_insurance.htm
First, the work streams – particularly life and p/c – have moved very slowly and have had a difficult time developing a strategy for moving forward. The p/c stream has only recently – last week! – started on the important step of reviewing critical concepts in unfair discrimination. But the scale of the issue of race and insurance is far too great for all the work to be done in one location, as evidenced by the lack of progress by the Committee.

Two, whenever CEJ has raised the issue of racial bias in subject matter committees, task forces and working groups, the response has always been that the issues are being addressed at the Committee on Race and the subject matter group declines to even examine issues of race and insurance in their subject matter areas. By excluding the subject matter groups from examining issues of race and insurance in their areas of expertise, the Committee on Race loses the opportunity for better understanding of racial impacts in particular phases of the insurance life cycle and the members of the subject matter groups lose the opportunity to engage more fully and better understand issues of race and insurance.

Consequently, we have urged the Committee on Race to distribute important and necessary work to the relevant subject matter committees, task forces and working groups, while continuing both the coordination of work on race and insurance and addressing the high-level issues that cross lines of insurance and phases of the insurance life cycle. We urge to Financial Condition (E) Committee to seek and accept a relevant charge related to exploring issues of race and insurance.

Financial Condition (E) Committee

- **E Committee**: Examine and identify investment practices of insurers that may disproportionately impact communities of color. Report to the Committee on Race by the 2022 Summer National Meeting.

Thank you for your consideration.
ACCOUNTING PRACTICES AND PROCEDURES (E) TASK FORCE

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The Accounting Practices and Procedures (E) Task Force met in San Diego, CA, Dec. 11, 2021. The following Task Force members participated: Cassie Brown, Chair, represented by Jamie Walker (TX); Trinidad Navarro, Vice Chair, represented by Rylynn Brown (DE); Lori K. Wing-Heier represented by David Phifer (AK); Alan McClain represented by Leo Liu (AR); Ricardo Lara represented by Kim Hudson and Susan Bernard (CA); Andrew N. Mais represented by William Arfas and Kenneth Cotrone (CT); Karima M. Woods represented by N. Kevin Brown (DC); David Altmaier represented by Robert Ridenour (FL); Michelle B. Santos (GU) Doug Ommen represented by Kevin Clark and Daniel Mathis (IA); Dean L. Cameron represented by Jessie Adamson and Eric Fletcher (ID); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by John Turchi (MA); Eric A. Cioppa represented by Vanessa Sullivan (ME); Anita G. Fox represented by Judy Weaver (MI); Grace Arnold represented by Kathleen Orth (MN); Chlora Lindley-Myers represented by John Rehagen (MO); Mike Causey represented by Amy Malm (WI); Allan L. McVey represented by Tonya Gillespie (WV); and Jeff Rude represented by Linda Johnson (WY).

1. Adopted its Summer National Meeting Minutes


Mr. Bruggeman stated that the Working Group adopted the following nonsubstantive revisions to statutory accounting guidance:

A. SSAP No. 32R—Preferred Stock: Revisions remove lingering references to clarify that historical cost is not a permitted valuation method. Other revisions ensure consistencies with previously adopted language. (Ref #2021-17)

B. SSAP No. 43R—Loan-Backed and Structured Securities: Revisions capture Securities Valuation Office (SVO)-identified credit tenant loans (CTLs) in scope of SSAP No. 43R. Revisions also remove examples of various securities from a non-scope paragraph. (Ref #2021-11)

C. Appendix F – NAIC Policy Statements: NAIC Policy Statement on Maintenance of Statutory Accounting Principles: In response to a referral received from the Financial Condition (E) Committee, revisions modify the historical use of the terms “substantive” and “nonsubstantive.” Effective Jan. 1, 2022, substantive modifications will be identified as a “new SAP concept,” while nonsubstantive modifications will be a “SAP clarification.” (Ref #2021-14)
D. Blanks Proposal: Adopted an agenda item supporting supplemental reporting of Federal Home Loan Bank (FHLB) borrowings classified as a deposit-type contract and reported on Exhibit 7 – Deposit-Type Contracts. This agenda item did not result in statutory revisions; however, it reflected support for blanks proposal 2021-15BWG. (Ref #2021-16)

E. Adopted the following editorial revisions (Ref #2021-19EP):

   i. SSAP No. 16R—Electronic Data Processing Equipment and Software: Revisions correct various paragraph references.

   ii. SSAP No. 43R: Revisions remove outdated references to guidance previously deleted.

F. Nullified Interpretation (INT) 20-10: Reporting Nonconforming Credit Tenant Loans as no longer applicable for statutory accounting. While the INT expired on Oct. 1, for historical documentation purposes, the Working Group nullified the reporting exceptions within the INT. The revisions adopted to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) make this guidance no longer relevant. (INT 20-10 and Ref# 2021-11)

Mr. Bruggeman said the Working Group exposed the following nonsubstantive revisions to statutory accounting guidance:

A. SSAP No. 22R—Leases:

   i. Revisions clarify that in any scenario in which a lease terminates early, all remaining leasehold improvements shall be immediately expensed. (Ref #2021-25)

   ii. Revisions reject Accounting Standards Update (ASU) 2021-05, Leases (Topic 842), Lessors—Certain Leases with Variable Lease Payments for statutory accounting. (Ref #2021-29)

B. SSAP No. 25—Affiliates and Other Related Parties and SSAP No. 43R: Revisions clarify the identification and reporting requirements for affiliated transactions and incorporate new disclosures to identify investments held that involve related parties. The new disclosures will require identification when investments are acquired through, or in, related parties, regardless of if they meet the definition of an affiliate. (Ref #2021-21)

C. SSAP No. 43R: Revisions reflect updated NAIC designation and designation category guidance adopted by the Valuation of Securities (E) Task Force to the P&P Manual for residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS). (Ref #2021-23)

D. SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance: Revisions reflect 2021 clarifications to life and health reinsurance disclosures and provide a proposed guidance document to address auditor inquiries based on disclosures initially reported at year-end 2020. (Ref #2021-31)

E. SSAP No. 68—Business Combinations and Goodwill: Revisions reject ASU 2021-03, Intangibles – Goodwill and Other (Topic 350) – Accounting Alternative for Evaluating Triggering Events for statutory accounting. (Ref #2021-28)

F. SSAP No. 72—Surplus and Quasi-Reorganizations: Revisions reject ASU 2021-04, Earnings Per Share (Topic 260), Debt—Modifications and Extinguishments (Subtopic 470-50), Compensation—Stock Compensation (Topic 718), and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40)—Issuer’s Accounting for Certain Modifications or Exchanges of Freestanding Equity-Classified Written Call Options for statutory accounting. Revisions incorporate guidance on how to account for changes in fair values for written call options. (Ref #2021-27)

G. SSAP No. 86—Derivatives: Agenda item seeks public comment regarding possible revisions in considering an expanded effective hedge relationship permitted under U.S. generally accepted accounting principles (GAAP) within ASU 2017-12: Derivatives and Hedging: Targeted Improvements to Accounting for Hedging Activities. (Ref #2021-20)

H. SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees: Revisions remove reference to the “standard scenario” to ensure consistency with VM-21, Requirements for Principle-Based Reserves for Variable Annuities. (Ref #2021-18)
I. **Appendix D—Nonapplicable GAAP Pronouncements**: Revisions reject ASU 2021-04, Presentation of Financial Statements (Topic 205), Financial Services—Depository and Lending (Topic 942), and Financial Services—Investment Companies (Topic 946), Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10786, Amendments to Financial Disclosures about Acquired and Disposed Businesses, and No. 33-10835, Update of Statistical Disclosures for Bank and Savings and Loan Registrants as not applicable for statutory accounting. (Ref #2021-30)

J. **Bond Proposal Project**: Exposed a discussion draft of potential reporting options to revise Schedule D, Part 1: Long-Term Bonds to capture more granularity and transparency of investments reported as bonds. It also exposed revisions to the proposed principle concepts in determining whether an asset-backed security (ABS) satisfies the credit enhancement criteria for reporting as a bond. (Ref #2019-21)

K. **Blanks Referrals**

i. Exposed and sponsored a proposal to the Blanks (E) Working Group to supplement reporting of subsidiary, controlled, and affiliated entities (SCA) investments reported in Schedule D, Part 1, Section 1: Valuation of Shares of Subsidiary, Controlled or Affiliated Companies. The supplemental data is consistent with SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities disclosure requirements, and it will assist state insurance regulators in identifying: 1) sub 1 and sub 2 filings are being submitted; and 2) situations where NAIC-approved values vary significantly from values reported on Schedule D-6-1. (Ref #2021-22)

ii. Exposed and sponsored a proposal to the Blanks (E) Working Group to add a new general interrogatory to require disclosure of when cryptocurrencies are directly held or permitted for the remittance of premiums. (Ref #2021-24)

L. **Editorial Revisions**: Exposed revisions to terminology references of “substantive” and “nonsubstantive” to reflect “new SAP concept” and “SAP clarification.” (Ref #2021-26EP)

Mr. Bruggeman stated that the comment period for items exposed is Feb. 18, 2022, except for agenda items 2021-18 and 2021-31, which have a Jan. 14, 2022, comment deadline to allow for possible adoption prior to the filing of the 2021 financial statements and their audited reports. He noted that these two items may be subject to a possible e-vote for adoption.

Mr. Bruggeman stated that the Working Group disposed agenda item 2020-24: Accounting and Reporting of Credit Tenant Loans without statutory revisions. He noted that with edits adopted to clarify the determination of a CTL, further discussion on this agenda item was no longer required. (Ref #2020-24)

Mr. Bruggeman provided that the Working Group received an update on the following items:


B. Received an update on the Working Group referral of agenda item 2019-49: Retroactive Reinsurance Exception regarding diversity in the reporting of companies applying the retroactive reinsurance exception, which allows certain contracts to be reported prospectively. The Casualty Actuarial and Statistical (C) Task Force discussed this item on Dec. 7 and exposed a presentation.

C. Received an update on U.S. GAAP exposures, noting that pending items will be addressed during the normal maintenance process.

D. Received an update on key pending projects and discussed priorities.

Mr. Bruggeman made a motion, seconded by Mr. Eft to adopt the report of the Statutory Accounting Principles (E) Working Group (Attachment One). The motion passed unanimously.

Mr. Hudson provided the report of the Blanks (E) Working Group, which met Nov. 16, 2021.

Mr. Hudson stated that the Working Group adopted its July 22 minutes (*see NAIC Proceedings – Summer 2021, Accounting Practices and Procedures (E) Task Force, Attachment Two*).

Mr. Hudson stated that the Working Group adopted its editorial listing and proposal 2021-14BWG, which expands the number of lines of business reported on Schedule H to match the lines of business reported on the Health Statement and modifies the instructions so they will be uniform between life/fraternal and property.

Mr. Hudson said the Working Group approved the State Filing Checklists.

Mr. Hudson said the Working Group rejected proposal 2021-11BWG requesting to add a new annual statement supplement to the Property/Casualty (P/C) statement to capture exposure data for Annual Statement Lines 4, 19.1, 19.2, and 21.2 of the Exhibit of Premiums and Losses. He noted that the Working Group also deferred for future discussion proposal 2021-13BWG for a public comment period ending March 4, 2022. Proposal 2021-13BWG adds a new supplement to capture premium and loss data for Annual Statement Lines 17.1, 17.2, and 17.3 of the Exhibit of Premiums and Losses (State Page) – Other Liability by more granular lines of business. He also stated that the Working Group exposed seven new proposals for a public comment period ending March 4, 2022.

Mr. Hudson announced that the long-time chair, Jake Garn (UT), is stepping down as chair of the Blanks (E) Working Group, but he will remain a member of the Working Group. He stated that Patricia Gosselin (DE) agreed to become the Working Group chair in 2022.

Mr. Hudson made a motion, seconded by Ms. Malm to adopt the report of the Blanks (E) Working Group (Attachment Two). The motion passed unanimously.

Having no further business, the Accounting Practices and Procedures (E) Task Force adjourned.
The Statutory Accounting Principles (E) Working Group met Dec. 11, 2021. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears and Kevin Clark, Co-Vice Chairs (IA); Kim Hudson and Susan Bernard (CA); William Arfanis, Kathy Belfi, and Kenneth Cotrone (CT); Rylynn Brown (DE); Kevin Fry (IL); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); Melissa Greiner, Kimberly Rankin, and Matt Milford (PA); Jamie Walker (TX); Greg Chew (VA); and Amy Malm (WI).

1. Adopted its Nov. 10, Oct. 25, Sept. 10, Aug. 26, July 20, and July 12 Minutes

Ms. Malm made a motion, seconded by Mr. Chew, to adopt the Working Group’s Nov. 10 (Attachment One-A), Oct. 25 (Attachment One-B), Sept. 10 (Attachment One-C), Aug. 26 (Attachment One-D), July 20 (see NAIC Proceedings – Summer 2021, Accounting Practices and Procedures (E) Task Force, Attachment One-A), and July 12 (see NAIC Proceedings – Summer 2021, Accounting Practices and Procedures (E) Task Force, Attachment One-B) minutes. The motion passed unanimously.

The Working Group met Dec. 2, Aug. 10, and July 29 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 6 (consultations with NAIC staff related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings. No actions were taken during these meetings. The discussion for the respective dates referenced above included review of the Fall National Meeting agenda, an update on the “SSAP No. 43R Project,” and a review of certain (company specific) financial information from 2020 year-end financial statements filed with the NAIC.

2. Adopted Non-Contested Positions

The Working Group held a public hearing to review comments (Attachment One-E) on previously exposed items.

a. Agenda Item 2019-24

Mr. Bruggeman directed the Working Group to agenda item 2019-24: SSAP No. 71 – Levelized and Persistency Commissions – Issue Paper. Robin Marcotte (NAIC) stated that this issue paper documents the discussions that occurred during the development of the nonsubstantive revisions to Statement of Statutory Accounting Principles (SSAP) No. 71—Policy Acquisition Costs and Commissions, which are effective Dec. 31. She stated that the adoption of the nonsubstantive revisions to SSAP No. 71 has been through the entire committee adoption process; however, the issue paper was directed to document the discussions for historical retention purposes. In addition to the revisions to SSAP No. 71, the original agenda item also recommended a new annual statement general interrogatory to identify when a third-party has been utilized for the payment of commission expenses. This new general interrogatory was adopted by the Blanks (E) Working Group for annual 2021 reporting.

Ms. Belfi made a motion, seconded by Mr. Fry, to adopt Issue Paper No. 165—Levelized Commissions (Attachment One-F). The motion passed unanimously.

b. Agenda Item 2021-11

Mr. Bruggeman directed the Working Group to agenda item 2021-11: SSAP No. 43R – Credit Tenant Loans – Scope. Julie Gann (NAIC) stated that this agenda item was drafted as a result of the Valuation of Securities (E) Task Force’s adopted revisions to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual), which clarified that the definition of a credit tenant loan (CTL) is specific to mortgage loans in scope of SSAP No. 37—Mortgage Loans. She stated that the revisions clarify that the application of the structural assessment to identify CTLs is limited to direct mortgage loans and pertains to the potential reclassification of investments from Schedule B: Mortgage Loans to Schedule D-1: Long-Term Bonds for qualifying investments. In response to the P&P Manual revisions, this agenda item proposed three items: 1) to nullify Interpretation (INT) 20-10: Reporting Nonconforming CTLs as no longer applicable; 2) to dispose agenda item 2020-24: Accounting and Reporting of Credit Tenant Loans without statutory revisions; and 3) nonsubstantive revisions to SSAP No. 43R—Loan-Backed and Structured Securities to explicitly identified Securities Valuation Office (SVO)-identified CTLs in scope and delete references to examples of “other Loan-Backed and Structured Securities” in paragraph 27.b, as that paragraph is not a scope paragraph. Ms. Gann stated that INT 20-10 was proposed for formal nullification, with information on why the
INT is no longer relevant, even though the INT expired on Oct. 1. She stated that this documentation will provide the historical documentation on why the INT was not renewed or other statutory accounting revisions were not considered.

Mr. Fry made a motion, seconded by Mr. Clark, to: 1) nullify INT 20-10 as no longer applicable (Attachment One-G); 2) dispose agenda item 2020-24 without statutory revisions; and 3) adopt the exposed nonsubstantive revisions to SSAP No. 43R (Attachment One-H). The motion passed unanimously.

c. Agenda Item 2021-16

Mr. Bruggeman directed the Working Group to agenda item 2021-16: SSAP No. 30R – FHLB Disclosures – Blanks Referral. Jim Pinegar (NAIC) stated that this agenda item was to identify Federal Home Loan Bank (FHLB) borrowings that are captured in scope of SSAP No. 52—Deposit-Type Contracts and reported in Exhibit 7 – Deposit-Type Contracts. He stated that due to the varied reporting on Exhibit 7 based on differing policy forms, FHLB borrowings in Exhibit 7 were not readily identifiable to financial statement users. This agenda item did not propose statutory revisions but resulted in a proposal to the Blanks (E) Working Group to include a supplemental footnote for FHLB funding agreements in Exhibit 7.

Ms. Greiner made a motion, seconded by Mr. Bartlett, to adopt agenda item 2021-16 (Attachment One-I), noting no statutory revisions but support for the corresponding Blanks (E) Working Group proposal. The motion passed unanimously.

d. Agenda Item 2021-17

Mr. Bruggeman directed the Working Group to agenda item 2021-17: SSAP No. 32R – Permitted Valuation Methods. Mr. Pinegar stated that this agenda item removes a lingering reference indicating that historical cost is a permissible valuation method and introduces other minor consistency modifications to SSAP No. 32R—Preferred Stock.

Ms. Walker made a motion, seconded by Mr. Hudson, to adopt the exposed nonsubstantive revisions to SSAP No. 32R (Attachment One-J). The motion passed unanimously.

e. Agenda Item 2021-19EP


Ms. Weaver made a motion, seconded by Mr. Clark, to adopt the exposed nonsubstantive revisions to SSAP No. 16R and SSAP No. 43R (Attachment One-K). The motion passed unanimously.

3. Reviewed Comments on Exposed Items

The Working Group held a public hearing to review comments (Attachment One-E) on previously exposed items.

a. Agenda Item 2021-18

Mr. Bruggeman directed the Working Group to agenda item 2021-18: VM-21 Scenario Consistency Update. Ms. Marcotte stated that this agenda item proposed edits to SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees to ensure consistency with VM-21, Requirements for Principle-Based Reserves for Variable Annuities. She stated that interested parties provided potential edits to the exposure, and the edits were shared with a few of the Life Actuarial (A) Task Force representatives, who suggested additional revisions. In an effort to have the updates in place for year-end 2021 reporting, a shortened exposure period of the combined edits was recommended so the Working Group could consider via e-vote potential adoption in January 2022.

Michael M. Monahan (American Council of Life Insurers—ACLI) stated that the ACLI supports a shortened exposure period and an e-vote for possible adoption by the Working Group.
Mr. Chew made a motion, seconded by Mr. Hudson, to expose agenda item 2021-18 until Jan. 14, 2022. The motion passed unanimously.

b. Agenda Item 2021-14

Mr. Bruggeman directed the Working Group to agenda item 2021-14: Policy Statement Terminology Change – Substantive and Nonsubstantive. Ms. Gann stated that this agenda item was drafted in response to a Financial Condition (E) Committee referral, which identified during the SSAP No. 71 discussions (Ref #2019-24: SSAP No. 71 – Levelized and Persistency Commission) that the statutory accounting terminology of “substantive” and “nonsubstantive” to describe statutory accounting revisions could be misunderstood by users that are not familiar with the specific definitions and application of those terms. She stated that those not familiar with the AP&P maintenance process may incorrectly reference a material financial impact as “substantive”, however, the use of the term in the AP&P Manual was to reflect the introduction of a new statutory accounting concept. She stated that the terms do not consider potential financial impact, and the introduction of a new statutory accounting principles (SAP) concept is a substantive change, regardless of any financial impact to a company, and SAP clarifications are nonsubstantive, even if a company previously misapplied the existing guidance and could have a financial impact from correcting past practice. She stated that this agenda item proposes revisions in the NAIC Policy Statement on Maintenance of Statutory Accounting Principles (Policy Statement) to replace the term “substantive” with “new SAP concept” and replace “nonsubstantive” with “SAP clarification.” She stated that interested parties suggested removal of the classifications completely with assessment as to the appropriate effective date and discussion process for every agenda item. She stated that this proposal went beyond the referral from the Committee to not revise the basis in determining the type of statutory revisions and only revise terminology. In addition, the Working Group can deviate from established processes to have more discussion, an issue paper, and an effective date for nonsubstantive (SAP clarification) changes, and it has utilized that ability in the past. Ms. Gann stated that if this concept is further desired by industry, a separate agenda item from interested parties could sponsor this change for further consideration.

Ms. Belfi made a motion, seconded by Ms. Malm, to adopt the exposed nonsubstantive revisions to the Policy Statement (Attachment One-L). The motion passed unanimously.

4. Considered Maintenance Agenda – Pending Listing – Exposures

Mr. Hudson made a motion, seconded by Mr. Bartlett, to move agenda items 2021-20 through 2021-31 to the active listing and expose all items for public comment. The motion passed unanimously.

Mr. Bruggeman stated that the public comment period for all agenda items (except 2021-18 and 2021-31) ends Feb. 18, 2022. The public comment period for agenda items 2021-18 and 2021-31 ends Jan. 14, 2022.

a. Agenda Item 2021-20

Mr. Bruggeman directed the Working Group to agenda item 2021-20: Effective Derivatives – ASU 2017-12. Ms. Gann stated that this agenda item was drafted to consider expanding guidance in SSAP No. 86—Derivatives for what qualifies as a highly effective hedging derivative. She stated that the intent is to mirror effective hedging determinations that the Financial Accounting Standards Board (FASB) permits within Accounting Standard Update (ASU) 2017-12, Derivatives and Hedging (Topic 815): Targeted Improvements to Accounting for Hedging Activities. While ASU 2017-12 was previously reviewed, the review was limited in scope and only adopted updates for hedging documentation, noting that a broader review would occur at a later date. Ms. Gann stated that both state insurance regulators and industry representatives requested further consideration of ASU 2017-12, particularly with regards to the permitted derivative arrangements that U.S. generally accepted accounting principles (GAAP) now allow to qualify as a highly effective hedge. She stated that in general, NAIC staff believe that if a hedging relationship is considered effective under U.S. GAAP, it should also be considered effective for statutory accounting. However, differences in the accounting between U.S. GAAP and statutory accounting need to be reviewed before those new effective hedging relationships are permitted to ensure the financial statement reporting and derivative impact is defined and understood. Ms. Gann stated that this agenda item will result in substantive revisions; however, the agenda item does not currently propose revisions but seeks public comment on several aspects in accordance with the current accounting and reporting provisions in SSAP No. 86. The agenda item details specifics, but she summarized a few items as follows:

- Partial Term Hedging – A provision that permits entities to enter into fair value hedges of interest rate risk for only a portion of the hedged financial instrument. Prior to ASU 2017-12, these arrangements were not generally successful
in being identified as highly effective due to timing differences between the underlying hedged item’s principal payment and the maturity of the hedging instrument. However, for statutory accounting, this could cause an issue if the underlying item is a liability and the hedging transactions results in an adjustment to the “basis of the hedged item.” Such an adjustment could result in a financial statement presentation that reduces the hedged liability when the contractual obligation has not actually been reduced, affecting the assessment of debt in the financial statements.

- Last of Layer – A provision that permits hedging in a closed portfolio of prepayable financial assets so that the items not expected to be affected by prepayments, defaults, and other factors affecting the timing and amount of cash flows are the underlying hedged item. In addition to U.S. GAAP specifications on how the derivative adjustments are reflected in the portfolio and not individual items, the guidance has the potential for derivative bifurcation so that a derivative can continue to effectively hedge one layer if another layer is no longer effective. The bifurcation of derivatives is not currently permitted in statutory accounting. and if changes are incorporated to allow this approach, the reporting of both the effective and noneffective portions of the hedging instrument will need to be determined.

- Expansion of Excluded Components – A provision that permits the ability to exclude a component from the assessment of hedge effectiveness. This also involves the bifurcation of derivatives and how the excluded components shall be reported for statutory accounting.

Mr. Bruggeman stated that the concepts in the agenda item will need significant input from both industry and state insurance regulators, especially with the reporting of derivatives and the resulting impact in the balance sheet. In addition to exposure, there was no objection to the recommendation for NAIC staff to work directly with industry to discuss and develop potential resolutions during the exposure period.

b. Agenda Item 2021-21

Mr. Bruggeman directed the Working Group to agenda item 2021-21: Related Party Reporting. Ms. Gann stated that this agenda item has been drafted in response to recent discussions on the reporting and disclosure requirements for investments that involve related parties. This agenda item clarifies the reporting of affiliate transactions within existing reporting lines in the investment schedules. The clarification is intended to be consistent with the definition of an affiliate pursuant to the Insurance Holding Company System Regulatory Act (#440), SSAP No. 25—Affiliates and Other Related Parties, and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities. Additionally, this agenda item incorporates new disclosures for investment transactions that involve related parties, regardless of whether the related party is classified as an affiliate. Ms. Gann stated that the agenda item proposes new reporting requirements so that direct investments, investments sponsored or originated by related parties, and investments with other related party involvement are specifically identified in the investment schedules using a new electronic column. She stated that the Blanks (E) Working Group is planning to expose a Blanks proposal to capture the new electronic columns for year-end 2022 reporting.

c. Agenda Item 2021-22

Mr. Bruggeman directed the Working Group to agenda item 2021-22: Schedule D-6-1, Supplemental Reporting. Mr. Pinegar stated that this agenda item proposes four additional data capture elements for Schedule D-6-1: Valuation of Shares of Subsidiary, Controlled or Affiliated Entities. He stated that SSAP No. 97 details several filing requirements, including a requirement for certain subsidiary, controlled, and affiliated entities (SCAs) to file information with the NAIC annually to support the values reported on Schedule D-6-1. If a reported value for a SCA investment materially differs from the value approved by the NAIC, the insurer is required to adjust the reported value in its next quarterly financial statement blank, unless otherwise directed by the insurer’s state of domicile. Mr. Pinegar stated that upon review of the 2019 SCA filings, approximately 17% of all valuation filings resulted in valuation decreases, and some entities have year-after-year valuation decreases. This proposal to add four additional electronic-only columns will assist state insurance regulators in identifying that valuation filings are being submitted when required and identifying situations where the NAIC-approved value varies significantly from values reported on Schedule D-6-1. Mr. Pinegar stated that the supplemental data to be captured is consistent with existing disclosure requirements, so the agenda item does not propose statutory revisions, but it will result in a concurrent proposal to the Blanks (E) Working Group to include the new electronic columns in Schedule D-6-1. Mr. Bruggeman stated that he views this agenda item, which is recommended for exposure, as a way for state insurance regulators to perform reviews and reconciliations of SCA valuations more efficiently.
d. **Agenda Item 2021-23**

Mr. Bruggeman directed the Working Group to agenda item 2021-23: SSAP No. 43R – Financial Modeling Updated Guidance. Mr. Pinegar stated that this agenda item reflects updated NAIC designation/NAIC designation category guidance adopted on Oct. 20 by the Valuation of Securities (E) Task Force to the P&P Manual for residential mortgage backed securities (RMBS) and commercial mortgage backed securities (CMBS). He stated that while the P&P Manual governs the financial modeling process, when this guidance was first adopted, a summarized process was reflected in the AP&P Manual. However, as the financial modeling concept is no longer new and is governed by the Task Force, NAIC staff have proposed two alternatives for possible exposure. The first option will retain summarized financial modeling guidance in SSAP No. 43R, updated to reflect the changes by the Task Force. The second option will remove the financial modeling guidance from SSAP No. 43R and refer users to the source financial modeling guidance in the P&P Manual.

Mr. Bruggeman stated that his preference is to expose both options, seeking input as to which option is preferable to state insurance regulators and industry. Mr. Hudson stated that California supports exposing both options for public comment.

e. **Agenda Item 2021-24**

Mr. Bruggeman directed the Working Group to agenda item 2021-24: Cryptocurrency General Interrogatory. Jake Stultz (NAIC) stated that in May, the Working Group adopted **INT 21-01: Accounting for Cryptocurrencies**, which clarified that directly held cryptocurrencies do not reflect cash and do not meet the definition of an admitted asset. He stated that while researching this topic, it was noted that some insurance companies held cryptocurrencies, but these were not always easy to identify in the statutory financial statements. At the request of state insurance regulators, this agenda item has been drafted to propose a new general interrogatory within the annual reporting blanks specific to the use or acceptance of cryptocurrencies. The general interrogatory will capture whether cryptocurrencies are held (and if held, identification of which schedules the cryptocurrencies are reported) and whether cryptocurrencies are accepted for the payment of premiums. Mr. Stultz stated that while the agenda item is recommended for exposure and does not propose statutory revisions, it will result in a proposal to the Blanks (E) Working Group to add this new general interrogatory to the annual statement for year-end 2022 reporting.

f. **Agenda Item 2021-25**

Mr. Bruggeman directed the Working Group to agenda item 2021-25: Leasehold Improvement After Lease Termination. Mr. Stultz stated that in 2019, the Working Group adopted substantive revisions resulting in **SSAP No. 22R—Leases**. The updated guidance rejected financing lease treatment that was adopted in U.S. GAAP, but it incorporated language from Accounting Standards Codification (ASC) Topic 842, which kept SSAP No. 22R as consistent as possible with the primary concepts in the U.S. GAAP standard. This agenda item has been drafted to address questions about the treatment of leasehold improvements in situations where a leased property is purchased by the lessee during the lease term. It was noted that guidance for these situations was not addressed in **SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements or SSAP No. 73—Health Care Delivery Assets and Leasehold Improvements in Health Care Facilities**. This agenda item proposes nonsubstantive revisions to SSAP No. 19 and SSAP No. 73 to clarify that in any scenario in which a lease terminates early, all remaining leasehold improvements shall be immediately expensed. This would include scenarios where the lease naturally terminates or when the lessee purchases a property it is leasing.

g. **Agenda Item 2021-26EP**

Mr. Bruggeman directed the Working Group to agenda item 2021-26EP: Editorial Updates (Substantive vs. Nonsubstantive). Mr. Pinegar stated that this agenda item is in response to the Working Group’s adoption of agenda item 2021-14, which modifies the use of the terminology of “substantive” and “nonsubstantive” in the Policy Statement. This agenda item reviews all remaining uses of those terms throughout the AP&P Manual and recommends changes where appropriate. Mr. Pinegar stated that changes are recommended in the preamble, table of contents, summary of changes, and the Policy Statement (Appendix F). He stated that in addition, a file has been posted to identify every use of the terms and includes the rationale of why some were not proposed for modification. As the intent is to use the new phraseology going forward, starting on or after Jan. 1, 2022, historical documents are not proposed for revision.

h. **Agenda Item 2021-27**

Mr. Bruggeman directed the Working Group to agenda item 2021-27: **ASU 2021-04, Issuer’s Accounting for Certain Modifications**. Mr. Stultz stated that this agenda item reviews **ASU 2021-04, Earnings Per Share (Topic 260), Debt**—
Modifications and Extinguishments (Subtopic 470-50), Compensation—Stock Compensation (Topic 718), and Derivatives and Hedging—Contracts in Entity’s Own Equity (Subtopic 815-40): Issuer’s Accounting for Certain Modifications or Exchanges of Freestanding Equity-Classified Written Call Options. He stated that ASU 2021-04 directs that when a freestanding equity-classified written call option is modified or exchanged and the instrument remains classified as equity after the modification/exchange, the differences in fair value before and after the modification are to be accounted for as an adjustment to equity. However conversely, ASU 2021-04 directs that if the modification/exchange is related to a debt instrument or line-of-credit, the differences in fair value before and after the modification may be capitalized in accordance with U.S. GAAP debt issuance guidance, a concept disallowed per SSAP No. 15—Debt and Holding Company Obligations. Mr. Stultz stated that this agenda item proposes to reject ASU 2021-04 for statutory accounting; however, it also proposes nonsubstantive modifications to SSAP No. 72—Surplus and Quasi-Reorganizations, incorporating minor updates related to the accounting for changes in fair value involving the exchange of a free-standing equity-classified written call options.

i. Agenda Item 2021-28

Mr. Bruggeman directed the Working Group to agenda item 2021-28: ASU 2021-03, Intangibles – Goodwill and Other. Mr. Pinegar stated that this agenda item reviews ASU 2021-03, Intangibles – Goodwill and Other – Accounting Alternative for Evaluating Triggering Events. He stated that ASU 2021-03 provides private companies and not-for-profit entities with an optional accounting alternative for the performance of a goodwill impairment triggering evaluation. The amendments allow for the assessment of goodwill impairment only as of the end of a reporting period. Mr. Pinegar stated that statutory accounting’s authoritative guidance regarding impairment is documented in INT 06-07: Definition of Phrase “Other Than Temporary” and does not permit the delay of an impairment assessment until a reporting period. He stated that this agenda item proposes nonsubstantive revisions to SSAP No. 68—Business Combinations and Goodwill to reject ASU 2021-03 for statutory accounting.

j. Agenda Item 2021-29

Mr. Bruggeman directed the Working Group to agenda item 2021-29: ASU 2021-05 – Variable Lease Payments. Mr. Stultz stated that this agenda item reviews ASU 2021-05, Leases (Topic 842): Lessors—Certain Leases with Variable Lease Payments. He stated that ASU 2021-05 applies to lessors with lease contracts that have variable lease payments that do not depend on a reference index or rate and/or would have resulted in the lessor being required to recognize a day one selling loss (at lease commencement) if those leases were classified as sales-type or direct financing. He stated that SSAP No. 22R requires nearly all leases to be treated as operating leases, and adoption of this guidance would be redundant and unnecessary, so this agenda item proposes nonsubstantive revisions in SSAP No. 22R to reject ASU 2021-05.

k. Agenda Item 2021-30

Mr. Bruggeman directed the Working Group to agenda item 2021-30: ASU 2021-06 – Amendments to SEC Paragraphs. Mr. Stultz stated that this agenda item reviews ASU 2021-06, Presentation of Financial Statements (Topic 205), Financial Services—Depository and Lending (Topic 942), and Financial Services—Investment Companies (Topic 946), Amendments to SEC Paragraphs Pursuant to SEC Final Rule Releases No. 33-10786, Amendments to Financial Disclosures about Acquired and Disposed Businesses, and No. 33-10835, Update of Statistical Disclosures for Bank and Savings and Loan Registrants. He stated that ASU 2021-06 provides formatting and paragraph references applicable to only U.S. Securities and Exchange Commission (SEC) registrants. This agenda item proposes nonsubstantive revisions to Appendix D—Nonapplicable GAAP Pronouncements to reject ASU 2021-06 as not applicable to statutory accounting.

l. Agenda Item 2021-31

Mr. Bruggeman directed the Working Group to agenda item 2021-31: Life Reinsurance Disclosure Clarifications. Ms. Marcotte stated that this agenda item is to address questions received from members of the American Institute of Certified Public Accountants’ (AICPA) NAIC Task Force regarding the life reinsurance disclosures and the related audited notes that were first effective in December 2020. The disclosures were adopted in SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance from agenda item 2017-28: Reinsurance Risk Transfer for Short Duration Contracts. Ms. Marcotte stated that preparers and auditors have highlighted unclear elements in the disclosures and requested several clarifications, specifically whether the disclosures apply to ceding and assuming contracts, the format expected for the audited notes, and how broadly to interpret the scope of certain disclosures. The proposed nonsubstantive revisions to SSAP No. 61R narrow the scope and clarify what is required in the disclosures. In order to allow for a possible adoption for year-end 2021 reporting, a shortened exposure period of Jan. 14, 2022, was recommended.
Ms. Marcotte summarized the proposed revisions by paragraph:

- **Paragraph 78 revision** is to provide clarity that a supplemental table is not required if the answer is none or not applicable. The disclosure responses indicating that such features were identified could be either in the audited notes or the audited supplemental table.

- **Paragraph 79 and 80 revisions** provide clarity that the disclosure applies to ceding contracts.

- **Paragraph 80 revisions** are to narrow the scope of the risk limiting features disclosure, which is currently broadly written. The proposed revisions would not require disclosure of excess of loss and stop loss deductible and caps, which are not adjustable. She stated that such clauses are standard features in such contracts.

- **Paragraph 82.b. revisions** would remove the disclosure of non-proportional reinsurance that does not result in significant surplus relief, as the disclosure would only capture immaterial items.

- **Paragraph 83 and 84 revisions** pertain to U.S. GAAP to statutory accounting reporting differences of reinsurance contracts. The revisions clarify that if the entity is not a U.S. GAAP preparer or not included in upstream U.S. GAAP preparer financial statements, then the disclosure can be noted as not applicable. She stated that because of the Life and Health Reinsurance Agreements Model Regulation (#791), the life and health disclosure will capture more reinsurance contracts than the related property/casualty (P/C) disclosures.

Ms. Marcotte noted that subsequent to posting the national meeting materials, NAIC staff also received a question on whether the disclosure was intended to be comparative, meaning the current and prior year. Mr. Bruggeman stated that these disclosures will generally be comparative, but the proposed revisions could be prospective; therefore, prior year 2020 disclosures did not have to be updated with these disclosure changes. Otherwise, he stated that the disclosures should be comparative and include the current and prior year. He noted that the disclosures needed to be exposed to make sure that revisions do not remove state insurance regulator-desired disclosures. He stated agreement with the revisions in paragraphs 83 and 84 regarding non-U.S. GAAP filers. He noted that if early statutory filers submit information before any action is taken by the Working Group, more information may be disclosed than will ultimately be required; however, the clarifications would still assist auditors.

Mr. Monahan stated that the ACLI supports a shortened exposure period and an e-vote for possible adoption by the Working Group.

5. **Discussed Other Matters**

   a. **Ref #2019-21: SSAP No. 43R – Update**

Ms. Gann stated that this agenda item, now referred to as the principles-based bond proposal project, intends to define the type of instruments eligible for reporting on Schedule D-1. She provided a brief history of the project, noting that the principles-based definition was exposed in May with comments considered in August. She stated that as part of the direction in August to begin drafting an issue paper and statutory revisions, the Working Group directed ongoing discussions with state insurance regulators and industry to discuss and refine the principles-based bond definition. She stated that as a part of this continued discussion, two items are recommended for exposure. The first is a discussion document, which presents possible reporting changes to incorporate improved transparency and granularity in Schedule D-1. This document requests information on potential changes in reporting lines, a new sub-schedule for Schedule D-1 to detail certain asset-backed securities (ABS), and potential changes to the columns and information currently reported in Schedule D-1. A key proposed element is to move away from the current “general categories” for reporting and replace those groupings with more useful reporting lines based on investment type. The exposure reviews items for possible change consideration and specifically requests comments on the removal of the general categories and whether those changes would hinder any tools or analyses performed. Ms. Gann stated that in terms of a possible new Sub-Schedule D-1, this schedule could include non-traditional reporting items and additional informational items, such as balloon payments and expected payoff dates. In response to comments received from industry, this could also be an opportunity to review how other informational data elements are captured, reviewing for usefulness and relevance for state insurance regulators.
Ms. Gann stated that the second item recommended for exposure proposes revisions to the “sufficiency” definition previously captured in the bond proposal definition, specifically what is required for sufficient credit enhancement for an ABS to qualify for reporting on Schedule D-1. She stated that for an ABS to be reported on Schedule D-1, sufficient credit enhancement must be present so that the holder is in a different economic position than had they directly owned the underlying collateral. In response to comments received, the agenda item now reflects the use of the term “substantive” credit enhancement, as the prior term of “sufficient” was more akin to a credit evaluation, which was not in line with the proposed principal bond concepts.

Mr. Clark stated that the latest phraseology update is in line with the principal concepts, and it will prevent situations where items are placed in a special purpose vehicle (SPV) and the SPV then issues bonds to an insurer. This new phraseology will prevent these situations by ensuring that the bond holder is in a different economic position than had they held the underlying collateral directly. He stated that the updated phraseology corrects prior notions that a quantitative assessment is required to determine the amount of credit enhancement, which was beyond the scope of the project.

Michael Reis (Northwestern Mutual), representing interested parties, stated appreciation for state insurance regulators and NAIC staff for their continued collaboration on this project, noting that they support the principles-based approach and believe a workable solution will be achieved. He stated that several topics remain outstanding, which include transitional reporting (reporting of items that may ultimately move schedules), as well as the accounting and reporting of items that do not meet the principal concepts. Other items of concern to interested parties relate to risk-based capital (RBC) and may need to be addressed through the Capital Adequacy (E) Task Force; however, interested parties remain willing to assist in the project.

Ms. Gann stated that to be sensitive to the time commitments of industry for year-end reporting, the draft issue paper and possible statutory revisions will not be exposed until later in the first quarter of 2022. In addition, the earliest the new principal concepts could be adopted and reflected in Schedule D-1 is likely Jan. 1, 2024. She stated that thus far, the project has included updated reporting guidance of residual tranches and the formation of an informal coordination group involving the chairs/vice chairs of the Statutory Accounting Principles (E) Working Group, Valuation of Securities (E) Task Force, Capital Adequacy (E) Task Force, and related RBC working groups to discuss appropriate RBC charges for residual tranches and other potential RBC impacts from the development of the principles-based bond definition. In addition, several other issues remain outstanding. Examples include defining an operating entity, which is required for an issuer obligation classification; when principal payment relies on refinancing; as well as transitional accounting and reporting guidance. Mr. Bruggeman stated that the intent of the informal coordination group is to ensure that all affected parties understand the types of investments that are being specifically addressed in the project, especially those that may be subject to RBC arbitrage.

Mr. Clark made a motion, seconded by Ms. Weaver, to expose the discussion draft of potential reporting options and the proposed revised guidance and related examples for defining and determining whether an ABS has substantive credit enhancement to qualify for reporting on Schedule D-1. The motion passed unanimously.


Ms. Gann stated that INT 20-03: Troubled Debt Restructuring Due to COVID-19 and INT 20-07: Troubled Debt Restructuring of Certain Debt Instruments Due to COVID-19 were adopted in response to modifications that were being made to loans and debt securities in response to COVID-19. The adopted INTs provided exceptions to the application of guidance in SSAP No. 36—Troubled Debt Restructuring. The INTs were originally scheduled to expire as of Dec. 31, but they were extended to Jan. 2, 2022, in accordance with the extension of the Coronavirus, Aid, Relief, and Economic Security (CARES) Act. She stated that NAIC staff received informal comments that industry would not request an extension, and they recommended that the INTs automatically expire on Jan. 2, 2022.

Mr. Monahan stated that the ACLI recommends allowing INT 20-03 and 20-07 to expire on Jan. 2, 2022. With this commentary, the Working Group did not propose further consideration.

c. Review of GAAP Exposure

Ms. Gann stated that the FASB has two U.S. GAAP exposures open for public comment, both of which do not warrant comment from the Working Group. One exposure proposes removing the U.S. GAAP troubled debt restructuring guidance for lenders as no longer necessary under the U.S. GAAP current expected credit loss (CECL) standard. Ms. Gann stated that the proposed FASB revisions may cause further U.S. GAAP to statutory accounting differences, as the CECL standard has not been adopted for statutory accounting.
Ms. Gann stated that in addition to these updates, Insurance Core Principle (ICP) 14, the international standard for asset valuation, is undergoing review. NAIC staff are participating in these discussions and will keep the Working Group informed of any updates.

d. Referral to the Casualty Actuarial and Statistical (C) Task Force – Update

Ms. Marcotte stated that the Casualty Actuarial and Statistical (C) Task Force met Dec. 7 to initially discuss a presentation regarding the Working Group referral on agenda item 2019-49: Retroactive Reinsurance Exception regarding diversity in reporting for retroactive intercompany reinsurance contracts, which meet the exception and allow for prospective reporting. She stated that actions taken on Dec. 7 resulted in a 45-day exposure of the presentation. She stated that the largest issue to address is whether to allocate premium back to prior years on annual statement Schedule P when multiple years of premium are ceded to a reinsurer. She noted that no matter which methodology is used, such contracts produce distortions, and determining what will produce the most useful Schedule P information is relevant. A response from the Task Force is not anticipated until late in the first quarter or early in the second quarter of 2022. Ms. Marcotte also noted that there may be disconnects between some of the SSAP No. 62R—Property and Casualty Reinsurance guidance in paragraphs 36 and 37 and the intercompany pooling guidance in the annual statement instructions.

e. Key Items from the Maintenance Agenda

Ms. Gann provided an update on outstanding projects; a summary of each is as follows:

- **ASU 2016-13, Financial Instruments – Credit Losses:** At a minimum, this topic will require review of statutory accounting’s incurred loss impairment guidance; however, multiple varying viewpoints and consideration will need to be made. One example provided is that the asset valuation reserve (AVR), a credit component utilized only by statutory accounting, could be a substitute for ASU 2016-13; however, only life companies are subject to AVR. While ASU 2016-13 has been delayed multiple times, its effective date for non-SEC filers is January 2023.

- **Goodwill:** While two agenda items remain outstanding (agenda item 2019-12: ASU 2014-17, Business Combinations – Pushdown Accounting and agenda item 2019-14: Attribution of Goodwill), additional disclosures are expected from the 2021 financials. Accordingly, NAIC staff recommend that these topics be deferred until the information from these new disclosures is shared with the Working Group.

- **Derivatives Hedging Fixed Indexed Products:** NAIC staff have identified this topic to be a priority project; however, the development of statutory revisions is currently paused as NAIC staff is monitoring discussions at the Index-Linked Variable Annuity (A) Subgroup. Prior Working Group and industry comments have noted that it would be ideal for both the reserve calculation and derivative guidance to move in tandem.

- **State Affordable Care Act (ACA) Reinsurance Programs:** This agenda item is to provide accounting and reporting guidance regarding state ACA reinsurance programs being run under Section 1332 waivers. NAIC staff will work with industry to develop additional revisions for Working Group consideration that expand the principles-based guidance to address the diversity in state programs identified in the prior exposure.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
The Statutory Accounting Principles (E) Working Group met Nov. 10, 2021. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears and Kevin Clark, Co-Vice Chairs (IA); Blase Abreo and Sheila Travis (AL); Kim Hudson (CA); William Arfanis (CT); Rylwynn Brown (DE); Cindy Andersen and Kevin Fry (IL); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); Melissa Greiner and Kimberly Rankin (PA); Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. **Reviewed Comments on Exposed Items**

The Working Group held a public hearing to review comments (Attachment One-A1) on previously exposed items.

   a. **Agenda Item 2021-15**

Mr. Bruggeman directed the Working Group to agenda item 2021-15: SSAP No. 43R – Residual Tranches. Julie Gann (NAIC) stated that this agenda item provides updates to SSAP No. 43R—Loan-Backed and Structured Securities to clarify that securitization residual tranches shall be reported on Schedule BA: Other Long-Term Invested Assets and valued at the lower of cost or fair value. She stated that during the Working Group’s continued collaboration with industry representatives on the “Bond Proposal Project” (agenda item 2019-21: SSAP No. 43R), inconsistencies were identified regarding the reporting of residual tranches. From information received, some entities already report residual tranches on Schedule BA, while other entities report these tranches on Schedule D-1: Long-Term Bonds with either a self-assigned 5GI or a self-assigned NAIC 6 designation. She stated that the use of the NAIC 5GI process for residual tranches is an incorrect application of the guidance as: 1) there are no contractual interest and principal payments to certify as current; and 2) the insurer cannot have an actual expectation of receiving all anticipated principal and interest payments. Residual tranches absorb the first losses in a securitization structure and only receive cash flows after all other tranches receive their contractual cash flows. Thus, a reporting entity cannot have an actual expectation on the collection of future payments. Ms. Gann stated that comments received from interested parties indicate support for the reporting of residual tranches on Schedule BA. However, due to the proximity to year-end 2021, they requested a Dec. 31, 2022, effective date. In addition, if the residual tranches are permitted to remain on Schedule D-1 for year-end 2021, interested parties support the requirement to report these securities with an NAIC 6 designation.

Ms. Gann stated that NAIC staff recommend that the Working Group adopt the exposed revisions to SSAP No. 43R with edits proposed by interested parties, which include a Dec. 31, 2022, effective date (with early adoption permitted). Additionally, NAIC staff recommend a memorandum from both the Working Group and the Valuation of Securities (E) Task Force to the Blanks (E) Working Group to clarify that self-assigned NAIC 5GI designations are not permitted for residual tranches, and such items reported on Schedule D-1 for year-end 2021 are required to be reported with an NAIC 6 designation. She stated that NAIC staff also recommend a referral to the Task Force with a request to clarify the Purposes and Procedures Manual of the NAIC Investment Office (P&P Manual) to mitigate future misapplication of the NAIC 5GI process.

Diane Bellas (Allstate), representing interested parties, stated that no further comments are offered on this agenda item. However, interested parties appreciate the ongoing collaboration and the consideration of interested parties’ comments and support adoption with the edits as recommended by NAIC staff.

Mr. Clark made a motion, seconded by Ms. Walker, to adopt agenda item 2021-15 and the exposed nonsubstantive revisions to SSAP No. 43R, with the edits presented by NAIC staff (Attachment One-A2). The motion also included direction for NAIC staff to provide: 1) a memorandum to the Blanks (E) Working Group to direct that self-assigned NAIC 5GI designations are not permitted for residual tranches, and such items reported on Schedule D-1 are required to be reported with an NAIC 6 designation; and 2) a referral to the Valuation of Securities (E) Task Force recommending that the Task Force consider edits to the P&P Manual to clarify the application of the NAIC 5GI process. The motion passed unanimously.
b. **Agenda Item 2021-12EP**

Mr. Bruggeman directed the Working Group to agenda item 2021-12EP: Editorial Updates. Robin Marcotte (NAIC) stated that the agenda item provides five editorial maintenance updates to the *Accounting Practices and Procedures Manual* (AP&P Manual). Four of the updates include minor formatting or revisions for consistency to the Preamble, Appendix A-001, Appendix C, and Appendix C-2. Ms. Marcotte stated that the remaining edit includes a minor update to improve the readability of the guidance for securities receivables in SSAP No. 21R—Other Admitted Assets.

Mr. Hudson made a motion, seconded by Ms. Malm, to adopt the exposed nonsubstantive editorial revisions to the Preamble, Appendix A-001, Appendix C, Appendix C-2, and SSAP No. 21R (Attachment One-A3). The motion passed unanimously.

c. **Agenda Item 2021-13**

Mr. Bruggeman directed the Working Group to agenda item 2021-13: Salvage – Legal Recoveries. Ms. Marcotte stated that this agenda item recommended nonsubstantive revisions to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses to clarify that salvage and subrogation estimates and recoveries should be reported as a reduction to both claims/losses and loss adjusting expenses (LAE), as appropriate. She stated that while this practice is believed to already be consistent with the current practice of most reporting entities, the revisions clarify that salvage and subrogation estimates and recoveries can include amounts related to both claims/losses and LAE. The corresponding estimates should be reported as a reduction of losses and/or LAE reserves. However, once the amounts for salvage and subrogation and coordination of benefits are received, they shall be reported as a reduction of paid losses and LAE depending on the nature of the costs being recovered. Ms. Marcotte stated that notice of this exposure was sent to the Casualty Actuarial and Statistical (C) Task Force, the Life Actuarial (A) Task Force, and the Health Actuarial (B) Task Force, and no comments were received. She stated that interested parties are supportive of the proposal, which also included an updated disclosure related to the reporting of estimated salvage and subrogation and their impact on unpaid claims, losses, or associated LAE.

Ms. Weaver made a motion, seconded by Mr. Kasinow, to adopt the exposed nonsubstantive revisions SSAP No. 55 (Attachment One-A4). The motion passed unanimously.

d. **INT 21-02T**

Mr. Bruggeman directed the Working Group to Interpretation (INT) 21-02T: Extension of the Ninety-Day Rule for the Impact of Hurricane Ida. Jake Stultz (NAIC) stated that this interpretation provides a 60-day extension to the “90-day rule” in SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers for policies affected by Hurricane Ida. He stated that the optional, temporary extension is supported by interested parties and would apply to uncollected premium balances, bills receivable for premiums, and amounts due from agents and policyholders and would automatically nullify on Jan. 24, 2022. The optional extension applies to year-end 2021 reporting. However, as it expires in January 2022, the INT will be reflected in Appendix H—Superseded SSAPs and Nullified Interpretations in the “As of March 2022” edition of the AP&P Manual.

Mr. Hudson made a motion, seconded by Ms. Brown, to adopt INT 21-02: Extension of the Ninety-Day Rule for the Impact of Hurricane Ida (Attachment One-A5). The motion passed unanimously.

Ms. Gann stated that the next Working Group meeting is expected to occur in-person on Dec. 11 in San Diego, CA. This meeting will be held as part of the Fall National Meeting and will be immediately followed by the Accounting Practices and Procedures (E) Task Force meeting. She stated that an audio option is available for individuals that register for the meeting. However, it is unknown at this time if that option will permit those registrants the ability to speak. She stated that information is available on the NAIC National Meeting web page.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
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October 22, 2021

Mr. Dale Bruggeman, Chairman  
Statutory Accounting Principles Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

RE: Ref #2021-15, SSAP No. 43R-Residual Tranches

Dear Mr. Bruggeman:

Interested parties (“IPs”) appreciate the opportunity to comment on the Statutory Accounting Principles Working Group (the Working Group) proposal Ref #2021-15, SSAP No. 43R-Residual Tranches (“the proposal”).

The proposal would require certain modifications to SSAP No. 43R to report non-rated residual tranches or interests, currently in the scope of SSAP No. 43R, on Schedule BA as Other Long-Term Invested Assets at lower of cost or market. Also proposed is that a footnote be added to further define “non-rated residual tranches or interests” as follows:

“Reference to “non-rated residual tranches or interests” intends to capture securitization tranches, beneficial interests, interests of structured finance investments, as well as other structures captured in scope of this statement, that reflect loss layers without contractual interest or principal payments. Payments to holders of these investments occur after contractual interest and principal payments have been made to other tranches or interests and are based on the remaining available funds. Although payments to holders can occur throughout an investment’s duration (and not just at maturity), such instances still reflect the residual amount permitted to be distributed after other holders have received contractual interest and principal payments.”

IPs have the following comments related to the proposal:

1) IPs agree that residual tranches or interests in scope of SSAP No. 43R, which meet the definition in the proposed footnote, should be reported on Schedule BA at lower of cost or market (“LOCOM”).

Some companies already report such investments on Schedule BA and others report them on Schedule D measured at either LOCOM or amortized cost. We believe the proposed
change in reporting would be cost justified as it would not be overly burdensome to insurers and would provide consistent reporting by insurers. It also would provide additional information for regulators to continue to evaluate such investments.

2) IPs believe an effective date of 12/31/2021 is achievable with regard to rating all residual tranches in the scope of SSAP No. 43R as NAIC 6. However, for various reasons noted below, IPs do not believe it would be feasible to transfer those residual tranches currently reported on Schedule D to Schedule BA for year-end 2021 reporting.

In conversations with NAIC staff and regulators, while working on the Working Group’s Bond Project (formerly known as the 43R Project), IPs have been asked if adopting the proposal effective 12/31/2021 is feasible and also if reporting such interests on Schedule BA separately depending on the underlying collateral (e.g., fixed income, equity, real estate, etc.; same categories that currently exist on Schedule BA) would be feasible beginning at year-end 2022.

IPs believe that the 12/31/2021 reporting is not feasible as it would be operationally difficult to change processes in a timely manner prior to year-end reporting, including any vendor modifications that would be required, as well as address downstream implications such as impacts on cash flow statements and investment schedule rollforwards, etc., to ensure there are no unintended consequences related to the various statutory blanks and related processes. IPs support making such a change beginning at year-end 2022 and support the more granular reporting requested (i.e., based on underlying collateral) as it will allow the requisite amount of time to address those operational items discussed above. IPs also support allowing those companies that can address their processes prior to year-end 2021, the opportunity to transfer the residual tranches in scope from Schedule D to BA in 2021. It is important that the Working Group make companies aware that (1) the transfer of residual tranches to Schedule BA is optional for year-end 2021/quarterly 2022 and (2) if they choose to transfer the residual tranches to Schedule BA at year-end 2021, they would also be required to transfer them at year-end 2022 into the more granular categories discussed above based on underlying collateral (e.g., equities, fixed income, real estate, etc.). For those companies that decide to transfer the residual tranches in 2021, Blanks instructions would be needed well in advance of year-end to provide clarity related to the following:

- The specific section and subsection of Schedule BA where the residual tranches and interests in scope of this proposal would be reported.
- How the various existing columns of Schedule BA would be used for such investments. For example, Schedule BA “cost” would be used to report “amortized cost” for such investments.
- Communicating that LOCOM would be applied to such investments and clarifying where both amortized cost and fair value would be reported on the existing Schedule BA.
3) IPs recommend certain modifications to the proposed footnote and changes to SSAP No. 43R as follows:

- Eliminate the reference to “non-rated” in paragraphs 26a, b, and c and the proposed footnote. IPs recommend eliminating the reference to non-rated as its definition may be interpreted inconsistently by various insurers (e.g., rated by the NAIC, rated by an NRSRO, insurer-rated such as NAIC 5 or 6?). We believe the intent is to exclude from Schedule D reporting, those investments that are typically not rated in the investment markets because their characteristics are not debt-like (e.g., no contractual payments of principal and/or interest) and thus we believe the inclusion of only the criteria “no contractual payments of principal and/or interest” will capture all investments intended to be captured.

- IPs recommend removing the term “structured finance investments” from the footnote as it is an undefined term and is not clear to IPs at to what it is intended to capture. We believe retaining the references to “securitization tranches and beneficial interests” is adequate and would be understood to include all those investments intended by the regulators to be in the scope of the proposal.

- IPs recommend modifying the footnote to include those investments “…that reflect loss layers without contractual interest or principal payments” to those investments “…that reflect loss layers without any contractual payments, whether principal, interest, or both”. This proposed change would be more complete and “all-encompassing”.

- Ensure LOCOM is clarified to be “lower of amortized cost or market”. The use of the term “amortized cost” versus “cost” more accurately reflects the type of investment and is more aligned with the use of the term in existing SSAP No. 43R.

The following proposal reflects IPs comments discussed above as related to the footnote:

“Reference to “residual tranches or interests” intends to capture securitization tranches and beneficial interests as well as other structures captured in scope of this statement, that reflect loss layers without any contractual payments, whether principal, interest, or both. Payments to holders of these investments occur after contractual interest and principal payments have been made to other tranches or interests and are based on the remaining available funds. Although payments to holders can occur throughout an investment’s duration (and not just at maturity), such instances still reflect the residual amount permitted to be distributed after other holders have received contractual interest and principal payments.”

We would be happy to discuss any of our recommendations above and appreciate the continued dialogue related to this topic and the overall Bond Project among the Working Group, NAIC Staff, Regulators, and IPs.

* * *
Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell                                      Rose Albrizio

cc: NAIC staff
    Interested parties
Mr. Dale Bruggeman, Chairman  
Statutory Accounting Principles Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

RE: Items Exposed for Comment by the Statutory Accounting Principles Working Group on August 26, 2021 with Comments due October 1, 2021

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the exposure drafts released for comment by the NAIC Statutory Accounting Principles (E) Working Group (the Working Group). We offer the following comments:

**Ref #2021-11 SSAP No. 43R**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed the following:

1. Revisions to *SSAP No. 43R—Loan-Backed and Structured Securities*, as illustrated in the proposal, to explicitly identify the SVO-Identified CTLs that are in scope of SSAP No. 43R. These revisions also propose to delete the examples of “other loan-backed and structured securities” in paragraph 27.b. Comments are requested if this deletion is perceived to remove investments from the scope of SSAP No. 43R.

2. Request for comment on the Working Group’s intent to nullify INT 20-10. (This INT nullifies automatically on Oct. 1, 2021, but it is anticipated that the explicit nullification will identify the revisions adopted by the VOSTF for historical reference.)

3. Disposal of agenda item 2020-24: Accounting and Reporting of Credit Tenant Loans without statutory revisions. This was the agenda item in response to the initial VOSTF referral and is no longer applicable with the adopted Task Force edits to clarify that CTLs are mortgage loans in scope of SSAP No. 37.
Interested parties have no comment on this item.

Ref #2021-12 NAIC Accounting Practices and Procedures Manual Editorial and Maintenance Update

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed editorial revisions to the Preamble, Appendix A-001: Investments of Reporting Entities, Appendix C Actuarial Guidelines – Appendices, Appendix C-2 Interpretations of the Emerging Actuarial Issues (E) Working Group, and SSAP No. 21R —Other Admitted Assets, as illustrated in the proposal.

Interested parties have no comment on this item.

Ref #2021-13 SSAP No. 55: Salvage - Legal Recoveries

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and took the following actions:

1. Exposed revisions to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses, as illustrated in the proposal, to clarify that salvage and subrogation recoveries should be reported as a reduction of losses and/or loss adjusting expense (LAE reserves), depending on the nature of the costs being recovered. In addition, updates to the disclosure in paragraph 17.h. were exposed.

2. Directed NAIC staff to coordinate develop conforming revisions to the Annual Statement instructions.

3. Directed notification of the exposure to the following actuarial Task Forces:
   a. Casualty Actuarial and Statistical (C) Task Force,
   b. Life Actuarial (A) Task Force, and
   c. Health Actuarial (B) Task Force

Interested parties support this proposal.

Ref #2021-14 Policy Statement Terminology Change – Substantive & Nonsubstantive

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to the NAIC Policy Statement on Maintenance of Statutory Accounting Principles, as illustrated in the proposal and suggested by the Financial Condition (E) Committee in their Aug. 14, 2021, referral, to alter the terminology used when discussing types of statutory accounting revisions.

After some discussion and consideration of the proposal and its impact on the implementation of new statutory accounting standards, interested parties concluded that the distinction between substantive (proposed to change to “development of new SSAPs or New SAP Concepts in an
Existing SSAPs”) and non-substantive (proposed to change to “Development of SAP Clarifications”) is at times confusing and that there would be more transparency in the development process if the distinction were eliminated. Instead, we recommend that all new standards be handled similarly but that the effective date for each new standard be determined by evaluating the complexity of implementation (e.g., the extent that systems changes are required) and the availability of data to insurers to implement the new standard. This determination would be made as the new standard is being completed and with feedback from industry as to the time needed to adopt the new requirements.

**INT 21-02T: Extension of Ninety-Day Rule for the Impact of Hurricane Ida**

The Working Group reached a tentative consensus for a one-time optional extension of the ninety-day rule for uncollected premium balances, bills receivable for premiums and amounts due from agents and policyholders required per SSAP No. 6, paragraph 9. For policies in effect as of the declaration of a state of emergency by either the states, U.S. territories or federal government, as described in paragraph 1, insurers with policyholders in areas impacted by Hurricane Ida, its aftermath and the related flooding may wait 150 days (90 days per existing guidance, plus a 60-day extension), not to extend beyond Jan. 23, 2022, before nonadmitting premiums receivable from those directly impacted policyholders as required per SSAP No. 6, paragraph 9. b. Existing impairment analysis remains in effect for these affected policies.

The Working Group noted that a temporary sixty day (60) extension had previously been provided for other nationally significant disasters including INT 20-11: Extension of Ninety-Day Rule for the Impact of 2020 Hurricanes, California Wildfires and Iowa Windstorms, INT 18-04: Extension of Ninety-Day Rule for the Impact of Hurricane Florence and Hurricane Michael; INT 17-01: Extension of Ninety-Day Rule for the Impact of Hurricane Harvey, Hurricane Irma and Hurricane Maria; INT 13-01: Extension of Ninety-Day Rule for the Impact of Hurricane/Superstorm Sandy; and INT 05-04: Extension of Ninety-day Rule for the Impact of Hurricane Katrina, Hurricane Rita and Hurricane Wilma.

This interpretation will be automatically nullified on Jan. 24, 2022 and will be included as a nullified INT in Appendix H – Superseded SSAPs and Nullified Interpretations in the “As of March 2022” *NAIC Accounting Practices and Procedures Manual.*

Interested parties support this proposal.

**Ref #2019-24 SSAP No. 71: Levelized Commissions**

The Working Group exposed Issue Paper No. 16x: Levelized Commissions to document the historical discussion and final action adopted through the Executive Committee/Plenary.

Interested parties have no further comment on this item.
Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell  
Rose Albrizio

cc: NAIC staff  
Interested parties
Statutory Accounting Principles (E) Working Group  
Maintenance Agenda Submission Form  
Form A

**Issue:** SSAP No. 43R – Residual Tranches

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**Description of Issue:** Although the broad principles-based bond proposal project is establishing principles for reporting investments on Schedule D-1: Long-Term Bonds, it has been identified that there is current inconsistency in practice for the reporting of non-rated residual tranches for structures captured in scope of SSAP No. 43R—Loan-Backed and Structured Securities. To address this current inconsistency, it has been requested that revisions occur as an interim step to provide specific accounting and reporting for these items.

As background information, SSAP No. 43R provides guidance for investments in loan-backed and structured securities, as well as purchased and retained beneficial interests in securitized financial assets. The guidance presumes that the investments within scope reflect fixed-income instruments, particularly with the Schedule D-1: Long-Term Bond reporting as well as the amortized cost measurement method, but it has been identified that non-rated, first loss layers without contractual principal or interest (known as residual tranches or interests) are technically captured within the legal-form structure currently permitted within scope of the guidance.

As part of the principles-based bond project discussions, it has been identified that some entities report these residual investments on Schedule BA: Other Long-Term Investments. However, it has been noted that other entities report these residual tranches on Schedule D-1, as in scope of SSAP No. 43R. Since items on Schedule D-1 are required to have NAIC designations, and these tranches are not (and cannot be) rated from a CRP or receive an NAIC designation, some entities have applied the “NAIC 5GI” process to self-assign an NAIC 5 designation. For life entities, an NAIC 5 permits an amortized cost valuation and for all lines of business a NAIC 5 receives a lower RBC charge than what is received if reporting on Schedule BA.

The NAIC 5GI process permits entities to self-assign an NAIC 5 when they can certify to the following three components:

1. Documentation necessary to permit a full credit analysis of the security does not exist or an NAIC CRP ratings for an FE or PL security is not available.
2. The issuer or obligor is current on all contracted interest and principal payments.
3. The insurer has an actual expectation of ultimate payment of all contracted interest and principal payments.

Use of the NAIC 5GI process for non-rated residual investments is an incorrect application of the guidance as 1) there are no contracted interest and principal payments to certify as current and 2) the insurer cannot have an actual expectation of receiving all contractual principal and interest of the underlying collateral as these tranches absorb the losses first for the securitization structure. Although cash flows may pass through to these holders at periodic intervals in the waterfall, ultimate returns depend on continued performance, therefore, there can be no actual expectation that future payments will be received.
From the discussions that have occurred on the principles-based bond project, there is general agreement that these non-rated residual tranches do not belong on Schedule D-1 as long-term bonds. This agenda item proposes minor revisions to SSAP No. 43R, as an interim action in advance of the adoption of the principles-based bond project, to prescribe the accounting and reporting for these non-rated residual investments to ensure consistent reporting. As detailed, it is proposed that these items remain in scope of SSAP No. 43R, as they are a component of a securitization, with specific guidance to report on Schedule BA with a lower of cost or fair value measurement.

Existing Authoritative Literature:

Reporting Guidance for All Loan-Backed and Structured Securities

26. Loan-backed and structured securities shall be valued and reported in accordance with this statement, the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*, and the designation assigned in the *NAIC Valuations of Securities* product prepared by the NAIC Securities Valuation Office or equivalent specified procedure. The carrying value method shall be determined as follows:

   a. For reporting entities that maintain an Asset Valuation Reserve (AVR), loan-backed and structured securities shall be reported at amortized cost, except for those with an NAIC designation of 6, which shall be reported at the lower of amortized cost or fair value.

   b. For reporting entities that do not maintain an AVR, loan-backed and structured securities designated highest-quality and high-quality (NAIC designations 1 and 2, respectively) shall be reported at amortized cost; loan-backed and structured securities that are designated medium quality, low quality, lowest quality and in or near default (NAIC designations 3 to 6, respectively) shall be reported at the lower of amortized cost or fair value.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): The Statutory Accounting Principles (E) Working Group has a comprehensive project to establish principles-based concepts for the definition for bond investments for reporting on Schedule D-1: Long-Term Bonds. This separate agenda item was directed as an interim action on Aug. 26, 2021, as it was identified that there is inconsistent reporting for non-rated residual tranches, with some entities reporting these non-rated loss-layer investments on D-1 with a self-assigned NAIC 5GI designation.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:

NAIC staff recommends that the Working Group move this item to the active listing, categorized as a new SAP concept, and expose revisions to SSAP No. 43R to establish specific accounting and reporting guidance for non-rated residual tranches or interests. Additionally, it is recommended that the Working Group sponsor a blanks proposal to capture a new reporting line specific for these items on Schedule BA and send a referral to the Valuation of Securities (E) Task Force to identify that the NAIC 5GI process shall not be used to self-assign an NAIC designation to non-rated residual investments.

Proposed edits to SSAP No. 43R:
Reporting Guidance for All Loan-Backed and Structured Securities

26. Loan-backed and structured securities shall be valued and reported in accordance with this statement, the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*, and the designation assigned in the *NAIC Valuations of Securities* product prepared by the NAIC Securities Valuation Office or equivalent specified procedure. The carrying value method shall be determined as follows:

a. For reporting entities that maintain an Asset Valuation Reserve (AVR), loan-backed and structured securities, excluding non-rated residual tranches or interests, shall be reported at amortized cost, except for those with an NAIC designation of 6, which shall be reported at the lower of amortized cost or fair value.

b. For reporting entities that do not maintain an AVR, loan-backed and structured securities designated highest-quality and high-quality (NAIC designations 1 and 2, respectively), excluding non-rated residual tranches or interests, shall be reported at amortized cost; loan-backed and structured securities that are designated medium quality, low quality, lowest quality and in or near default (NAIC designations 3 to 6, respectively) shall be reported at the lower of amortized cost or fair value.

c. For non-rated residual tranches or interests captured in scope of this statement, all reporting entities (regardless of AVR) shall report the item on Schedule BA: Other Long-Term Invested Assets at the lower of cost or fair value. Changes in the reported value from the prior period shall be recorded as unrealized gains or losses.

New Footnote: Reference to “non-rated residual tranches or interests” intends to capture securitization tranches, beneficial interests, interests of structured finance investments, as well as other structures captured in scope of this statement, that reflect loss layers without contractual interest or principal payments. Payments to holders of these investments occur after contractual interest and principal payments have been made to other tranches or interests and are based on the remaining available funds. Although payments to holders can occur throughout an investment’s duration (and not just at maturity), such instances still reflect the residual amount permitted to be distributed after other holders have received contractual interest and principal payments.

Staff Review Completed by: Julie Gann, NAIC Staff – September 2021

Status:
On September 9, 2021, in response to an e-vote to expose, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 43R—Loan-Backed and Structured Securities to clarify that non-rated residual tranches shall be reported on Schedule BA – Other Long-Term Investments and valued at the lower of cost or fair value.

On November 10, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, exposed revisions to SSAP No. 43R—Loan-Backed and Structured Securities, incorporating edits proposed by interested parties and clarifying application of IMR/AVR, as illustrated below. The revisions clarify that residual tranches or interests shall be reported on Schedule BA – Other Long-Term Investments and valued at the lower of amortized cost or fair value. While the revisions are nonsubstantive in nature, the guidance is effective Dec. 31, 2022, with early application permitted. (This means that reporting entities can continue reporting on Schedule D-1: Long-Term Bonds for 2021 but could reclassify the instruments to Schedule BA – Other Long-Term Investments utilizing the “Other” or another Schedule BA reporting line that is appropriate for the investment for year-end 2021.) In addition,
the Working Group provided guidance to the Blanks (E) Working Group to clarify that a self-assigned NAIC 5GI is not permitted for residual tranches, and such items reported on Schedule D-1 for year-end 2021 are required to be reported with an NAIC 6 designation.

**Adopted revisions to SSAP No. 43R**

26. Loan-backed and structured securities shall be valued and reported in accordance with this statement, the *Purposes and Procedures Manual of the NAIC Investment Analysis Office*, and the designation assigned in the *NAIC Valuations of Securities* product prepared by the NAIC Securities Valuation Office or equivalent specified procedure. The carrying value method shall be determined as follows:

   a. For reporting entities that maintain an Asset Valuation Reserve (AVR), loan-backed and structured securities, excluding residual tranches or interests, shall be reported at amortized cost, except for those with an NAIC designation of 6, which shall be reported at the lower of amortized cost or fair value.

   b. For reporting entities that do not maintain an AVR, loan-backed and structured securities designated highest-quality and high-quality (NAIC designations 1 and 2, respectively), excluding residual tranches or interests, shall be reported at amortized cost; loan-backed and structured securities that are designated medium quality, low quality, lowest quality and in or near default (NAIC designations 3 to 6, respectively) shall be reported at the lower of amortized cost or fair value.

   c. For residual tranches or interests FN captured in scope of this statement, all reporting entities shall report the item on Schedule BA: Other Long-Term Invested Assets at the lower of amortized cost or fair value. Changes in the reported value from the prior period shall be recorded as unrealized gains or losses. For reporting entities that maintain an AVR, the accounting for unrealized gains and losses shall be in accordance with *SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve*.

   **New Footnote:** Reference to “residual tranches or interests” intends to capture securitization tranches and beneficial interests as well as other structures captured in scope of this statement, that reflect loss layers without any contractual payments, whether principal or interest, or both. Payments to holders of these investments occur after contractual interest and principal payments have been made to other tranches or interests and are based on the remaining available funds. Although payments to holders can occur throughout an investment’s duration (and not just at maturity), such instances still reflect the residual amount permitted to be distributed after other holders have received contractual interest and principal payments.

56. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with *SSAP No. 3—Accounting Changes and Corrections of Errors*. Subsequent revisions to this statement include:

   a. Substantive revisions pertaining to valuation and impairment based on expected cash flows, as detailed in *Issue Paper No. 140—Substantive Revisions to SSAP No. 43—Loan-Backed and Structured Securities*, were effective September 30, 2009. (Transition guidance previously included in SSAP No. 43R was removed from the SSAP in the *As of March 2018 Accounting Practices and Procedures Manual* but is retained for historical purposes in the issue paper.)
b. Substantive revisions to incorporate a new method to determine the final NAIC designation were effective, on a prospective basis, for reporting periods ending on or after December 31, 2009. In 2011, revisions were incorporated to this process to be consistent with the (P&P Manual). These revisions expanded the guidance to explicitly detail the process for “financial modeling” and “modified filing exempt” securities.

c. Nonsubstantive revisions to clarify the accounting for gains and losses between AVR and IMR securities were adopted in June 2010 with a January 1, 2011, effective date with early application allowed. Reporting entities that had previously bifurcated gains and losses between AVR and IMR for sale transactions were restricted from reversing prior bifurcations and were prohibited from reverting to a process that did not bifurcate gains and losses in the period between adoption and the effective date.

d. Nonsubstantive revisions, reflected in paragraph 50, to incorporate guidance from INT 00-11: EITF 98-15: Structured Notes Acquired for a Specified Investment Strategy were effective September 11, 2000.

e. Nonsubstantive revisions pertaining to the calculation of investment income for prepayment penalty and/or acceleration fees, reflected in paragraph 13, were effective January 1, 2017, on a prospective basis with early application permitted.

f. Nonsubstantive revisions to eliminate the modified filing exempt (MFE) method were effective March 31, 2019, with early adoption permitted for year-end 2018. Early adoption was considered an “all or nothing” approach. As such, reporting entities that did not elect to early adopt were required to apply the MFE process to all applicable SSAP No. 43R securities as of year-end 2018, whereas reporting entities that elected to early adopt were not permitted to use the MFE process for any SSAP No. 43R securities for year-end 2018.

g. Revisions adopted April 2019 to explicitly include mortgage-referenced securities in scope of this statement are effective December 31, 2019.

gh. Nonsubstantive revisions adopted in November 2021 to clarify that residual tranches or interests (as defined in footnote ___) shall be reported at the lower of amortized cost or fair value on Schedule BA: Other Invested Assets are effective December 31, 2022. Reporting entities may elect to reclassify residual tranches or interests to Schedule BA in advance of the effective date. As of the effective date, residual tranches or interests previously reported on Schedule BA shall be reclassified to the appropriate residual tranche Schedule BA reporting line based on the underlying characteristics of the investment structure.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/Fall 2021/TF/App/SAP/Minutes/Att One-A2_21-15 - SSAP No. 43R - Residual Tranches.docx
Maintenance updates provide revisions to the *Accounting Practices and Procedures Manual*, such as editorial corrections, reference changes and formatting.

<table>
<thead>
<tr>
<th>SSAP/App.</th>
<th>Description/Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preamble</td>
<td>Incorporates a paragraph number for the existing statutory hierarchy section.</td>
</tr>
<tr>
<td>Appendix A-001</td>
<td>Updates designation codes for preferred stock as noted in section 2 of <em>Appendix A-001: Investments of Reporting Entities</em>.</td>
</tr>
<tr>
<td>Appendix C</td>
<td>Updates reference to the <em>former</em> Emerging Actuarial Issues (E) Working Group as well as adding reference to the Valuation Analysis (E) Working Group’s use of included interpretations.</td>
</tr>
<tr>
<td>Appendix C-2</td>
<td>Updates reference to the <em>former</em> Emerging Actuarial Issues (E) Working Group as well as adding reference to the Valuation Analysis (E) Working Group’s use of included interpretations.</td>
</tr>
<tr>
<td>SSAP No. 21R</td>
<td>Updates improve the readability of paragraph 9 regarding receivables for securities.</td>
</tr>
</tbody>
</table>

**Recommendation:**
NAIC staff recommend that the Statutory Accounting Principles (E) Working Group move this agenda item to the active listing, categorize as nonsubstantive, and expose editorial revisions as illustrated below.

**Status:**
On August 26, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed editorial revisions to the Preamble, *Appendix A-001: Investments of Reporting Entities, Appendix C Actuarial Guidelines – Appendices, Appendix C-2 Interpretations of the Emerging Actuarial Issues (E) Working Group*, and *SSAP No. 21R —Other Admitted Assets*, as illustrated below.


**Preamble**

41. The multitude of unique circumstances and individual transactions makes it virtually impossible for any codification of accounting principles to be totally comprehensive. Application of SAP, either contained in the SSAPs or defined as GAAP and adopted by the NAIC, to unique circumstances or individual transactions should be consistent with the concepts of conservatism, consistency, and recognition.
V. Statutory Hierarchy

42. The following Hierarchy is not intended to preempt state legislative and regulatory authority.

Level 1
- SSAPs, including U.S. GAAP reference material to the extent adopted by the NAIC from the FASB Accounting Standards Codification\[1\] (FASB Codification or GAAP guidance)

Level 2
- Consensus positions of the Emerging Accounting Issues (E) Working Group as adopted by the NAIC (INTs adopted before 2016)
- Interpretations of existing SSAPs as adopted by the Statutory Accounting Principles (E) Working Group (INTs adopted in 2016 or beyond)

Level 3
- NAIC Annual Statement Instructions
- Purposes and Procedures Manual of the NAIC Investment Analysis Office

Level 4
- Statutory Accounting Principles Preamble and Statement of Concepts\[2\]

Level 5
- Sources of nonauthoritative GAAP accounting guidance and literature, including: (a) practices that are widely recognized and prevalent either generally or in the industry, (b) FASB Concept Statements, (c) AICPA guidance not included in FASB Codification, (d) International Financial Reporting Standards, (e) Pronouncements of professional associations or regulatory agencies, (f) Technical Information Service Inquiries and Replies included in the AICPA Technical Practice Aids, and (g) Accounting textbooks, handbooks and articles

432. If the accounting treatment of a transaction or event is not specified by the SSAPs, preparers, regulators and auditors of statutory financial statements should consider whether the accounting treatment is specified by another source of established statutory accounting principles. If an established statutory accounting principle from one or more sources in Level 2 or 3 is relevant to the circumstances, the preparer, regulator or auditor should apply such principle. If there is a conflict between statutory accounting principles from one or more sources in Level 2 or 3, the preparer, regulator or auditor should follow the treatment specified by the source in the higher level—that is, follow Level 2 treatment over Level 3. Revisions to guidance in accordance with additions or revisions to the NAIC statutory hierarchy should be accounted for as a change in accounting principle in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors.

\[1\] Effective September 15, 2009, the FASB Codification is the source of authoritative U.S. generally accepted accounting principles. As of that date, the FASB Codification superseded all then-existing non-SEC accounting and reporting standards. All other nongrandfathered, non-SEC accounting literature not included in the FASB Codification is nonauthoritative. As of September 15, 2009, AICPA Statements of Position are no longer reviewed as part of the statutory maintenance process as they are no longer considered authoritative GAAP literature. If the AICPA were to address an issue that affects the FASB Codification, an accounting standard update (ASU) would be issued and reviewed for applicability to statutory accounting.
The Statutory Accounting Principles Statement of Concepts incorporates by reference FASB Concepts Statements One, Two, Five and Six to the extent they do not conflict with the concepts outlined in the statement. However, for purposes of applying this hierarchy the FASB Concepts Statements shall be included in Level 5 and only those concepts unique to statutory accounting as stated in the statement are included in Level 4.

Appendix A-001 Investments of Reporting Entities

Update designation codes for preferred stock – the codes marked for deletion are no longer in use. Note: the blanks have already been updated through an editorial update that occurred in March 2021.

Section 2. Investment Risks Interrogatories

3. Amounts and percentages of the reporting entity’s total admitted assets held in bonds and preferred stocks by NAIC designation:

<table>
<thead>
<tr>
<th></th>
<th>Bonds</th>
<th></th>
<th>Preferred</th>
<th></th>
</tr>
</thead>
<tbody>
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<td></td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Bonds</td>
<td></td>
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<td>Preferred</td>
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<td>NAIC – 1</td>
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<td>NAIC P/RP</td>
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<td>NAIC – 2</td>
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<td>NAIC P/RP</td>
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<tr>
<td>NAIC – 3</td>
<td>$</td>
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<td>NAIC P/RP</td>
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</tr>
<tr>
<td>NAIC – 4</td>
<td>$</td>
<td></td>
<td>NAIC P/RP</td>
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</tr>
<tr>
<td>NAIC – 5</td>
<td>$</td>
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<td>NAIC P/RP</td>
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</tr>
<tr>
<td>NAIC – 6</td>
<td>$</td>
<td></td>
<td>NAIC P/RP</td>
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</tr>
</tbody>
</table>

Appendix C Actuarial Guidelines - Appendices

Updates reference to the former Emerging Actuarial Issues (E) Working Group as well as adding reference the Valuation Analysis (E) Working Group’s use of included interpretations.


Appendix C-2 Interpretations of the Emerging Actuarial Issues (E) Working Group

Updates reference to the former Emerging Actuarial Issues (E) Working Group as well as adding reference the Valuation Analysis (E) Working Group’s use of included interpretations.

Introduction

The former Emerging Actuarial Issues (E) Working Group (EAIWG) and the current Valuation Analysis (E) Working Group (VAWG) respond to questions of application, interpretation and clarification with respect to Actuarial Guideline XXXVIII—The Application of the Valuation of Life Insurance Policies Model Regulation (AG 38). Following an abbreviated public comment and review period of no less than seven days, the Working Group will adopt by consensus formal interpretations on issues presented before it. These interpretations will then be reported to the Financial Condition (E) Committee, which, after adopting, will direct the Financial Analysis (E) Working Group to follow the interpretations in performing its reviews of the reserving methodologies under AG 38. These interpretations will not become effective until formally adopted by the Financial Condition (E) Committee. In no event shall a consensus opinion of the former EAIWG Working Group or current VAWG supersede or otherwise conflict with AG 38.

SSAP No. 21R—Other Admitted Assets

Updates improve the readability of paragraph 9 regarding receivables for securities.

9. Sales of securities are recorded as of the trade date. A receivable due from the broker is established in instances when a security has been sold, but the proceeds from the sale have not yet been received. Unless the
receivable for securities, meets the criteria set forth in paragraph 11, the receivable for securities is an admitted asset to the extent it conforms to the requirements of this statement. For other than a receivables arising from the sale of a security which was acquired on a “To Be Announced” (“TBA”) basis, or from the sale of securities that are received as stock distributions that may be restricted (unregistered) or in physical form, and which has yet to be actually received, admissibility shall be in accordance with (see paragraph 12), meets the criteria set forth in paragraph 11, the receivable for securities is an admitted asset to the extent it conforms to the requirements of this statement.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Salvage - Legal Recoveries

Check (applicable entity):

<table>
<thead>
<tr>
<th>Modification of Existing SSAP</th>
<th>P/C</th>
<th>Life</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Issue or SSAP Interpretation</td>
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</table>

Description of Issue:
This agenda item recommends nonsubstantive revisions to **SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses** to clarify that salvage and subrogation estimates and recoveries can include amounts related to both claims/losses and loss adjusting expenses. The corresponding estimates should be reported as a reduction of losses and/or loss adjusting expense (LAE) reserves. Once the amounts for salvage and subrogation and coordination of benefits recoveries (COB) are received, they are reported as a reduction of paid losses and LAE depending on the nature of the costs being recovered.

SSAP No. 55 contains salvage and subrogation guidance. Key points of the guidance regarding salvage, subrogation and COB are as follows:

- Salvage, subrogation and coordination of benefits recoveries are estimated using the same techniques used for estimating unpaid claims/losses and unpaid loss adjusting expenses.
- Separate recoverables are not established. Estimated salvage, subrogation and coordination of benefit recoveries (net of associated expenses) are deducted from the liability for unpaid claims or losses (for reporting entities that choose to anticipate such recoveries).
- Salvage, subrogation and coordination of benefits recoveries received (net of associated expenses) are reported as a reduction to paid losses/claims.

This agenda item is in response to an industry request. The proposed clarification provides additional detail regarding loss adjusting expenses for salvage, subrogation and coordination of benefits that is believed to be consistent with current practice by a majority of reporting entities. For example, if legal fees are recovered in a subrogation lawsuit, it is believed that such amounts are currently being reported as reduction in paid adjusting expenses for legal fees. SSAP No. 55 does not explicitly discuss the recovery of loss adjusting expenses in the discussion of salvage, subrogation and COB. However, the property and casualty annual statement instructions, which are level two on the statutory hierarchy of authoritative literature, includes an explicit reference to reduce loss adjusting expenses for such amounts in the Schedule P instructions (See Existing Authoritative Literature below).

Existing Authoritative Literature:

SSAP No. 55 provides the following (bolding added for emphasis):

**General**

11. The liability for claim reserves and claim liabilities, unpaid losses, and loss/claim adjustment expenses shall be based upon the estimated ultimate cost of settling the claims (including the effects of inflation and other societal and economic factors), using past experience adjusted for current trends, and
any other factors that would modify past experience. These liabilities shall not be discounted unless authorized for specific types of claims by specific SSAPs, including SSAP No. 54R and SSAP No. 65—Property and Casualty Contracts.

12. Various analytical techniques can be used to estimate the liability for IBNR claims, future development on reported losses/claims, and loss/claim adjustment expenses. These techniques generally consist of statistical analysis of historical experience and are commonly referred to as loss reserve projections. The estimation process is generally performed by line of business, grouping contracts with like characteristics and policy provisions. The decision to use a particular projection method and the results obtained from that method shall be evaluated by considering the inherent assumptions underlying the method and the appropriateness of those assumptions to the circumstances. No single projection method is inherently better than any other in all circumstances. The results of more than one method should be considered.

13. For each line of business and for all lines of business in the aggregate, management shall record its best estimate of its liabilities for unpaid claims, unpaid losses, and loss/claim adjustment expenses. Because the ultimate settlement of claims (including IBNR for death claims and accident and health claims) is subject to future events, no single claim or loss and loss/claim adjustment expense reserve can be considered accurate with certainty. Management’s analysis of the reasonableness of claim and loss and loss/claim adjustment expense reserve estimates shall include an analysis of the amount of variability in the estimate. If, for a particular line of business, management develops its estimate considering a range of claim or loss and loss/claim adjustment expense reserve estimates bounded by a high and a low estimate, management’s best estimate of the liability within that range shall be recorded. The high and low ends of the range shall not correspond to an absolute best-and-worst case scenario of ultimate settlements because such estimates may be the result of unlikely assumptions. Management’s range shall be realistic and, therefore, shall not include the set of all possible outcomes but only those outcomes that are considered reasonable. Management shall also follow the concept of conservatism included in the Preamble when determining estimates for claims reserves. However, there is not a specific requirement to include a provision for adverse deviation in claims.

14. In the rare instances when, for a particular line of business, after considering the relative probability of the points within management’s estimated range, it is determined that no point within management’s estimate of the range is a better estimate than any other point, the midpoint within management’s estimate of the range shall be accrued. It is anticipated that using the midpoint in a range will be applicable only when there is a continuous range of possible values, and no amount within that range is any more probable than any other. For purposes of this statement, it is assumed that management can quantify the high end of the range. If management determines that the high end of the range cannot be quantified, then a range does not exist, and management’s best estimate shall be accrued. This guidance is not applicable when there are several point estimates which have been determined as equally possible values, but those point estimates do not constitute a range. If there are several point estimates with equal probabilities, management should determine its best estimate of the liability.

15. If a reporting entity chooses to anticipate salvage and subrogation recoverables (including amounts recoverable from second injury funds, other governmental agencies, or quasi-governmental agencies, where applicable), the recoverables shall be estimated in a manner consistent with paragraphs 11-13 of this statement. Estimated salvage and subrogation recoveries (net of associated expenses) shall be deducted from the liability for unpaid claims or losses. If a reporting entity chooses to anticipate coordination of benefits (COB) recoverables of Individual and Group Accident and Health Contracts, the recoverables shall be estimated in a manner consistent with paragraphs 11-13 of this statement and shall be deducted from the liability for unpaid claims or losses. A separate receivable shall not be established for these recoverables. In addition, all of these recoverables are also subject to the impairment guidelines established in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets and an entity shall not reduce its reserves for any recoverables deemed to be impaired. Salvage and subrogation recoveries received (net of associated expenses) are reported as a reduction to paid losses/claims. Coordination of benefits...
Ref #2021-13

(COB) recoveries received of Individual and Group Accident and Health Contracts (net of associated expenses) are reported as a reduction to paid claims.

16. Changes in estimates of the liabilities for unpaid claims or losses and loss/claim adjustment expenses resulting from the continuous review process, including the consideration of differences between estimated and actual payments, shall be considered a change in estimate and shall be recorded in accordance with SSAP No. 3—Accounting Changes and Corrections of Errors. SSAP No. 3 requires changes in estimates to be included in the statement of operations in the period the change becomes known. This guidance also applies to the period subsequent to the March 1 filing deadline for annual financial statements through the filing deadline of June 1 for audited annual financial statements.

Disclosures

17. The financial statements shall include the following disclosures for each year full financial statements are presented. The disclosure requirement in paragraph 17.d. is also applicable to the interim financial statements if there is a material change from the amounts reported in the annual filing. Life and annuity contracts are not subject to this disclosure requirement.

   a. The balance in the liabilities for unpaid claims and unpaid losses and loss/claim adjustment expense reserves at the beginning and end of each year presented;

   b. Incurred claims, losses, and loss/claim adjustment expenses with separate disclosures of the provision for insured or covered events of the current year and increases or decreases in the provision for insured or covered events of prior years;

   c. Payments of claims, losses, and loss/claim adjustment expenses with separate disclosures of payments of losses and loss/claim adjustment expenses attributable to insured or covered events of the current year and insured or covered events of prior years;

   d. The reasons for the change in the provision for incurred claims, losses, and loss/claim adjustment expenses attributable to insured or covered events of prior years. The disclosure should indicate whether additional premiums or return premiums have been accrued as a result of the prior-year effects. (For Title reporting entities, “provision” refers to the known claims reserve included in Line 1 of the Liabilities page, and “prior years” refers to prior report years);

   e. Information about significant changes in methodologies and assumptions used in calculating the liability for unpaid claims and claim adjustment expenses, including reasons for the change and the effects on the financial statements for the most recent reporting period presented;

   f. A summary of management’s policies and methodologies for estimating the liabilities for losses and loss/claim adjustment expenses, including discussion of claims for toxic waste cleanup, asbestos-related illnesses, or other environmental remediation exposures;

   g. Disclosure of the amount paid and reserved for losses and loss/claim adjustment expenses for asbestos and/or environmental claims, on a direct, assumed and net of reinsurance basis (the reserves required to be disclosed in this section shall exclude amounts relating to policies specifically written to cover asbestos and environmental exposures). Each company should report only its share of a group amount (after applying its respective pooling percentage) if the company is a member of an intercompany pooling agreement; and
Estimates of anticipated salvage and subrogation (including amounts recoverable from second injury funds, other governmental agencies, or quasi-governmental agencies, where applicable), deducted from the liability for unpaid claims or losses.

The Property and Casualty Annual Statement Instructions for Schedule P, Part 1 discuss salvage and subrogation regarding loss reserve and paid claims and then provide additional detail regarding losses and loss adjusting expenses in a later paragraph as excerpted below (bolding added for emphasis):

Cumulative salvage and subrogation received and losses and expenses paid should be reported for each specific year. For “prior,” report only salvage and subrogation received and losses and expenses paid in current year.

In Schedule P, Part 1, salvage and subrogation received should be reported net of reinsurance, if any. Loss payments are to be reported net of salvage and subrogation received in Schedule P.

Adjusting & Other Payments, Column 9, should only reflect ceded recoveries made in 1997 and subsequent. Adjusting & Other Payments, Column 8, should reflect net payments in 1996 and prior and direct and assumed payments for 1997 and subsequent.

Premiums earned and losses paid, unpaid, and incurred should reconcile with the Statement of Income page. The workpapers that show a reconciliation explaining reinsurance, discounting, and salvage and subrogation adjustments should be available for examination on request.

Report in Column 23 the estimated amount of anticipated salvage and subrogation that has been taken as credit (netted) in the reserves for unpaid losses and loss adjustment expenses reported in Column 24. (Note: Column 23 is a memo column only as the amounts contained therein have already been taken into consideration in Columns 13 through 20.)

The Life and Health Annual Statement Instructions for Note 36 (matches SSAP No. 55, paragraph 17h disclosure.)

36. Loss/Claim Adjustment Expenses

Instruction:

The financial statement shall include the following disclosures for each year full financial statements are presented. Life and annuity contracts are not subject to this disclosure requirement:

- The balance in the liabilities for unpaid loss/claim adjustment expense reserves at the beginning and end of each year presented.
- Incurred loss/claim adjustment expenses with separate disclosures of the provision for insured or covered events of the current year and increases or decreases in the provision for insured or covered events of prior years.
- Payments of loss/claim adjustment expenses with separate disclosure of payment of loss/claim adjustment expenses attributable to insured or covered events of the current year and insured or covered events of prior years.
- Estimates of anticipated salvage and subrogation (including amounts recoverable from second injury funds, other governmental agencies, or quasi-governmental agencies, where applicable), deducted from the liability for unpaid claims or losses.
Illustration:
The balance in the liability for unpaid accident and health claim adjustment expenses as of and ______ was $_______ and $______, respectively.

The Company incurred $_______ and paid $_______ of claim adjustment expenses in the current year, of which $_______ of the paid amount was attributable to insured or covered events of prior years. The Company did not increase or decrease the provision for insured events of prior years.

The Company took into account estimated anticipated salvage and subrogation of the liability for unpaid claims/losses and reduced such liability by $_______.

The Health Annual Statement Instructions for note 31 matches SSAP No. 55, paragraph 17h disclosure.

31. Anticipated Salvage and Subrogation
Instruction:
Estimates of anticipated salvage and subrogation (including amounts recoverable from second injury funds, other governmental agencies, or quasi-governmental agencies, where applicable), deducted from the liability for unpaid claims or losses. Refer to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses for accounting guidance.

Illustration:
The Company took into account estimated anticipated salvage and subrogation in its determination of the liability for unpaid claims/losses and reduced such liability by $______________.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None


Staff Review Completed by:
Robin Marcotte, NAIC Staff - August 2021

Staff Recommendation:
NAIC staff recommends that the Working Group move this agenda item to the active listing, categorized as nonsubstantive, and expose revisions to SSAP No. 55, which clarify that subrogation recoveries should be reported as a reduction of losses and/or loss adjusting expense LAE reserves, depending on the nature of the costs being recovered. In addition, updates to the disclosure in paragraph 17h are recommended. In conjunction, with the agenda item, NAIC staff should be directed to coordinate develop conforming revisions to the annual statement instructions. While NAIC staff believes the proposed clarification is consistent with the current practice of most entities, the Working Group should notify the Casualty Actuarial and Statistical (C) Task Force, the Life Actuarial (A) Task Force and the Health Actuarial (B) Task Force of the exposure.
**SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses** proposed revisions

**General**

11. The liability for claim reserves and claim liabilities, unpaid losses, and loss/claim adjustment expenses shall be based upon the estimated ultimate cost of settling the claims (including the effects of inflation and other societal and economic factors), using past experience adjusted for current trends, and any other factors that would modify past experience. These liabilities shall not be discounted unless authorized for specific types of claims by specific SSAPs, including SSAP No. 54R and SSAP No. 65—Property and Casualty Contracts.

12. Various analytical techniques can be used to estimate the liability for IBNR claims, future development on reported losses/claims, and loss/claim adjustment expenses. These techniques generally consist of statistical analysis of historical experience and are commonly referred to as loss reserve projections. The estimation process is generally performed by line of business, grouping contracts with like characteristics and policy provisions. The decision to use a particular projection method and the results obtained from that method shall be evaluated by considering the inherent assumptions underlying the method and the appropriateness of those assumptions to the circumstances. No single projection method is inherently better than any other in all circumstances. The results of more than one method should be considered.

13. For each line of business and for all lines of business in the aggregate, management shall record its best estimate of its liabilities for unpaid claims, unpaid losses, and loss/claim adjustment expenses. Because the ultimate settlement of claims (including IBNR for death claims and accident and health claims) is subject to future events, no single claim or loss and loss/claim adjustment expense reserve can be considered accurate with certainty. Management's analysis of the reasonableness of claim or loss and loss/claim adjustment expense reserve estimates shall include an analysis of the amount of variability in the estimate. If, for a particular line of business, management develops its estimate considering a range of claim or loss and loss/claim adjustment expense reserve estimates bounded by a high and a low estimate, management’s best estimate of the liability within that range shall be recorded. The high and low ends of the range shall not correspond to an absolute best-and-worst case scenario of ultimate settlements because such estimates may be the result of unlikely assumptions. Management’s range shall be realistic and therefore, shall not include the set of all possible outcomes but only those outcomes that are considered reasonable. Management shall also follow the concept of conservatism included in the Preamble when determining estimates for claims claim and loss and loss/claim adjustment expense reserves. However, there is not a specific requirement to include a provision for adverse deviation in claims.

14. In the rare instances when, for a particular line of business, after considering the relative probability of the points within management’s estimated range, it is determined that no point within management’s estimate of the range is a better estimate than any other point, the midpoint within management’s estimate of the range shall be accrued. It is anticipated that using the midpoint in a range will be applicable only when there is a continuous range of possible values, and no amount within that range is any more probable than any other. For purposes of this statement, it is assumed that management can quantify the high end of the range. If management determines that the high end of the range cannot be quantified, then a range does not exist, and management’s best estimate shall be accrued. This guidance is not applicable when there are several point estimates which have been determined as equally possible values, but those point estimates do not constitute a range. If there are several point estimates with equal probabilities, management should determine its best estimate of the liability.

15. If a reporting entity chooses to anticipate salvage and subrogation recoverables (including amounts recoverable from second injury funds, other governmental agencies, or quasi-governmental agencies, where applicable), the recoverables shall be estimated in a manner consistent with paragraphs 10-12 of this statement. Estimated salvage and subrogation recoveries (net of associated recovery expenses) shall be deducted from the liability for unpaid claims, unpaid losses, and unpaid loss/claim adjustment expenses, depending on the whether the subrogation represents a recovery of claims/losses or loss/claims adjustment expenses.
expenses or losses. If a reporting entity chooses to anticipate coordination of benefits (COB) recoverables of Individual and Group Accident and Health Contracts, the recoverables shall be estimated in a manner consistent with paragraphs 11-13 of this statement and shall be deducted from the liability for unpaid claims or losses. A separate receivable shall not be established for these recoverables. In addition, all of these recoverables are also subject to the impairment guidelines established in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets (SSAP No. 5R) and an entity shall not reduce its reserves for any recoverables deemed to be impaired. Salvage and subrogation recoveries received (net of associated recovery expenses) are reported as a reduction to paid losses/claims and/or paid loss/claim adjustment expenses. Coordination of benefits (COB) recoveries received of Individual and Group Accident and Health Contracts (net of associated recovery expenses) are reported as a reduction to paid claims.

Disclosures

17. The financial statements shall include the following disclosures for each year full financial statements are presented. The disclosure requirement in paragraph 17.d. is also applicable to the interim financial statements if there is a material change from the amounts reported in the annual filing. Life and annuity contracts are not subject to this disclosure requirement.

a. The balance in the liabilities for unpaid claims and unpaid losses and loss/claim adjustment expense reserves at the beginning and end of each year presented;

b. Incurred claims, losses, and loss/claim adjustment expenses with separate disclosures of the provision for insured or covered events of the current year and increases or decreases in the provision for insured or covered events of prior years;

c. Payments of claims, losses, and loss/claim adjustment expenses with separate disclosures of payments of losses and loss/claim adjustment expenses attributable to insured or covered events of the current year and insured or covered events of prior years;

d. The reasons for the change in the provision for incurred claims, losses, and loss/claim adjustment expenses attributable to insured or covered events of prior years. The disclosure should indicate whether additional premiums or return premiums have been accrued as a result of the prior-year effects. (For Title reporting entities, “provision” refers to the known claims reserve included in Line 1 of the Liabilities page, and “prior years” refers to prior report years);

e. Information about significant changes in methodologies and assumptions used in calculating the liability for unpaid claims and claim adjustment expenses, including reasons for the change and the effects on the financial statements for the most recent reporting period presented;

f. A summary of management’s policies and methodologies for estimating the liabilities for losses and loss/claim adjustment expenses, including discussion of claims for toxic waste cleanup, asbestos-related illnesses, or other environmental remediation exposures;

g. Disclosure of the amount paid and reserved for losses and loss/claim adjustment expenses for asbestos and/or environmental claims, on a direct, assumed and net of reinsurance basis (the reserves required to be disclosed in this section shall exclude amounts relating to policies specifically written to cover asbestos and environmental exposures). Each company should report only its share of a group amount (after applying its respective pooling percentage) if the company is a member of an intercompany pooling agreement; and
h. Estimates of anticipated salvage and subrogation (including amounts recoverable from second injury funds, other governmental agencies, or quasi-governmental agencies, where applicable), deducted from the liability for unpaid claims, or losses or their associated adjusting expenses.

Status:
On August 26, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and took the following actions:

1. Exposed revisions to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses, as illustrated above, to clarify that salvage and subrogation recoveries should be reported as a reduction of losses and/or loss adjusting expense (LAE reserves), depending on the nature of the costs being recovered. In addition, updates to the disclosure in paragraph 17.h. were exposed.
2. Directed NAIC staff to coordinate develop conforming revisions to the Annual Statement instructions.
3. Directed notification of the exposure to the following actuarial Task Forces:
   a. Casualty Actuarial and Statistical (C) Task Force,
   b. Life Actuarial (A) Task Force, and
   c. Health Actuarial (B) Task Force

On November 10, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, exposed revisions SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses, as shown above. The revisions clarify that subrogation recoveries should be reported as a reduction of losses and/or loss adjusting expense (LAE) reserves, depending on the nature of the costs being recovered. Included in this adoption is an update to the related disclosures to isolate the reporting of estimated salvage and subrogation and their impact on unpaid claims, losses, or associated LAE.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/Fall 2021/TF/App/SAP/Minutes/Att One-A4_21-13 Salvage legal fees.docx
Interpretation of the Statutory Accounting Principles Working Group

INT 21-02: Extension of Ninety-Day Rule for the Impact of Hurricane Ida

INT 21-02T Dates Discussed

September 9, 2021; November 10, 2021

INT 21-02T References

SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers

INT 21-02T Issue

1. Hurricane Ida and its aftermath has resulted in tremendous loss of life and property, the extent to which is currently not known. The Federal Emergency Management Agency (FEMA) lists Louisiana, New Jersey and New York as having emergency declarations because of the hurricane and related flooding. This interpretation is intended to cover storm impacted policies in areas in which a state of emergency was declared. State regulators and insurers are taking action to provide policyholders affected by this disaster with the support and understanding that is deserved.

2. Should a 60-day extension of the 90-day rule for uncollected premiums be temporarily granted to insurers for policies in U.S. jurisdictions where a state of emergency was declared which were affected by the hurricane, its aftermath and related flooding?

INT 21-02T Discussion

3. The Working Group reached a consensus for a one-time optional extension of the ninety-day rule for uncollected premium balances, bills receivable for premiums and amounts due from agents and policyholders required per SSAP No. 6, paragraph 9, as described within this paragraph.

   a. For policies in effect as of the declaration of a state of emergency by either the states, U.S. territories or federal government, as described in paragraph 1, insurers with policyholders in areas impacted by Hurricane Ida, its aftermath and the related flooding may wait 150 days (90 days per existing guidance, plus a 60-day extension), not to extend beyond Jan. 23, 2022, before nonadmitting premiums receivable from those directly impacted policyholders as required per SSAP No. 6, paragraph 9.

   b. Existing impairment analysis remains in effect for these affected policies.

4. The Working Group noted that a temporary sixty day (60) extension had previously been provided for other nationally significant disasters including INT 20-11: Extension of Ninety-Day Rule for the Impact of 2020 Hurricanes, California Wildfires and Iowa Windstorms; INT 18-04: Extension of Ninety-Day Rule for the Impact of Hurricane Florence and Hurricane Michael; INT 17-01: Extension of Ninety-Day Rule for the Impact of Hurricane Harvey, Hurricane Irma and Hurricane Maria; INT 13-01: Extension of Ninety-Day Rule for the Impact of Hurricane/Superstorm Sandy; and INT 05-04: Extension of Ninety-day Rule for the Impact of Hurricane Katrina, Hurricane Rita and Hurricane Wilma.

5. Due to the short-term nature of the applicability of this extension, which expires Jan. 23, 2022, this interpretation will be publicly posted on the Statutory Accounting Principles (E) Working Group web page. This
interpretation will be automatically nullified on Jan. 24, 2022, and will be included as a nullified INT in Appendix H – Superseded SSAPs and Nullified Interpretations in the “As of March 2022” Accounting Practices and Procedures Manual.

INT 21-02 Status

6. No Further discussion is planned.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/Fall 2021/TF/App/SAP/Minutes/Att One-A5_INT 21-02 - Hurricane Ida.docx
Statutory Accounting Principles (E) Working Group
E-Vote
October 25, 2021

The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded Oct. 25, 2021. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Co-Vice Chair (IA); Sheila Travis (AL); Kim Hudson (CA); Eric Moser (IL); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); Kimberly Rankin (PA); Jamie Walker (TX); Doug Stolte (VA); and Amy Malm (WI).

1. Exposed Agenda Items 2021-16, 2021-17, 2021-18 and 2021-19EP

The Working Group conducted an e-vote to consider exposure of agenda items 2021-16: SSAP No. 30R – FHLB Disclosures – Blanks Referral, 2021-17: SSAP No. 32R – Permitted Valuation Methods, 2021-18: VM 21 Scenario Consistency Update, and 2021-19EP: Editorial Revisions. A summary of each is as follows:

1) Agenda item 2021-16 does not propose statutory accounting revisions; however, it resulted in a referral to the Blanks (E) Working Group to include a supplemental data capture footnote for Federal Home Loan Bank (FHLB) borrowings that are classified as a deposit-type contract and reported in Exhibit 7 – Deposit-Type Contracts.

2) Agenda item 2021-17 proposes revisions to Statement of Statutory Accounting Principles (SSAP) No. 30R—Unaffiliated Common Stock to remove a reference that indicates that historical cost is an allowable valuation method for redeemable preferred stock. Such valuation methods were previously superseded in July 2020 when SSAP No. 30—Unaffiliated Common Stock was substantively revised.

3) Agenda item 2021-18 proposes to SSAP No. 108—Derivatives Hedging Variable Annuity Guarantees to ensure consistency with the Valuation Manual, specifically removing reference to the “standard scenario,” as that language is no longer utilized in VM-21, Requirements for Principle-Based Reserves for Variable Annuities.

4) Agenda item 2021-19EP proposes minor editorial corrections in accordance with the maintenance process. The agenda item proposes correcting paragraph references in SSAP No. 16R—Electronic Data Processing Equipment and Software and the removal of outdated references in SSAP No. 43R—Loan-Backed and Structured Securities.

Mr. Hudson made a motion, seconded by Mr. Kasinow, to expose agenda items 2021-16, 2021-17, 2021-18, and 2021-19EP for a public comment period ending Nov. 12. The motion passed unanimously.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force conducted an e-vote that concluded Sept. 10, 2021. The following Working Group members participated: Dale Bruggeman, Chair (OH); Kevin Clark, Co-Vice Chair (IA); Kim Hudson (CA); Kathy Belfi (CT); Eric Moser (IL); Stewart Guerin (LA); Judy Weaver (MI); Doug Bartlett (NH); Bob Kasinow (NY); and David Smith (VA).

1. **Exposed Agenda Item 2021-15 and INT 21-02T**

The Working Group conducted an e-vote to consider exposure of agenda item 2021-15: SSAP No. 43R – Residual Tranches and Interpretation 21-02T – Hurricane Ida. A summary of each is as follows:

1) Agenda item 2021-15 proposes revisions to **SSAP No. 43R—Loan-Backed and Structured Securities**, clarifying that for all instruments within scope, nonrated residual tranches shall be reported on Schedule BA – Other Long-Term Investments and valued at the lower of cost or fair value. These provisions are proposed to be in effect for 2021 year-end reporting.

2) INT 21-02T proposes that for policies affected by Hurricane Ida, a 60-day extension to the “90-day rule” in **SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers** be granted for uncollected premiums balances, bills receivable for premiums, and amounts due from agents and policyholders. The temporary extension is proposed to be automatically nullified on Jan. 24, 2022.

Mr. Clark made a motion, seconded by Mr. Smith, to expose agenda item 2021-15 and INT 21-02T for a 21-day public comment period ending Oct 1. The motion passed unanimously.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/MemberMeetings/Fall2021/TF/App/SAP/Minutes/Att-One-C_09102021-EvoteStatAcctWGminTPR.docx.
The Statutory Accounting Principles (E) Working Group of the Accounting Practices and Procedures (E) Task Force met Aug. 26, 2021. The following Working Group members participated: Dale Bruggeman, Chair (OH); Carrie Mears and Kevin Clark, Co-Vice Chairs (IA); Sheila Travis (AL); Kim Hudson (CA); William Arfanis (CT); Rylynn Brown (DE); Cindy Andersen, Eric Moser and Kevin Fry (IL); Doug Bartlett (NH); Bob Kasinow (NY); Melissa Greiner and Kimberly Rankin (PA); Ludi Skinner and Jamie Walker (TX); Doug Stolte and David Smith (VA); and Amy Malm (WI).

1. Reviewed Comments on Exposed Items

The Working Group held a public hearing to review comments (Attachment One-D1) on previously exposed items.

a. Agenda Item 2021-04

Mr. Bruggeman directed the Working Group to agenda item 2021-04: Valuation of Foreign Insurance SCAs. Fatima Sediqzad (NAIC) stated that this agenda item originated from comments received during the development of agenda item 2018-26: SCA Loss Tracking – Accounting Guidance, which adopted revisions in Statement of Statutory Accounting Principles (SSAP) No. 97—Investments in Subsidiary, Controlled and Affiliated Entities to state that reported equity method losses of an investment in a subsidiary, controlled, or affiliated entity (SCA) would not create a negative value in an SCA investment; thus, equity method losses would stop at zero. However, those adopted revisions also clarified that to the extent that there was a financial guarantee or commitment, it would require recognition under SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets. In November 2020, the Working Group adopted agenda item 2020-18: SSAP No. 97 Update, which removed a lingering, superseded reference regarding negative equity method loss valuations. Ms. Sediqzad stated that SSAP No. 97 requires specific limited statutory basis of accounting adjustments to paragraph 8.b.ii. (insurance-related SCA) and paragraph 8.b.iv. (foreign insurance SCA) entities. These adjustments are to prevent assets held by an SCA from receiving a more favorable accounting treatment than had they been held directly by the insurer. It was during the Working Group’s discussion of agenda item 2020-18 that industry requested consideration of whether foreign insurance SCAs should continue to be subject to the long-standing SSAP No. 97 statutory adjustments and the adjustments should result in a negative SCA valuation. Interested parties’ initial response was that foreign insurance operations are subject to foreign jurisdiction regulations and should be allowed to stand independently of a domestic insurer; thus, in the absence of a guarantee or commitment, equity valuation should not go negative. Industry inquired whether foreign insurance subsidiaries captured in scope of SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies are also intended to reflect the limited statutory adjustments, as required in SSAP No. 97, and whether the equity method of those investments shall reflect a negative value in the absence of a required U.S. generally accepted accounting principles (GAAP) audit.

Ms. Sediqzad stated that it is important to separate the SSAP No. 97, paragraph 13 (equity method) adjustments, which stop at zero from the SSAP No. 97, paragraph 9 (limited statutory basis of accounting) adjustments, which intentionally do not stop at zero. However, it is noted that reporting entities with investments captured under SSAP No. 48, which requires an audit for admittance, may not recognize that additional adjustments are needed if the investment is nonadmitted. Ms. Sediqzad also noted that if these SSAP No. 48 investments are not audited, reporting entities may have difficulty calculating the required adjustments to be made pursuant to SSAP No. 97, paragraph 9. From this discussion, in May 2021, the Working Group exposed nonsubstantive revisions to SSAP No. 48 and SSAP No. 97 to clarify the application of the guidance and limit when the statutory adjustments are required for foreign insurance subsidiaries.

Ms. Sediqzad noted that comments received from the exposure were supportive of the exposed edits. She recommended that the Working Group adopt the exposed nonsubstantive revisions to SSAP No. 48 to clarify that the adjustments in SSAP No. 97, paragraph 9 may result in a negative equity valuation; however foreign insurance SCA entities may stop at zero, provided that the entity does not provide services or hold assets on behalf of a U.S.-based reporting entity.

Angelica Tamayo-Sanchez (New York Life), representing interested parties, stated appreciation for the Working Group’s consideration of this matter, as they believe foreign insurance SCAs are distinctly different from SSAP No. 97, paragraph 8.b.ii. entities, and this amendment will reflect the appropriate accounting of such items.
Mr. Hudson made a motion, seconded by Mr. Kasinow, to adopt the exposed nonsubstantive revisions in SSAP No. 48 and SSAP No. 97 (Attachment One-D2). The motion passed unanimously.

b. Agenda Item 2021-10

Mr. Bruggeman directed the Working Group to agenda item 2021-10: SSAP No. 32R – Clarification of Effective Call Price. Jim Pinegar (NAIC) stated that this agenda item proposes a clarification of the valuation ceiling for perpetual preferred and publicly traded preferred stock warrants in SSAP No. 32R—Preferred Stock. He stated that SSAP No. 32R requires that perpetual preferred stock be reported at fair value, with a valuation ceiling not to exceed any currently “effective call price.” However, as questions arose regarding the interpretation of this requirement, the exposed revisions clarify that the valuation ceiling will only apply in cases where the issuer has announced that the instrument will be called, or the call is currently exercisable, by the issuer. Mr. Pinegar stated that this interpretation will ensure that instruments in scope of SSAP No. 32R are not reported at a value exceeding an amount for which the item can be immediately called and will properly reflect the economics of these equity investments. He stated that the exposed footnote interpretation received informal comments indicating that interested parties support this proposal.

Ms. Malm made a motion, seconded by Mr. Bartlett, to adopt the exposed nonsubstantive revisions in SSAP No. 32R (Attachment One-D3). The motion passed unanimously.

2. Considered Maintenance Agenda – Pending Listing – Exposures

a. Agenda Item 2021-11

Mr. Bruggeman directed the Working Group to agenda item 2021-11: SSAP No. 43R – Credit Tenant Loans – Scope. Julie Gann (NAIC) stated that this agenda item was drafted because the Valuation of Securities (E) Task Force recently adopted revisions to the credit tenant loan (CTL) guidance in the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual). She stated that with the newly adopted guidance, mortgage loans in scope of SSAP No. 37—Mortgage Loans will continue historical practice, with reporting entities having the ability to file the structures with the NAIC Securities Valuation Office (SVO) for a structural assessment to determine whether the mortgage loan can be reclassified from Schedule B: Mortgage Loans to Schedule D-1: Long-Term Bonds. Security structures that have underlying real estate risk, whether they are referred to as CTLs or by another name that qualify in scope of SSAP No. 26R—Bonds or SSAP No. 43R—Loan-Backed and Structured Securities, shall follow the accounting and reporting provisions of those applicable SSAPs. Ms. Gann stated that upon review of the Task Force adoptions, the temporary reporting provisions directed in INT 20-10: Reporting Nonconforming CTLs are no longer applicable. She stated that the Working Group could either nullify INT 20-10 or let the INT automatically expire on Oct. 1. Additionally, she stated that with the Task Force adoptions, NAIC staff are recommending disposal, without statutory revisions, of agenda item 2020-24: Accounting and Reporting of Credit Tenant Loans. She stated that NAIC staff are also recommending limited revisions to: 1) clarify that mortgage loans in scope of SSAP No. 37 that qualify under the SVO structural assessment as CTLs are in scope of SSAP No. 43R; and 2) remove outstanding references to examples of loan-backed and structured securities from SSAP No. 43R, paragraph 27.b. She stated that the proposed exposure period would end on Oct. 1, which is the same day INT 20-10 is scheduled to no longer be in effect. However, after comments are received, the Working Group could consider making an explicit statement regarding whether to allow the INT to automatically expire or that the Working Group has intentionally nullified the INT. Mr. Bruggeman stated that an affirmative action of the Working Group would likely be beneficial for historical record. He stated that the revisions only affect mortgage loans that are in the form of a CTL, not similarly named items that are in the legal form of a security.

Michael M. Monahan (American Council of Life Insurers—ACLI) stated that the ACLI supports exposure of the aforementioned items, as recommended by NAIC staff.

John Garrison (Lease-Backed Securities Working Group) stated support for the exposures, as recommended by NAIC staff, as the edits are in line with the recent adoptions of the Task Force.

Ms. Weaver made a motion, seconded by Mr. Clark, to expose for a public comment period ending Oct. 1: 1) nonsubstantive revisions detailed in agenda item 2021-11; 2) the disposal, without statutory revisions, of agenda item 2020-24; and 3) whether INT 20-10 should be allowed to automatically nullify or if explicit nullification comments are warranted by the Working Group. The motion passed unanimously.
b. **Agenda Item 2021-12EP**

Mr. Bruggeman directed the Working Group to agenda item 2021-12EP: Editorial Updates. Robin Marcotte (NAIC) stated that this agenda item contains five editorial maintenance updates to the *Accounting Practices and Procedures Manual* (AP&P Manual). Four of the updates include minor formatting or revisions for consistency to the *Preamble, Appendix A-001, Appendix C,* and *Appendix C-2.* Ms. Marcotte stated that the remaining edit includes a minor update to improve the readability of the guidance for securities receivables in *SSAP No. 21R—Other Admitted Assets.*

Mr. Hudson made a motion, seconded by Ms. Weaver, to expose agenda item 2021-12EP for a public comment period ending Oct. 1. The motion passed unanimously.

c. **Agenda Item 2021-13**

Mr. Bruggeman directed the Working Group to agenda item 2021-13: Salvage – Legal Recoveries. Ms. Marcotte stated that this agenda item recommends nonsubstantive revisions to *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses* to clarify that salvage and subrogation estimates and recoveries should be reported as a reduction to both claims/losses and loss adjusting expenses (LAEs), as appropriate. However, once the amounts for salvage, subrogation, and coordination of benefits (COB) recoveries are received, they are reported as a reduction of paid losses and LAEs depending on the nature of the costs being recovered. Ms. Marcotte stated that SSAP No. 55 does not explicitly discuss the recovery of LAEs in the discussion of salvage, subrogation, and COB; however, the property/casualty (P/C) annual statement instructions, which are Level Two on the statutory hierarchy of authoritative literature, includes an explicit reference to reduce LAEs for such amounts in the instructions for *Schedule P – Analysis of Losses and Loss Expenses.* She stated that the proposed clarification, which was requested by industry, provides additional detail regarding LAEs for salvage, subrogation, and COB that is believed to be consistent with current practice by most reporting entities. She stated that even though NAIC staff believe the proposed clarification is consistent with the current practice of most entities, the Working Group should notify the Casualty Actuarial and Statistical (C) Task Force, the Life Actuarial (A) Task Force, and the Health Actuarial (B) Task Force of the exposure.

Mr. Hudson made a motion, seconded by Mr. Stolte, to expose agenda item 2021-13 and send notice of the exposure to the Casualty Actuarial and Statistical (C) Task Force, the Life Actuarial (A) Task Force, and the Health Actuarial (B) Task Force. The motion passed unanimously.

d. **Agenda Item 2021-14**

Mr. Bruggeman directed the Working Group to agenda item 2021-14: Policy Statement Terminology Change. He stated that this agenda item was drafted in response to a referral received from the Financial Condition (E) Committee regarding the Working Group’s historical use of statutory accounting terminology of “substantive” and “nonsubstantive” to describe statutory accounting revisions being considered by the Working Group. The use of these terms could be misunderstood by users that are not familiar with the specific definitions. Mr. Bruggeman stated that the suggestions provided in the referral have been incorporated into the agenda item for exposure consideration. Ms. Gann stated that the agenda item only currently proposes modifications to the *NAIC Policy Statement on Statutory Accounting Principles Maintenance Agenda Process,* as that is the source document for those definitions. Once approved by the Working Group, it is anticipated that an editorial agenda item will be utilized to change the remaining references throughout the AP&P Manual. Mr. Bruggeman stated that after adoption, the new terms will be used on a go-forward basis and updating historical documents will not occur.

Mr. Hudson made a motion, seconded by Mr. Bartlett, to receive the referral from the Financial Condition (E) Committee and expose agenda item 2021-14. The motion passed unanimously.

3. **Considered Maintenance Agenda – Active Listing**

a. **Agenda Item 2019-24**

Mr. Bruggeman directed the Working Group to agenda item 2019-24: Levelized and Persistency Commission – Issue Paper. He stated that this agenda item is to document the historical background regarding discussions during the development of the nonsubstantive revisions to *SSAP No. 71—Policy Acquisition Costs and Commissions.* He noted that the nonsubstantive revisions to SSAP No. 71 were adopted through the NAIC committee process, with final adoption occurring by the Executive (EX) Committee and Plenary at the Summer National Meeting.
Mr. Stolte made a motion, seconded by Mr. Hudson, to expose Issue Paper No. 16x: Levelized Commission for a public comment period. The motion passed unanimously.

Mr. Bruggeman stated that all the items exposed for comment have an Oct. 1 comment deadline.

4. Discussed Other Matters

a. Received and Responded to a Valuation of Securities (E) Task Force Referral on WCFIs

Ms. Marcotte stated that in July 2021, the Valuation of Securities (E) Task Force adopted changes to the P&P Manual incorporating revisions consistent with the revisions approved by the Working Group in May 2020 to SSAP No. 105R—Working Capital Finance Investments. Additionally, the Task Force directed a 30-day exposure and a referral to the Working Group regarding additional proposed P&P Manual edits concerning unrated and nonguaranteed subsidiary obligors in Working Capital Finance Investment (WCFI) programs. Ms. Marcotte stated that although the public comment period for this item has ended, Task Force support staff have confirmed that the Working Group will have additional time to respond to the referral.

Ms. Marcotte stated that the referral received provided notification of an exposed policy change that would direct the SVO to rely upon the NAIC designation of an unrated subsidiary obligor’s parent entity for WCFI programs, without notching for the subsidiary. She stated that a referral was provided to the Working Group, as a qualifying NAIC designation of the obligor is a required element for admittance of WCFI receivables under SSAP No. 105R. She stated that the Task Force’s exposure is a variation of the industry’s prior recommendations, which were previously rejected by the Working Group. The Task Force exposure proposes to require the rating of the WCFI program parent to be relied on for unrated, unsecured obligated obligors. If the Task Force agrees and deems it essential that the SVO assign NAIC designations to WCFI transactions with unrated, non-guaranteed obligors, then this policy change will affect how NAIC designations are assigned to WCFI transactions. The policy would direct SVO staff to apply/imply the credit rating of the parent to unrated, unguaranteed subsidiaries for WCFI programs even if they do not have financial information on the subsidiary. This direction is noted in the exposed SVO memo as contrary to current SVO credit substitution methodologies and is noted as not a generally accepted credit rating technique, as implied parent support is not legally enforceable.

Ms. Marcotte stated that the draft referral response notes that although the Task Force oversees the process to determine NAIC designations, the proposed methodology is a significant departure for how SVO ratings are otherwise assigned. However, the provisions within SSAP No. 105R were established in accordance with historical practices, which allow the SVO to apply its credit substitution methodology as it does for other asset classes. If the Task Force chooses to move away from the historical application of financial analysis (and use of the credit substitution methodology in determining NAIC designations for WCFI programs), the Working Group may deem it necessary to incorporate additional guardrail provisions to SSAP No. 105R, as the NAIC designation of the obligor may no longer provide the intended safeguards for WCFI programs. The draft referral response also noted that the proposed P&P Manual revisions include two elements that would require further coordination to avoid inconsistencies with SSAP No. 105R.

Mr. Bruggeman stated that while the Task Force has the responsibility for determining credit quality and NAIC designations, SSAP No. 105R has historically required reliance on a parent for such determination. However, the proposed policy would require the SVO to imply an NAIC designation to an unrated entity based on the parent entity’s credit quality, all without guarantees or other legally binding provisions that provide assurance that the parent will be legally or contractually obligated to financially cover the obligations of the unrated entity. Although, for a given program, and not related to the parent/sub relationship, the SVO may not notching or otherwise not give a rating to that program. Mr. Bruggeman stated that if the SVO takes such action, the Working Group may consider additional changes to SSAP No. 105R.

Mr. Fry stated that despite the Task Force’s proposal to no longer rely on the parent for a subsidiary’s credit determination, the WCFI program has several mitigants and is well controlled with several safeguards. He stated that this is a safe asset class with a proven track record.

Mr. Hudson made a motion, seconded by Mr. Arfanis, to receive the referral from the Task Force and send the referral response. The motion passed unanimously.

5. Reviewed and Discussed the Proposed Principles-Based Bond Definition

The Working Group held a public hearing to review comments (Attachment One-D4) on previously exposed items.
a. **Agenda Item 2019-21**

Mr. Bruggeman directed the Working Group to agenda item 2019-21: SSAP No. 43R. Ms. Gann stated that in October 2020, a small group of state insurance regulators and industry met regularly to draft a principles-based bond definition. The intent of this project is to clarify what should be reported on Schedule D-1, regardless of whether the instrument is in scope of SSAP No. 26R or SSAP No. 43R. In May 2021, the Working Group exposed the principles-based bond definition, along with a glossary and appendices with examples for application purposes. As a result of the exposure, three comment letters were received. Ms. Gann stated that NAIC staff are requesting Working Group input as to whether the proposed definition provides the general framework that should be used to proceed with the development of an issue paper and statutory accounting revisions. She stated that with direction from the Working Group to move forward with these principle concepts, all elements are still subject to continuous discussion, and revisions are expected to occur throughout the process.

Ms. Gann stated that depending on the Working Group’s direction, the next steps would include the development of: 1) an issue paper and proposed revisions to incorporate the bond concepts; 2) guidance that specifically details accounting and reporting for items that may no longer be eligible for Schedule D-1 reporting as a bond; and 3) reporting revisions to incorporate more granularity on Schedule D-1. She stated that due to the significance of the changes expected, the earliest application of the new standard would likely be Jan. 1, 2024. She stated that in addition to directing development of an issue paper, it is recommended that the Working Group repurpose the “43R small group” as a “43R study group” and request that additional state insurance regulators volunteer to participate as regular members. She stated that until revised guidance is adopted and effective, reporting entities can continue reporting as they have been for items currently in scope of SSAP No. 26R or SSAP No. 43R. However, an interim agenda item is anticipated to clarify that non-rated residual tranches or interests should be reported on Schedule BA: Other Long-Term Invested Assets.

Mr. Clark stated appreciation for the collaboration with industry on the SSAP No. 43R project. Creating a bond definition that is based on substance rather than legal form, is critical for state insurance regulators’ understanding of the types of risks present in an insurer’s investment portfolio, especially those reported on Schedule D-1. He stated that the development of a principles-based approach will accommodate a vast array of investment structures and is the best way to accomplish this goal.

In response to an inquiry from Ms. Weaver, Mr. Bruggeman stated that the intent of the project is to properly classify bonds and investments so that they are reported on an appropriate schedule and receive an adequate risk-based capital (RBC) charge. Ms. Mears stated that this was her understanding, but she also wanted to reiterate that the role of the project is reporting, not to determine credit quality nor modify the NAIC designation process. Accordingly, lower quality instruments that meet the definition of a bond will still qualify for Schedule D-1 reporting.

Michael Reis (Northwestern Mutual), representing interested parties, stated appreciation to the Iowa regulators and NAIC staff in their collaborative efforts with this project. He stated that the principle concepts will be helpful to ensure appropriate reporting while preventing potential investment reporting abuses. He stated that interested parties are generating additional examples for discussion to ensure there are not any unintended consequences, and they look forward to the continued collaboration. Mr. Bruggeman stated that the intent of the project is to remain principles-based; however, certain circumstances may require additional specificity to ensure clarity of the standard.

Ms. Gann stated in response to an inquiry from Mr. Bruggeman that the intent is to not allow pure grandfathering of existing structures. However, transition accommodations will likely be considered. Mr. Clark stated that grandfathering would negate the benefits of the project, especially as prior investments would not be subject to the new guidance. State insurance regulators would not know which investments follow the new guidance, especially as prior investments might not be liquidated for several years. Mr. Clark identified that transition guidance is anticipated as part of the additional discussions.

Ms. Gann summarized the comments received from Pinnacol Assurance, noting that they pertain to what is known as “stapled investments,” as certain debt security holders are contractually obligated to hold a corresponding equity component. Mr. Clark stated that the prevalence of these investments is likely more common than originally anticipated; however, review of the differentiation of these investments versus those that are in substance no different than had the insurer held 100% of an equity interest (that has been recharacterized as a debt), will be reviewed as a part of this project.

Aaron Sarfatti (Equitable) inquired if the risk characteristics of an investment can be separated from the bond definition. He inquired due to certain investments having a broad range of outcomes, whether an investment should qualify as a bond and whether the current RBC infrastructure provides an adequate charge. He stated that he believes that any subordinate debt structure should not qualify for bond treatment, unless there is a special exception provided by the Working Group or the SVO.
The concepts proposed would not adequately capture credit quality of possible investor outcomes. Mr. Bruggeman stated that the role of statutory accounting is to address the reporting of certain instruments, while investment quality is determined through NAIC designations through the Valuation of Securities (E) Task Force; risk charges of investments, often determined based on the reported NAIC designations, are determined through the Capital Adequacy (E) Task Force. He stated that as the project proceeds, the Working Group will consider appropriate referrals, as deemed necessary. Mr. Sarfatti stated that he will submit a comment letter to the appropriate working groups or task forces to further articulate his points.

Caleb Brainerd (Athene) inquired of Mr. Sarfatti if his comments mean that any subordinated tranche should not qualify as a bond or that only the most subordinated tranche would not qualify. Mr. Sarfatti stated that any subordinated tranche has a binary outcome, and while differing tranches have varying degrees of outcome uncertainty, the current RBC treatments for such items are likely not adequate, and he recommends additional review by state insurance regulators. Mr. Brainerd stated that he does not agree that all tranches have a binary outcome and will await Equitable’s comment letter.

In response to a submitted inquiry, Mr. Bruggeman stated that in terms of the permitted practice process, the bond proposal will not have an impact on the process per se. However, if an accounting treatment other than what is adopted by the Working Group is sought, it would require approval from an insurer’s domestic regulator as a permitted practice.

Mr. Clark made a motion, seconded by Ms. Malm, to affirm the direction of the exposed principle-based bond concepts, repurpose the “43R small group” as a “43R study group,” and direct staff to proceed with an interim project to require non-rated residual tranches or interests be reported on Schedule BA. The motion passed unanimously.

Having no further business, the Statutory Accounting Principles (E) Working Group adjourned.

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July 15, 2021

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Comments on Ref# 2021-04: SSAP No. 97 – Valuation of Foreign Insurance SCAs

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to provide comments on Ref# 2021-04 (the “exposure draft”), which was re-exposed by the Statutory Accounting Principles Working Group (the “Working Group”) on May 20, 2021.

The exposure draft proposes to make the following changes to the SSAP No. 97 and SSAP No. 48:

SSAP No. 97 Paragraph 9

Note that the outcome of these adjustments can result in a negative equity valuation of the investment for all paragraph 8.b.ii. entities. For a paragraph 8.b.iv. entity, the application of these adjustments will stop at zero, and will not result in negative equity valuation unless the 8.b.iv entity provides services to the reporting entity or its affiliates or holds assets on behalf of the reporting entity. If such services, including reinsurance transactions, are occurring, the adjustments required in this paragraph can result in a negative equity valuation. (See additional equity method application guidance in paragraph 13.e. regarding guarantees and financial support.)

SSAP No. 48 Paragraph 6

Investments in these ventures, except for joint ventures, partnerships and limited liability companies with a minor ownership interest, shall be reported using an equity method as defined in SSAP No. 97—Investments in Subsidiary, Controlled and
Statutory Accounting Principles Working Group  
July 15, 2021  
Page 2

Affiliated Entities, paragraphs 8.b.i. through 8.b.iv. (The equity method calculation may result with a negative valuation of the investment, therefore the SSAP No. 97 equity method calculation shall occur regardless of whether the investment is supported by an audit and the reporting entity will nonadmit the investment.) A reporting entity whose shares of losses in a SSAP No. 48 entity exceeds its investment in the SSAP No. 48 entity shall disclose the information required by SSAP No. 97, paragraph 35.a.

Interested parties agree with these changes. As stated in our previous comment letters on this topic, there are significant differences between 8.b.ii and 8.b.iv subsidiaries that warrant different accounting treatment. Interested parties believe that the proposed edits to SSAP No. 97 provide for the appropriate accounting for 8.b.iv subsidiaries while at the same time providing effective guardrails to prevent any potential abuses of the rules.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell                    Rose Albrizio

cc: NAIC staff  
    Interested parties

https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/fall 2021/tf/app/sap/minutes/att one-d1 comment ltrs/att one-d1a_dkb2352.docx
July 15, 2021

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: New York Life’s Comments on Item 2021-04 SSAP No. 97 – Valuation of Foreign Insurance SCAs

Dear Mr. Bruggeman:

New York Life (“NYL”) appreciates the opportunity to provide comments on Item 2021-04 (the “Exposure”), which was re-exposed by the Statutory Accounting Principles (E) Working Group (the “SAPWG”) on May 20, 2021.

The Exposure proposes to make the following changes to the SSAP No. 97 and SSAP No. 48

SSAP No. 97 Paragraph 9

Note that the outcome of these adjustments can result in a negative equity valuation of the investment for all paragraph 8.b.ii. entities. For a paragraph 8.b.iv. entity, the application of these adjustments will stop at zero, and will not result in negative equity valuation unless the 8.b.iv entity provides services to the reporting entity or its affiliates or holds assets on behalf of the reporting entity. If such services, including reinsurance transactions, are occurring, the adjustments required in this paragraph can result in a negative equity valuation. (See additional equity method application guidance in paragraph 13.e. regarding guarantees and financial support.)

SSAP No. 48 Paragraph 6

Investments in these ventures, except for joint ventures, partnerships and limited liability companies with a minor ownership interest, shall be reported using an equity method as defined in SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, paragraphs 8.b.i. through 8.b.iv. (The equity method calculation may result with a negative valuation of the investment, therefore the SSAP No. 97 equity method calculation shall occur regardless of whether the investment is supported by an audit and the reporting entity will nonadmit the investment.) A reporting entity whose shares of losses in a SSAP No. 48 entity exceeds its investment in the SSAP No. 48 entity shall disclose the information required by SSAP No. 97, paragraph 35.a.
NYL agrees with the proposed changes to both SSAPs. We believe that the language being proposed reflects the appropriate accounting for an 8.b.iv entity and at the same time prevents potential interpretations that would allow an 8.b.iv entity’s equity to be floored at zero if the 8.b.iv is only in existence to benefit the reporting entity.

Thank you for considering our comments.

Sincerely,

Robert M. Gardner
Senior Vice President and Controller

Douglas A. Wheeler
Senior Vice President, Office of Governmental Affairs
Statutory Accounting Principles (E) Working Group  
Maintenance Agenda Submission Form  
Form A

**Issue: SSAP No. 97 – Valuation of Foreign Insurance SCAs**

**Check (applicable entity):**

- Modification of existing SSAP [ ]
- New Issue or SSAP [ ]
- Interpretation [ ]

**Description of Issue:**

In March 2020, agenda item 2018-26 – SCA Loss Tracking – Accounting Guidance adopted guidance in SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities to state that reported equity method losses of an investment in a subsidiary controlled or affiliated entity (SCA) would not create a negative value in a SCA investment, thus equity method losses would stop at zero. However, the agenda item also clarified that to the extent there was a financial guarantee or commitment, it would require appropriate recognition under SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets.

In November 2020, the Working Group adopted agenda item 2020-18 - SSAP No. 97 Update and removed a lingering, superseded reference regarding negative equity method loss valuations.

However guidance in SSAP No. 97 also requires specific adjustments to 8.b.ii (insurance related SCA) and 8.b.iv (foreign insurance SCA) entities. These long-standing adjustments require the non-admission of certain assets to achieve a limited statutory basis of accounting. The adjustments have typically been viewed as necessary in order to prevent assets being held by SCA receiving more favorable treatment than had the assets been held directly by the insurer. (e.g., requiring the nonadmittance of certain assets per SSAP No. 20—Nonadmitted Assets). Per SSAP No. 97, an equity method of accounting for 8.b.ii and 8.b.iv entities would be a beginning point which would then be adjusted by the provisions of SSAP No. 97, paragraph 9 (see “authoritative literature section”). It is important to note the outcome of these adjustments can result in a negative equity valuation of the investment. Again, this is so assets held by an SCA aren’t reported at a higher value than had they been held directly by the insurer.

During the discussion of agenda item 2020-18, industry comments requested consideration of whether 8.b.iv entities should be subject to the provisions of SSAP No. 97, specifically that paragraph 9 adjustments may result in a negative equity valuation. While stating many positions, industry’s primary response that foreign insurance operations are subject to foreign jurisdiction and should be allowed to stand independently of a domestic insurer – thus in the absence of a guarantee or commitment, equity valuation should not go negative and thus stop at zero.

Comments were received from industry noted that the circumstances that would cause a foreign insurance reporting entity to record negative equity is not prevalent, however indicated the potential to arise in the future.

At the direction of the NAIC staff have drafted this agenda item to determine if further edits to SSAP No. 97 are required, specifically if the required statutory adjustments to 8.b.iv entities should no longer be able to result in a negative equity valuation.

One note, NAIC staff reviewed all SCA filings for the last 3 years, noting that less than 7% of all SCA filings were 8.b.iv entities. It was further noted that there was not a single instance of an 8.b.iv in a negative equity situation.
Existing Authoritative Literature:
Paragraph 9 of SSAP No. 97 details the modifications that are necessary to adjust audited U.S. Generally Accepted Accounting Principle (GAAP) financial statements to a limited statutory basis of accounting. These long-standing adjustments ensure that assets held by an SCA are not accounted for in a more favorable manner than had the assets been held directly by the insurer.

SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities

9. The limited statutory basis of accounting for investments in noninsurance SCA entities, subject to paragraph 8.b.ii. and foreign insurance SCA entities, subject to paragraph 8.b.iv., shall be adjusted for the following:

   a. Nonadmit assets pursuant to the following statutory accounting principles as promulgated by the NAIC in the Accounting Practices and Procedures Manual:

      i. SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers

      ii. SSAP No. 16R—Electronic Data Processing Equipment and Software

      iii. SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements

      iv. SSAP No. 20—Nonadmitted Assets

      v. SSAP No. 21R—Other Admitted Assets (e.g., collateral loans secured by assets that do not qualify as investments are nonadmitted under SAP)

      vi. SSAP No. 29—Prepaid Expenses

      vii. SSAP No. 105R—Working Capital Finance Investments

   b. Expense costs that are capitalized in accordance with GAAP but are expensed pursuant to statutory accounting as promulgated by the NAIC in the Accounting Practices and Procedures Manual (e.g., deferred policy acquisition costs, preoperating, development and research costs, etc.);

   c. Adjust depreciation for certain assets in accordance with the following statutory accounting principles:

      i. SSAP No. 16R—Electronic Data Processing Equipment and Software

      ii. SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements

      iii. SSAP No. 68—Business Combinations and Goodwill

   d. Nonadmit the amount of goodwill of the SCA in excess of 10% of the audited U.S. GAAP equity of the SCA’s last audited financial statements.

   e. Nonadmit amount of the net deferred tax assets (DTAs) of the SCA in excess of 10% of the audited U.S. GAAP equity of the SCA’s last audited financial statements.

   f. Nonadmit any surplus notes held by the SCA issued by the reporting entity.
Adjust the U.S. GAAP annuity account value reserves of a foreign insurance SCA, with respect to the business it wrote directly, using the commissioners’ annuity reserve valuation method (CARVM) as defined in paragraphs 14 and 15 of Appendix A-820 (including the reserving provisions in the various Actuarial Guidelines which support CARVM). The valuation interest rate and mortality tables to be used in applying CARVM should be that prescribed by the foreign insurance SCA's country of domicile. If the Foreign SCA’s country of domicile does not prescribe the necessary tables and/or rates, no reserve adjustment shall be made.

**Note that the outcome of these adjustments, can result in a negative equity valuation of the investment.**

**SSAP No. 97, Exhibit C:**

7. **Q – Is it possible for an SCA investment valued using an equity method to be reported as a negative value?**

7.1 **A – Yes, the equity method noninsurance SCA could have a negative equity.** For example, SSAP No. 97, paragraph 8.b.ii., relating to noninsurance SCA entities, may require some assets to be reported as a negative value (nonadmitted) in paragraph 9. In this example, a paragraph 8.b.ii. SCA subsidiary that is only holding furniture, which is nonadmitted, would be reflected with negative equity to the extent the value of the nonadmitted asset(s) exceed(s) reported equity. It should be noted that although SSAP No. 97, paragraph 13.e., discusses some situations in which the equity method should be discontinued, this does not apply to SCA entities, which meet the requirements of paragraph 8.b.ii. In addition, SSAP No. 97, paragraph 13.e., lists some situations where the equity method for 8.b.ii and 8.b.iv entities would result in a valuation that is less than zero.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): Agenda items 2018-26 – SCA Loss Tracking – Accounting Guidance and 2020-18 – SSAP No. 97 Update were previously adopted. Agenda item 2018-26 resulted in revisions to **SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets** and **SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities** stating that equity losses of an SCA would not go negative (thus stopping at zero), however the guaranteed liabilities would be reported to the extent there is a financial guarantee or commitment. Agenda item 2020-18 resulted in revisions with clarifying edits to Exhibit C, question 7, in SSAP No. 97, as well as removed a superseded statement that guarantees or commitments from the insurance reporting entity to the SCA could result in a negative equity valuation of the SCA.

**Information or issues (included in Description of Issue) not previously contemplated by the Working Group:**

None

**Convergence with International Financial Reporting Standards (IFRS): N/A**

**Staff Recommendation:**

Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose the intent to move this item to the disposal listing without statutory edits. Per staff's review of SCA Sub 2 filings filed with an 8b(iv) valuation method, there were no noted instances of negative value SCAs, therefore we do not recommend revisions to the existing guidance. This exposure will allow industry to determine if they are aware of any prevalent examples of a negative equity valuation in a foreign insurance SCA (8.b.iv) and provide detailed information to NAIC staff for assessment.
NAIC staff highlights that if such an event (negative equity due to nonadmitted assets) was to actually occur at some point, and the company was to question whether the negative equity in the SCA should be reported, that this should be addressed directly with the state of domicile. With this approach, the domiciliary state would be able to assess the limited statutory edits that were performed, the extent to which assets are held in the SCA that would be nonadmitted if held directly by the insurer, and how the SCA obtained those assets.

Staff Review Completed by: Fatima Sediqzad - NAIC Staff  
February 2021

Status:
On March 15, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed the intent to move this agenda item to the disposal listing without statutory edits. Industry is requested submit comments on any prevalent examples of a negative equity valuation in a foreign insurance subsidiary, controlled or affiliated (SCA) investment with detailed information for assessment.

On May 20, 2021, the Statutory Accounting Principles (E) Working Group exposed revisions to SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities, as shown below, to indicate that the equity method valuation referenced in SSAP No. 97 can result in a negative equity valuation and to limit the statutory adjustments in SSAP No. 97, paragraph 9. The exposure includes proposed guidance based on comments received, which propose that foreign insurance SCAs shall stop at zero (and thus not be subject to negative equity valuations) when applying paragraph 9 adjustments in cases where the foreign insurance subsidiary is not engaged in providing services to, or holdings assets on behalf of, U.S. insurers.

Exposed Revisions:

SSAP No. 97, paragraph 9

9. The limited statutory basis of accounting for investments in noninsurance SCA entities, subject to paragraph 8.b.ii. and foreign insurance SCA entities, subject to paragraph 8.b.iv., shall be adjusted for the following:

   a. Nonadmit assets pursuant to the following statutory accounting principles as promulgated by the NAIC in the Accounting Practices and Procedures Manual;

   i. SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers

   ii. SSAP No. 16R—Electronic Data Processing Equipment and Software

   iii. SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements

   iv. SSAP No. 20—Nonadmitted Assets

   v. SSAP No. 21R—Other Admitted Assets (e.g., collateral loans secured by assets that do not qualify as investments are nonadmitted under SAP)

   vi. SSAP No. 29—Prepaid Expenses
vii. **SSAP No. 105R—Working Capital Finance Investments**

b. Expense costs that are capitalized in accordance with GAAP but are expensed pursuant to statutory accounting as promulgated by the NAIC in the *Accounting Practices and Procedures Manual* (e.g., deferred policy acquisition costs, preoperating, development and research costs, etc.);

c. Adjust depreciation for certain assets in accordance with the following statutory accounting principles:

i. **SSAP No. 16R—Electronic Data Processing Equipment and Software**

ii. **SSAP No. 19—Furniture, Fixtures, Equipment and Leasehold Improvements**

iii. **SSAP No. 68—Business Combinations and Goodwill**

d. Nonadmit the amount of goodwill of the SCA in excess of 10% of the audited U.S. GAAP equity of the SCA’s last audited financial statements.

e. Nonadmit amount of the net deferred tax assets (DTAs) of the SCA in excess of 10% of the audited U.S. GAAP equity of the SCA’s last audited financial statements.

f. Nonadmit any surplus notes held by the SCA issued by the reporting entity.

g. Adjust the U.S. GAAP annuity account value reserves of a foreign insurance SCA, with respect to the business it wrote directly, using the commissioners’ annuity reserve valuation method (CARVM) as defined in paragraphs 14 and 15 of Appendix A-820 (including the reserving provisions in the various Actuarial Guidelines which support CARVM). The valuation interest rate and mortality tables to be used in applying CARVM should be that prescribed by the foreign insurance SCA’s country of domicile. If the Foreign SCA’s country of domicile does not prescribe the necessary tables and/or rates, no reserve adjustment shall be made.

Note that the outcome of these adjustments can result in a negative equity valuation of the investment for all paragraph 8.b.ii. entities. For a paragraph 8.b.iv. entity, the application of these adjustments will stop at zero, and will not result in negative equity valuation unless the 8.b.iv entity provides services to the reporting entity or its affiliates or holds assets on behalf of the reporting entity. If such services, including reinsurance transactions, are occurring, the adjustments required in this paragraph can result in a negative equity valuation. (See additional equity method application guidance in paragraph 13.e. regarding guarantees and financial support.)

**SSAP No. 48, paragraph 6**

6. Investments in these ventures, except for joint ventures, partnerships and limited liability companies with a minor ownership interest, shall be reported using an equity method as defined in **SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entities**, paragraphs 8.b.i. through 8.b.iv. *(The equity method calculation may result with a negative valuation of the investment, therefore the SSAP No. 97 equity method calculation shall occur regardless of whether the investment is supported by an audit and the reporting entity will nonadmit the investment.)* A reporting entity whose shares of losses in a SSAP No. 48 entity exceeds its investment in the SSAP No. 48 entity shall disclose the information required by SSAP No. 97, paragraph 35.a.
On August 26, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, exposed revisions to SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies and SSAP No. 97—Investments in Subsidiary, Controlled and Affiliated Entites, as illustrated above. The revisions in SSAP No. 48 direct that the equity method valuation referenced in SSAP No. 97 can result in a negative equity valuation regardless of if the investment is supported by an audit. The revisions in SSAP No. 97 direct that when applying the “limited statutory accounting adjustments” (SSAP No. 97, paragraph 9) to foreign insurance SCAs (SSAP No. 97, paragraph 8.b.iv. entities), the resultant equity value shall stop at zero (and thus not be subject to negative equity valuations) in cases where the foreign insurance subsidiary is not providing services to, or holding assets on behalf of, U.S. insurers.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/Fall 2021/TF/App/SAP/Minutes/Att One-D2_21-04 - SSAP No. 97 - Valuation Foreign SCAs.docx
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

**Issue:** SSAP No. 32R – Clarification of ‘Effective Call Price’

**Check (applicable entity):**

- Modification of Existing SSAP: X
- New Issue or SSAP: 
- Interpretation: 

**Description of Issue:** For a brief historical context, in July 2020, the Working Group adopted *Issue Paper No. 164—Preferred Stock* and substantively revised SSAP No. 32R—Preferred Stock. The substantively revised SSAP No. 32R was effective January 1, 2021, however in October 2020, agenda item 2020-31, permitted early application of the newly revised standard.

NAIC staff have received implementation questions regarding the application of a valuation ceiling for certain callable instruments in scope of SSAP No. 32R. The valuation ceiling requires that perpetual preferred, mandatory convertible preferred stock as well as publicly traded preferred stock warrants be reported at fair value, with a valuation ceiling that is **not to exceed any currently effective call price**. Questions on both the application and interpretation of this limitation have been brought to NAIC staff, accordingly this agenda item has been drafted to propose a clarification of this valuation ceiling.

Callable preferred stock is a type of preferred stock in which the issuer has the right to call or redeem at a pre-set price on or after a pre-defined calendar date. The call redemption terms such as price, premium and other applicable characteristics are specified in the instrument’s prospectus. It is important to note that callable preferred stock generally have a five-year lock out period in which the issuer cannot call the preferred stock. Additionally, prior to redemption (call), the issuer must send notice to the shareholders, detailing the date and conditions of the redemption.

NAIC staff recommend that an appropriate interpretation for the application of the valuation ceiling is that the limitation should only apply in situations where the call is **currently exercisable** by the issuer, or the issuer has provided notice of its intent to call the preferred stock. If the valuation ceiling were to apply earlier (in advance of the call date), in situations where preferred stock is purchased in advance of its available call date, a reporting entity would be required to artificially limit the preferred stock’s value, despite being able to liquidate it on the open market for fair value. This limitation could apply for years as calls are typically not available to the issuer for a period of at least 5 years post issuance.

For example, if perpetual preferred stock were purchased at $140 (its current fair value), but the preferred stock had a call available to the issuer at $120 in 5 years, a reporting entity would be required to report a day 1 unrealized loss for $20. To require the recognition of an unrealized loss in these situations does not appear to appropriately reflect the economics of the equity investment, especially when the instrument can be sold at its current fair value without incurring a loss. It is important to note that market conditions will likely influence the market value of the preferred stock as a call date nears – gradually decreasing any excess of fair value over the call price by the time the security is callable by the issuer. NAIC staff support maintaining a (clarified) valuation limitation to protect against unlikely scenarios where a callable security’s fair value increases but will be called at a lower price.
Existing Authoritative Literature: The ‘currently effective call price’ valuation ceiling is referenced in numerous sections within SSAP No. 32R—Preferred Stock and is applicable to both perpetual and mandatory convertible preferred stock as well as publicly traded preferred stock warrants. For emphasis, relevant guidance has been bolded below.

Balance Sheet Amount

11. Preferred stock shall be valued based on (a) the underlying characteristics (redeemable, perpetual or mandatory convertible), (b) the quality rating expressed as an NAIC designation, and (c) whether an asset valuation reserve (AVR) is maintained by the reporting entity:

a. For reporting entities that do not maintain an AVR:
   i. Highest-quality or high-quality redeemable preferred stocks (NAIC designations 1 and 2), which have characteristics of debt securities, shall be valued at cost or amortized cost. All other redeemable preferred stocks (NAIC designations 3 to 6) shall be reported at the lower of cost, amortized cost, or fair value.
   ii. Perpetual preferred stock and publicly traded preferred stock warrants shall be reported at fair value, not to exceed any currently effective call price.
   iii. Mandatory convertible preferred stocks (regardless if the preferred stock is redeemable or perpetual) shall be reported at fair value, not to exceed any currently effective call price, in the periods prior to conversion. Upon conversion to common stock, these securities shall be in scope of SSAP No. 30R.
   iv. For preferred stocks reported at fair value, unrealized gains and losses shall be recorded as a direct credit or charge to unassigned funds (surplus)

b. For reporting entities that maintain an AVR:
   i. Highest-quality, high-quality or medium quality redeemable preferred stocks (NAIC designations 1 to 3) shall be valued at amortized cost. All other redeemable preferred stocks (NAIC designations 4 to 6) shall be reported at the lower of amortized cost or fair value.
   ii. Perpetual preferred stock and publicly preferred stock warrants shall be valued at fair value, not to exceed any currently effective call price.
   iii. Mandatory convertible preferred stocks (regardless if the preferred stock is redeemable or perpetual) shall be reported at fair value, not to exceed any currently effective call price, in the periods prior to conversion. Upon conversion to common stock, these securities shall be in scope of SSAP No. 30R.
   iv. For preferred stocks reported at fair value, the accounting for unrealized gains and losses shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve.

Impairment of Redeemable Preferred Stock

12. An other-than-temporary impairment shall be considered to have occurred if it is probable that the reporting entity will be unable to collect all amounts due according to the contractual terms of the preferred stock in effect at the date of acquisition. An assessment of other-than-temporary impairment shall occur whenever mandatory redemption rights or sinking fund requirements do not occur. A decline in fair value which is other-than-temporary includes situations where the reporting entity has made a decision to sell the preferred stock prior to its maturity at an amount below its carrying value (i.e., amortized cost). If it is
determined that a decline in the fair value of a redeemable preferred stock is other-than-temporary, an impairment loss shall be recognized as a realized loss equal to the entire difference between the redeemable preferred stock’s carrying value and its fair value, not to exceed any currently effective call price, at the balance sheet date of the reporting period for which the assessment is made. The measurement of the impairment loss shall not include partial recoveries of fair value subsequent to the balance sheet date. For reporting entities required to maintain an AVR, realized losses shall be accounted for in accordance with SSAP No. 7.

13. In periods subsequent to the recognition of other-than-temporary impairment loss for a redeemable preferred stock, the reporting entity shall account for the other-than-temporarily impaired preferred stock as if the preferred stock had been purchased on the measurement date of the other-than-temporary impairment. The fair value of the redeemable preferred stock on the other-than-temporary impairment measurement date shall become the new cost basis of the redeemable preferred stock and the new cost basis shall not be adjusted for subsequent recoveries in fair value. The discount or reduced premium recorded for the preferred stock, based on the new cost basis, shall be amortized over the remaining life of the preferred stock in the prospective manner based on the amount and timing of future estimated cash flows. The preferred stock shall continue to be subject to impairment analysis for each subsequent reporting period. Future declines in fair value which are determined to be other-than-temporary shall be recorded as realized losses.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): Previous activity was summarized above, in the ‘Description of Issue’ section.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 32R—Preferred Stock clarifying that for the ‘effective call price’ valuation ceiling to occur that 1) the call be currently exercisable by the issuer, or 2) the issuer of the security has announced that the instruments will be redeemed/called.

Proposed edits to SSAP No. 32R:

Balance Sheet Amount

11. Preferred stock shall be valued based on (a) the underlying characteristics (redeemable, perpetual or mandatory convertible), (b) the quality rating expressed as an NAIC designation, and (c) whether an asset valuation reserve (AVR) is maintained by the reporting entity New Footnote (FN):

a. For reporting entities that do not maintain an AVR:

i. Highest-quality or high-quality redeemable preferred stocks (NAIC designations 1 and 2), which have characteristics of debt securities, shall be valued at cost or amortized cost. All other redeemable preferred stocks (NAIC designations 3 to 6) shall be reported at the lower of cost, amortized cost, or fair value.

ii. Perpetual preferred stock and publicly traded preferred stock warrants shall be reported at fair value, not to exceed any currently effective call price.
Mandatory convertible preferred stocks (regardless if the preferred stock is redeemable or perpetual) shall be reported at fair value, not to exceed any currently effective call price, in the periods prior to conversion. Upon conversion to common stock, these securities shall be in scope of SSAP No. 30R.

For preferred stocks reported at fair value, unrealized gains and losses shall be recorded as a direct credit or charge to unassigned funds (surplus).

b. For reporting entities that maintain an AVR:

i. Highest-quality, high-quality or medium quality redeemable preferred stocks (NAIC designations 1 to 3) shall be valued at amortized cost. All other redeemable preferred stocks (NAIC designations 4 to 6) shall be reported at the lower of amortized cost or fair value.

ii. Perpetual preferred stock and publicly preferred stock warrants shall be valued at fair value, not to exceed any currently effective call price.

iii. Mandatory convertible preferred stocks (regardless if the preferred stock is redeemable or perpetual) shall be reported at fair value, not to exceed any currently effective call price, in the periods prior to conversion. Upon conversion to common stock, these securities shall be in scope of SSAP No. 30R.

iv. For preferred stocks reported at fair value, the accounting for unrealized gains and losses shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve.

Impairment of Redeemable Preferred Stock

12. An other-than-temporary impairment shall be considered to have occurred if it is probable that the reporting entity will be unable to collect all amounts due according to the contractual terms of the preferred stock in effect at the date of acquisition. An assessment of other-than-temporary impairment shall occur whenever mandatory redemption rights or sinking fund requirements do not occur. A decline in fair value which is other-than-temporary includes situations where the reporting entity has made a decision to sell the preferred stock prior to its maturity at an amount below its carrying value (i.e., amortized cost). If it is determined that a decline in the fair value of a redeemable preferred stock is other-than-temporary, an impairment loss shall be recognized as a realized loss equal to the entire difference between the redeemable preferred stock’s carrying value and its fair value, not to exceed any currently effective call price, at the balance sheet date of the reporting period for which the assessment is made. The measurement of the impairment loss shall not include partial recoveries of fair value subsequent to the balance sheet date. For reporting entities required to maintain an AVR, realized losses shall be accounted for in accordance with SSAP No. 7.

New Footnote (FN) – In all situations noted in this statement in which the fair value is limited to the currently effective call price, this limitation only applies when the call is 1) currently exercisable by the issuer, or 2) the issuer has announced that the instruments will be redeemed/called.

Staff Review Completed by: Jim Pinegar, NAIC Staff – June 2021

Status:
On July 20, 2021, in response to an e-vote to expose, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 32R—Preferred Stock to clarify that the “effective call price” valuation limitation, for all instruments within scope
of the standard, shall only apply if the call is currently exercisable by the issuer or if the issuer has announced that the instrument will be redeemed/called.

On August 26, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to *SSAP No. 32R—Preferred Stock*, as illustrated above, to clarify that the “effective call price” valuation limitation, for all instruments within scope of the standard, shall only apply if the call is currently exercisable by the issuer or if the issuer has announced that the instrument will be redeemed/called.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/Fall 2021/TF/App/SAP/Minutes/Att One-D3_21-10 - SSAP No. 32R - Effective Call Price.docx
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July 15, 2021

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Ref #2019-21 – SSAP No. 43R, Proposed Bond Definition

Dear Mr. Bruggeman:

Interested parties would like to thank the Statutory Accounting Principles Working Group (SAPWG) for the opportunity to comment on the proposed bond definition in Reference #2019-21 – SSAP No. 43R, Proposed Bond Definition (the “Proposed Bond Definition” or “Exposure”). Interested parties would also like to thank SAPWG for the opportunity to regularly provide input to regulators and NAIC staff as the Proposed Bond Definition was being more fully developed; especially the collaborative environment where open and honest dialogue was encouraged so that the nuances of a very complicated project could be properly addressed.

Overall, interested parties are supportive of the proposed principles-based Proposed Bond Definition. We believe it is flexible enough to accommodate the continued evolution of the bond market, while having safeguards that help prevent potential regulatory abuses. The Proposed Bond Definition does come with a cost to industry though, which is primarily driven by the requirement to analyze and document that certain bonds meet specific thresholds (“meaningful” and “sufficient”). It may be necessary to have practical accommodations upon adoption (i.e., transition requirements for existing investments in an insurer’s investment portfolio) as it is our understanding the Proposed Bond Definition will require such analysis and documentation “as if” it was done when the bonds were issued. It may be difficult to do this “as if” analysis and documentation with bonds that were issued many years previously and/or where documentation is not available to perform such an analysis.

Interested parties would also like to address several areas of the Proposed Bond Definition where greater clarity may be needed and/or where we believe the requirements are too stringent. Interested parties will limit our comments to those we believe are substantive and will address several editorial comments directly with the SAPWG Working Group.

One item that may have escaped our full attention during the development of the Proposed Bond Definition relates to interest only and principal only strips. While we believe such investments generally qualify under the Proposed Bond Definition, it is unclear if such investments are an Issuer Credit Obligation (US Treasury Strips?) or Asset Backed Security (Mortgage Backed Security Strips?) as well as how the sufficiency criteria would apply to the latter when there are, or are not, agency guarantees. We intend to work with the SAPWG Working Group to get proper clarity on such investments.
The interested parties believe the examples in the Proposed Bond Definition are integral to applying it as well as providing a principles-based way of preventing perceived regulatory abuses such as ensuring legal form bonds, with in-substance equity-like characteristics, are not reported as bonds. Interested parties would like to provide three comments on these examples.

1) Example 1 of Appendix I prevents a legal form debt investment, that is required to be purchased with a pro rata share of an equity interest, from being a bond where there is a restriction on selling, assigning or transferring the debt investment without also selling, assigning, or transferring the pro rata equity interest to the same party. While the debt investment would have legal priority of payment over the equity interest, both interests are contractually required to be held in the same proportion by the reporting entity and cannot be independently sold, assigned or transferred, which only gives the reporting entity priority of payment over itself. The structure does not alter the risk profile in a way that results in different performance relative to if an investor were to just directly invest in the underlying assets. Therefore, the debt investment does not represent a creditor relationship in substance. Interested parties agree with this assessment but would like to emphasize that such investments will need to find a reporting home, other than Schedule D, Bonds, where the proper accounting of both the debt and equity interest is addressed. For such a situation where the underlying fund predominantly holds debt securities, it may also be appropriate that such investment, in total, be applied a bond-like risk-based capital charge.

Similarly, accounting and reporting will need to be addressed for any and all debt investments that do not meet the Proposed Bond Definition, but that are recognized as bonds in the financial markets. For example, 1) debt instruments issued by funds, that are treated as bonds in the capital markets, but would be excluded from the Proposed Bond Definition under Example III of Appendix I or 2) non-agency mortgage-backed securities that are treated as bonds in the capital markets but would be excluded from the Proposed Bond Definition under Example I of Appendix II, and therefore would not be reported as bonds on Schedule D. We understand the SAPWG Working Group intends to address the accounting and reporting, and potentially an appropriate risk-based capital charge for these investments, and any other bonds that do not meet the Proposed Bond Definition. Interested parties would like to emphasize the importance of addressing them appropriately and reaffirm that we stand ready to offer our assistance.

2) As mentioned previously, interested parties believe the examples in the Proposed Bond Definition are integral to applying the new proposed definition and generally find them helpful. However, the sufficiency examples in Appendix II do not include an example for a more traditional ABS, such as a collateralized loan obligation (CLO). Interested parties believe such an example would be beneficial to the Proposed Bond Definition and are currently working on developing one. We plan to share this with the SAPWG Working Group and are hopeful it can be added to the Proposed Bond Definition.

3) Interested parties believe Examples I and II of Appendix I do a good job of delineating a principle-based solution for preventing in-substance equity-like investments from being reported as bonds on Schedule D. Example III, however, we believe needs to be amended to ensure that it does not affect well-structured debt investments from being reported on Schedule D as bonds.

First, real world collateralized fund obligation debt instruments (CFO Debt Instruments), that are treated as bonds in the marketplace, are much more complicated and nuanced than the simplified example and interested parties have been challenged in applying the example to investments they own. For example, many CFO Debt Instruments are self-amortizing (in full or in part) and it is unclear if the following provision applies to the anticipated bullet maturity or total principal balance.
“Additionally, a debt instrument for which repayment relies significantly upon the ability to refinance or sell the underlying equity interests at maturity subjects to a point-in-time equity valuation risk that is characteristic of the substance of the equity holder relationship rather than a creditor relationship. Therefore, such reliance would preclude the rebuttable presumption from being overcome.”

Notwithstanding this lack of perceived clarity, many may interpret the phrase “relies significantly” that limits refinancing or underlying assets sales for repayment, to mean only approximately 10 – 20% of such repayment is allowed from these sources. We do not believe this is appropriate nor that it makes the CFO Debt Instruments equity-like. We note that this is apparently independent of overcollateralization and would treat CFO Debt Instruments the same whether they are 10x overcollateralized or 1x overcollateralized. It also seems to contradict the factors on the previous page where it says a reporting entity should consider the overcollateralization. We believe overcollateralization (and the other factors listed) should be evaluated collectively when making an equity-like determination rather than the seemingly hard and fast rule noted above.

This hard and fast rule also makes it equity-like if repayment substantially relies on refinancing. Interested parties agree that refinancing risk is an important consideration, but it typically is a determining factor in assessing credit quality as opposed to a factor in determining whether it is a debt security or an equity-like one. Interested parties believe that the credit quality of an investment will decline as the refinancing risk increases, but also believe that it should be eligible for Schedule D treatment, assuming the refinancing risk is commensurate with that of other debt securities.

The vast majority of debt in the private and public capital markets is structured as bullet maturities and it is universally accepted that the source of repayment typically is going to be from a refinancing event occurring at or near the time of the debt maturity. For CFO Debt Instruments, interested parties believe that it can also be acceptable to expect to be refinanced at maturity, but only if the expectation that the level of overcollateralization will remain at prudent levels such that a reasonable investor would be willing to refinance the maturity with replacement debt. The assessment of the debt’s ability to be refinanced needs to take into account the expectation for the initial, ongoing and “at maturity” overcollateralization, as well as the other structural enhancements that are likely to benefit the investor refinancing the debt. There is further little substantive difference between refinancing risk for debt issued by a CFO when compared to debt issued by an SEC ‘40 Act Fund.

Lastly, interested parties have also noted investments where the debt is issued from a feeder fund, which in turn invests in another fund, that invests directly in debt securities. While we do not believe Example III is intended to prohibit such investments, interested parties believe further clarity on these arrangements is warranted as they could be construed to be debt backed by equity interests.

Interested parties are hopeful we can re-assess Example III of Appendix I with the SAPWG working group to provide both greater clarity as well as additional flexibility on whether debt backed by equity should be eligible for reporting on Schedule D as bonds.

*****
Thank you for considering interested parties’ comments. Interested parties are committed to working with NAIC staff and SAPWG on this very complicated and important topic. If you have any questions in the interim, please do not hesitate to contact us or Mike Reis at michaelreis@northwesternmutual.com or 414-241-8293.

Sincerely,

D. Keith Bell           Rose Albrizio

cc: interested parties

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The Lease-Backed Securities Working Group

July 15, 2021

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Ref #2019-21 – SSAP No. 43R, Proposed Bond Definition

Dear Mr. Bruggeman:

Our group, the Lease-Backed Securities Working Group, would like to thank the Statutory Accounting Principles Working Group (SAPWG) for the opportunity to comment on the proposed bond definition in Reference #2019-21 – SSAP No. 43R, Proposed Bond Definition (the “Proposed Bond Definition” or “Exposure”).

As you know, our group has been working closely for over a year now with members of SAPWG as well as the Valuation of Securities Task Force (VOSTF) and the Securities Valuation Office (SVO) to clarify the appropriate accounting and reporting treatment for the class of investments we are most concerned with: Lease-Backed Securities, Credit-Tenant Loans and Ground Lease Financings. We believe that together we have arrived at the correct outcome for these securities, and we are deeply appreciative of the consideration we received from all the regulators, as well as the time and effort that was put in by all parties to achieve that goal.

With regard to the broader effort to update the definition and classification of bonds and asset-backed securities which is the subject of the current exposure, we agree with many of the comments which have been submitted by other interested parties. However, we would like to offer the following additional comments:

1.) As a specific matter, paragraph 2 of the exposure lists various securities which would fall into the category of “issuer credit obligations”. Among others, these include:

   g. ETCs, EETCs, and CTLs for which repayment is fully supported by a lease to an operating entity (emphasis added).

   With regard to CTLs, although it is not explicitly stated here, we assume that the phrase “fully-supported” would extend to CTLs which meet the newly-revised definition in the P&P Manual: that is “Credit Tenant Loans” with a residual balance no greater than 5%.

2.) From a broader perspective, the current language in SSAP 43R, “Loan-Backed and Structured Securities”, draws a clear distinction between “structured securities” and “loan-backed securities” -- which are “not included in structured securities” -- and “for which the payment of interest and/or principal is directly proportional to the payments received by the issuer from the underlying assets”.

   These loan-and-lease-backed “pass-through securities” have long been accepted insurance company investments, as codified in SSAP 43R for many years. We believe that it is important not to lose this distinction between “pass-through” and “structured” securities, and we worry that the division of the
The Lease-Backed Securities Working Group

universe of bonds neatly into “issuer credit obligations” and “asset-backed securities” (a phrase which does not seem to appear at all in the current version of 43R) may be confusing to the market.

This is especially true, as the phrase “Asset-Backed Security” is commonly used to refer to pools of assets which have been carved-up, or “tranch ed” into multiple securities, and for which the cash flows received by investors are not “directly proportional” to the payments flowing from the underlying assets.

This confusion is made worse by the requirement in Paragraph 3.b of the Exposure that in order to qualify as an “asset-backed security” an investment must include “sufficient credit enhancement through guarantees (or other similar forms of recourse) subordination and/or overcollateralization” [Paragraph 3.b].

The examples in Appendix II of the exposure seek to clarify the “sufficiency criteria” for credit enhancement for various types of bonds. The principal used is that credit enhancement needs to be “sufficient to absorb losses similar to other debt instruments of similar quality”.

We believe that when this language is exposed, it will be both very confusing to market participants and difficult to implement in practice. This is because it conflates two concepts: credit quality and accounting classification. Who would bear the responsibility for determining: a) which debt instruments were of “similar quality”, and b) the amount of credit enhancement “sufficient” to achieve a certain credit quality? These are highly subjective judgments for which the answers could vary from deal to deal based on the specific characteristics of each individual transaction. How would disagreements be resolved?

This language also runs the risk of making it appear that all “asset-backed securities” must be “structured securities” with an equity tranche, or “first-loss” piece – or otherwise, they would not qualify as “bonds”.

While this may not have been the intent of the regulators, the current language seems to point in that direction. We would hope that as the process moves forward these important issues could be further clarified. In order for markets to function in an orderly manner, there need to be clear “guardrails” for both regulators and investors, and a clear distinction between accounting rules and standards, and credit quality.

We look forward to continuing the dialog we have established over the past year with the regulator community in clarifying the treatment of “CTLs”, Lease-backed Securities, and Ground-Lease Securities, and we are grateful for the opportunity to comment on the current exposure.

Thank you for considering our comments,

JMGarrison

John Garrison
On behalf of The Lease-Backed Securities Working Group

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July 12, 2021

Mr. Dale Bruggeman  
Chair, Statutory Accounting Principles (E) Working Group  
c/o Ms. Julie Gann at jgann@naic.org  
Mr. Jim Pinegar at jpinegar@naic.org  
Ms. Robin Marcotte at rmarcotte@naic.org  
Ms. Fatima Sediqzad at fsediqzad@naic.org  
Mr. Jake Stultz at jstultz@naic.org  

Re: Proposed Definition of “Bond,” issued May 20, 2021 (last updated May 26, 2021)

Ladies and Gentlemen:

I serve as Vice President and Chief Investment Officer of Pinnacol Assurance (“Pinnacol”), Colorado’s state workers’ compensation insurance fund. This advice represents Pinnacol’s Comment to the Proposed Bond Definition (the “Definition”) issued by the Statutory Accounting Principles (E) Working Group on May 20, 2021.

As you know, many insurers have statutory limits on the amount of “other invested assets” they can own—Colorado limits an insurer’s “other invested assets” to 5% of the portfolio. Any “other invested assets” in excess of the 5% limitation cannot be considered “admitted assets” comprising part of the insurer’s surplus but instead, will reduce that surplus dollar for dollar.

The reason all this is important is that Pinnacol has invested around $85 million in five separate rated note structures which are comprised of two parts. The first part represents loans made by the manager of the investment to various borrowers (which would seem to be characterizable as a Bond and not an equity interest). The second part represents an equity interest in the vehicle issuing the notes. The ultimate underlying investments in these strategies are comprised of private debt, which generates the cash flows to pay Pinnacol’s returns on both the notes and the equity components.

According to the examples set forth in the proposed definition of “Bond,” it appears that the existence of the equity interest (which cannot be traded separately from the notes) in the rated notes programs in which Pinnacol has invested would disqualify these investments as “Bonds.” This would mean that Pinnacol would suffer a reduction in its surplus by at least $85 million.
The proposed definition of “Bond” suggests that whether an investment qualifies as a “Bond” is an all or nothing proposition— if a structured rated note investment contains certain equity like characteristics, it will not be characterizable as a Bond, even though a significant portion of the investment represents a creditor relationship which otherwise would qualify as a Bond. Pinnacol believes a more reasonable approach (and one which better reflects economic reality) would be to allow insurers to characterize that portion of their investment which represents a creditor relationship as a Bond (and therefore, categorizable as an admitted asset constituting part of the insurer’s surplus) with only the equity portion of the investment not being characterized as a Bond (and if in excess of 5% of the portfolio, not qualifying as an admitted asset). In other words, we suggest that the definition of a Bond recognize that portions of an investment may be characterized as a Bond while other portions may not. This bifurcation will better reflect the economic reality of each investment and protect insurer surplus from the dramatic dilution that otherwise will be experienced by adopting an “all or nothing” definition of Bond.

In conclusion, we contend that the Working Group’s “all or nothing” approach to characterization of an investment as a “Bond” poses great harm to the industry and is not reflective of the fact that a significant portion of rated note structured investments are creditor relationships properly characterized as Bonds. Instead, we urge the Working Group to adopt a definition of Bond which at the very least, permits those portions of an investment which truly reflect a creditor relationship to be treated as a Bond.

Sincerely,

PINNACOL ASSURANCE

David L. Bomberger
Vice President, Chief Investment Officer

cc: Mr. Joel Hornbostel
    Jon Atkins, Esq.
    Mr. Francis Rooney
    Marc Lieberman, Esq.

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October 1, 2021

Mr. Dale Bruggeman, Chairman  
Statutory Accounting Principles Working Group  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197

RE: Items Exposed for Comment by the Statutory Accounting Principles Working Group on August 26, 2021 with Comments due October 1, 2021

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the exposure drafts released for comment by the NAIC Statutory Accounting Principles (E) Working Group (the Working Group). We offer the following comments:

Ref #2021-11 SSAP No. 43R

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed the following:

1. Revisions to SSAP No. 43R—Loan-Backed and Structured Securities, as illustrated in the proposal, to explicitly identify the SVO-Identified CTLs that are in scope of SSAP No. 43R. These revisions also propose to delete the examples of “other loan-backed and structured securities” in paragraph 27.b. Comments are requested if this deletion is perceived to remove investments from the scope of SSAP No. 43R.

2. Request for comment on the Working Group’s intent to nullify INT 20-10. (This INT nullifies automatically on Oct. 1, 2021, but it is anticipated that the explicit nullification will identify the revisions adopted by the VOSTF for historical reference.)

3. Disposal of agenda item 2020-24: Accounting and Reporting of Credit Tenant Loans without statutory revisions. This was the agenda item in response to the initial VOSTF referral and is no longer applicable with the adopted Task Force edits to clarify that CTLs are mortgage loans in scope of SSAP No. 37.
Interested parties have no comment on this item.

**Ref #2021-12 NAIC Accounting Practices and Procedures Manual Editorial and Maintenance Update**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed editorial revisions to the Preamble, *Appendix A-001: Investments of Reporting Entities, Appendix C Actuarial Guidelines – Appendices, Appendix C-2 Interpretations of the Emerging Actuarial Issues (E) Working Group*, and *SSAP No. 21R — Other Admitted Assets*, as illustrated in the proposal.

Interested parties have no comment on this item.

**Ref #2021-13 SSAP No. 55: Salvage - Legal Recoveries**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and took the following actions:

1. Exposed revisions to *SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses*, as illustrated in the proposal, to clarify that salvage and subrogation recoveries should be reported as a reduction of losses and/or loss adjusting expense (LAE reserves), depending on the nature of the costs being recovered. In addition, updates to the disclosure in paragraph 17.h. were exposed.

2. Directed NAIC staff to coordinate develop conforming revisions to the Annual Statement instructions.

3. Directed notification of the exposure to the following actuarial Task Forces:
   a. Casualty Actuarial and Statistical (C) Task Force,
   b. Life Actuarial (A) Task Force, and
   c. Health Actuarial (B) Task Force

Interested parties support this proposal.

**Ref #2021-14 Policy Statement Terminology Change – Substantive & Nonsubstantive**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to the *NAIC Policy Statement on Maintenance of Statutory Accounting Principles*, as illustrated in the proposal and suggested by the Financial Condition (E) Committee in their Aug. 14, 2021, referral, to alter the terminology used when discussing types of statutory accounting revisions.

After some discussion and consideration of the proposal and its impact on the implementation of new statutory accounting standards, interested parties concluded that the distinction between substantive (proposed to change to “development of new SSAPs or New SAP Concepts in an
Existing SSAPs”) and non-substantive (proposed to change to “Development of SAP Clarifications”) is at times confusing and that there would be more transparency in the development process if the distinction were eliminated. Instead, we recommend that all new standards be handled similarly but that the effective date for each new standard be determined by evaluating the complexity of implementation (e.g., the extent that systems changes are required) and the availability of data to insurers to implement the new standard. This determination would be made as the new standard is being completed and with feedback from industry as to the time needed to adopt the new requirements.

INT 21-02T: Extension of Ninety-Day Rule for the Impact of Hurricane Ida

The Working Group reached a tentative consensus for a one-time optional extension of the ninety-day rule for uncollected premium balances, bills receivable for premiums and amounts due from agents and policyholders required per SSAP No. 6, paragraph 9. For policies in effect as of the declaration of a state of emergency by either the states, U.S. territories or federal government, as described in paragraph 1, insurers with policyholders in areas impacted by Hurricane Ida, its aftermath and the related flooding may wait 150 days (90 days per existing guidance, plus a 60-day extension), not to extend beyond Jan. 23, 2022, before nonadmitting premiums receivable from those directly impacted policyholders as required per SSAP No. 6, paragraph 9. b. Existing impairment analysis remains in effect for these affected policies.

The Working Group noted that a temporary sixty day (60) extension had previously been provided for other nationally significant disasters including INT 20-11: Extension of Ninety-Day Rule for the Impact of 2020 Hurricanes, California Wildfires and Iowa Windstorms, INT 18-04: Extension of Ninety-Day Rule for the Impact of Hurricane Florence and Hurricane Michael; INT 17-01: Extension of Ninety-Day Rule for the Impact of Hurricane Harvey, Hurricane Irma and Hurricane Maria; INT 13-01: Extension of Ninety-Day Rule for the Impact of Hurricane/Superstorm Sandy; and INT 05-04: Extension of Ninety-day Rule for the Impact of Hurricane Katrina, Hurricane Rita and Hurricane Wilma.

This interpretation will be automatically nullified on Jan. 24, 2022 and will be included as a nullified INT in Appendix H – Superseded SSAPs and Nullified Interpretations in the “As of March 2022” NAIC Accounting Practices and Procedures Manual.

Interested parties support this proposal.

Ref #2019-24 SSAP No. 71: Levelized Commissions

The Working Group exposed Issue Paper No. 16x: Levelized Commissions to document the historical discussion and final action adopted through the Executive Committee/Plenary.

Interested parties have no further comment on this item.
Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell

Rose Albrizio

cc: NAIC staff
    Interested parties
November 15, 2021

Mr. Dale Bruggeman, Chairman
Statutory Accounting Principles Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Items Exposed for Comment by the Statutory Accounting Principles Working Group by eVote on October 25, 2021 with Comments due November 12

Dear Mr. Bruggeman:

Interested parties appreciate the opportunity to comment on the exposure drafts released for comment by the NAIC Statutory Accounting Principles (E) Working Group (the Working Group). We offer the following comments:

**Ref #2021-16: SSAP No. 30R – FHLB Disclosure – Blanks Referral**

On October 25, 2021, in response to an e-vote to expose, the Working Group exposed this agenda item for public comment. While this agenda item does not propose statutory accounting revisions, it resulted in a referral to the Blanks (E) Working Group to include a supplemental data capture footnote for FHLB borrowings that are classified as a deposit-type contract and reported on *Exhibit 7 – Deposit-Type Contracts*.

Interested parties support the proposed change in this item.

**Ref #2021-17: SSAP No. 32R – Permitted Valuation Methods**

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to *SSAP No. 32R—Preferred Stock* to remove lingering references which indicate that cost is an allowable valuation method for redeemable preferred stock.

Interested parties have no comment on this item.
Ref #2021-18: VM-21 Scenario Consistency Update

The Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 108R—Derivatives Hedging Variable Annuity Guarantees to ensure consistency with revisions to VM-21, removing references to the standard scenario. The Working Group also provided notice of the exposure to the Life Actuarial (A) Task Force. Interested parties support this proposal.

Interested parties agree with this proposal but recommend the following edits for the Working Group’s consideration:

14. Deferred assets and deferred liabilities recognized under paragraph 13.b. shall be amortized using a straight-line method into realized gains or realized losses over a finite amortization period. The amortization timeframe shall equal the Macaulay duration of the guarantee benefit cash flows based on the VM-21 Standard Projection with prescribed assumption run scenario that produces the VM-21 adjusted run scenario that produces the scenario reserve closest to conditional tail expectation (CTE) 70 (adjusted), but shall not exceed a period of 10 years. The CTE 70 (adjusted) VM-21 Standard Projection with prescribed assumption run and the scenario reserve closest to the CTE 70 (adjusted) are determined using the method (company specific market path (CSMP) or conditional tail expectations (CTE) with prescribed assumptions (CTEPA)) applied by the reporting entityFN to calculate the prescribed projections amount.

Ref #2021-19: Editorial and Maintenance Update

The Working Group exposed the editorial revisions, as shown in the proposal, for public comment.

Interested parties have no comment on this item.

* * *

Thank you for considering interested parties’ comments. If you have any questions in the interim, please do not hesitate to contact us.

Sincerely,

D. Keith Bell

Rose Albrizio

cc: NAIC staff
    Interested parties

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Statutory Issue Paper No. 165

Levelized Commission

STATUS
Finalized December 11, 2021

Original SSAP: SSAP No. 71; Current Authoritative Guidance: SSAP No. 71

Type of Issue:
Common Area

SUMMARY OF ISSUE

1. This issue paper documents for historical purposes the discussion of nonsubstantive revisions to SSAP No. 71—Policy Acquisition Costs and Commissions. The intent of these nonsubstantive revisions is to provide clarifying guidance to existing accounting requirements regarding levelized commission arrangements. The statutory accounting guidance in SSAP No. 71 has been in place since 1998 and is based on pre-codification guidance.

SUMMARY CONCLUSION

2. The nonsubstantive revisions to SSAP No. 71 adopted by the Statutory Accounting Principles (E) Working Group on March 15, 2021, the Accounting Practices and Procedures (E) Task Force on March 23, 2021, and the Financial Condition (E) Committee on April 13, 2021 (illustrated in Exhibit A), reflect the following:

   a. Provides additional descriptive guidance to assist with identifying levelized commission arrangements.

   b. Emphasizes the requirements noted in the original SSAP No. 71 guidance that levelized commission arrangements require full recognition of the liability amount. In addition, interest and or fees incurred to date are accrued.

   c. Specifies an effective December 31, 2021, for contracts in effect as of that date.

Policy Acquisition Costs Overview

3. Acquisition costs are those costs that are incurred in the acquisition of new and renewal insurance contracts and include costs that vary with and are primarily related to the acquisition of insurance contracts (e.g., agent and broker commissions, certain underwriting and policy issue costs, and medical and inspection fees). Pursuant to SSAP No. 71, as originally effective January 1, 2001, for the initial SAP Codification, specifically states that acquisition costs and commissions are expensed as incurred. This provision is a fundamental difference from U.S. generally accepted accounting principles (U.S. GAAP) and reflects a statutory concept that was employed prior to codification, as detailed in Issue Paper No. 71—Policy Acquisition Costs and Commissions.

   a. Under U.S. GAAP, paid or accrued acquisition costs, which include commission costs, are capitalized and reported as a deferred asset and expensed over time to match the recognition of revenue. Note that under U.S. GAAP and SAP, the liabilities associated with acquisition costs are the same. However, U.S. GAAP allows capitalization of certain acquisition costs where SAP requires immediate expense recognition. From information received on the
basis of U.S. GAAP, commission obligations from the writing of an insurance policy would be recognized as a deferred acquisition cost regardless of a third-party arrangement.

b. The departure from U.S. GAAP is consistent with original and ongoing SAP concepts that focus on the solvency of reporting entities for the protection of policyholders and not the matching of revenue to expenses. As detailed in the Preamble, the ultimate objective of solvency regulation is to ensure that policyholder, contract holder and other legal obligations are met when they come due and that companies maintain capital and surplus at all times and in such forms as required by statute to provide a margin of safety.

c. As detailed in the Statutory Accounting Recognition Concept, accounting treatments that defer expense recognition do not generally represent acceptable SAP treatment. Even if consideration had occurred to mirror U.S. GAAP and allow the capitalization of expenses as “deferred assets,” such assets would not be considered admitted assets for statutory accounting. This is because such items do not reflect assets with economic value available for policyholder claims. Nonadmitted assets are required to be charged to surplus in the period in which they arise. As such, in either scenario under SAP, the financial statements of the reporting entity would reflect a reduction of available surplus (either through the recognition of expense or through a direct surplus charge for nonadmitted assets) for acquisition costs and commissions.

Levelized Commission - Background

4. Agenda item 2019-24 on levelized and persistency commission was drafted and presented to the Statutory Accounting Principles (E) Working Group at the request of a state department of insurance after the practice was identified on a financial examination. The issues received by the Working Group related to the use of levelized commission arrangements and the amount to be recorded as a liability in accordance with SSAP No. 71 and SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets.

5. Both SSAP No. 71 and SSAP No. 5R have relevant guidance on this topic:

   a. SSAP No. 71 describes levelized commission arrangements as follows:

4. Levelized commissions occur in situations where agents receive normal (non-level) commissions with payments made by a third party. It is intended, but not necessarily guaranteed, that the amounts paid to the agents by the third party would ultimately be repaid (with interest explicit or implied) to the third party by levelized payments (which are less than the normal first year commissions but exceed the normal renewal commissions) from the reporting entity. These transactions are, in fact, funding agreements between a reporting entity and a third party. The continuance of the stream of payments specified in the levelized commission contract is a mechanism to bypass recognition of those expenses which are ordinarily charged to expense in the first year of the contract. Consequently, the normal link between the persistency of the policy, the continuance of the premium payment or the maintenance of the agent's license with the reporting entity is not maintained with respect to the payment stream.
b. SSAP No. 5R defines liabilities as follows:

**Liabilities**

2. A liability is defined as certain or probable\(^1\) future sacrifices of economic benefits arising from present obligations of a particular entity to transfer assets or to provide services to other entities in the future as a result of a past transaction(s) or event(s).

3. A liability has three essential characteristics: (a) it embodies a present duty or responsibility to one or more other entities that entails settlement by probable\(^1\) future transfer or use of assets at a specified or determinable date, on occurrence of a specified event, or on demand, (b) the duty or responsibility obligates a particular entity, leaving it little or no discretion to avoid the future sacrifice, and (c) the transaction or other event obligating the entity has already happened. This includes, but is not limited to, liabilities arising from policyholder obligations (e.g., policyholder benefits, reported claims and reserves for incurred but not reported claims). Liabilities shall be recorded on a reporting entity's financial statements when incurred.

4. Estimates (e.g., loss reserves) are required in financial statements for many ongoing and recurring activities of a reporting entity. The mere fact that an estimate is involved does not of itself constitute a loss contingency. For example, estimates of losses utilizing appropriate actuarial methodologies meet the definition of liabilities as outlined above and are not loss contingencies.

**Levelized Commission Funding Agreement**

6. The levelized commission arrangements identified for agenda item 2019-24 had the following key elements:

   a. A third party (referred to as a “funding-agent”) paid selling agents commission amounts for business directly written on behalf of the reporting entity. These payments typically occurred in the first year of policy issuance and were consistent with normal initial sales commissions considered policy acquisition costs.

   b. The reporting entity repaid the funding-agent through a levelized commission arrangement that spread out the commission repayment over multiple years (e.g., 3-6 years). The yearly commission repayments to the funding agent also included additional fees and explicit or implicit interest charged to the reporting entity. Consistent with the guidance in SSAP No. 71, paragraph 4, this levelized commission arrangement is repaying the funding-agent amounts “which are less than the normal first year commissions but exceed the normal renewal commissions.” As noted, SSAP No. 71 characterizes such agreements as in substance, a funding agreement (i.e. loan).

   c. The example agreement between the reporting entity and the funding agent specified that the funding agent will not be reimbursed by the reporting entity if the policies that generate the commission are cancelled prior to the policy anniversary date. This reduction in commission payment for policy cancellation is not materially different than direct agreements with agents that have commission “claw back” features. However, regardless of claw back features, commission is fully accrued and expenses upfront. In the event there

\(^1\) FASB Statement of Financial Accounting Concepts No. 6, Elements of Financial Statements, states: Probable is used with its usual general meaning, rather than in a specific accounting or technical sense (such as that in FASB Statement 5, Accounting for Contingencies, paragraph 3), and refers to that which can reasonably be expected or believed on the basis of available evidence or logic but is neither certain nor proved.
is a policy cancellation / lapse, then the liability accrued and recognized expense is adjusted for the amount of the commission that will not be paid.

7. The regulator noted that the reporting entity was not accruing all of the commission liability to the third-party funding agent. The insurance reporting entity employing the disputed practice asserted that the payments to the funding agent were theoretically avoidable until the policy had passed the anniversary date. The reporting entity did not accrue the full amount of initial sales commission that had already been paid on its behalf by the funding agent, which should have been recognized at the time the policy was sold. Although the entity should have recognized the full initial sales commission per SSAP No. 71, the reporting entity also did not accrue the next total expected payment to the third-party. The reporting entity only accrued the next payment when they viewed it as “earned” by the third-party agent. This “earned” date was typically the next policy anniversary when the payment to the funding agent became unavoidable. With this approach, the reporting entity was essentially incorporating a 100% lapse assumption in their process to recognize commission expense, as they would only recognize the commission expense when the policy continued passed a specific lapse date. This assumption is not permitted in statutory accounting, and therefore not reflected in other aspects of their financial statements such as policy reserves.

8. The reporting entities employing the disputed practice asserted that even though commission has been paid by the funding-agent to the sub agent, that no commission should be accrued by the reporting entity until after the end of each policy year when the policy has persisted past its anniversary. The reporting entity was asserting that inserting a persistency clause into a funding agreement allowed them to avoid the liability accrual and expense recognition for the initial acquisition costs for the issued policy at the time the policy was issued.

9. The assertion from the reporting entity is not consistent with SSAP No. 71, paragraph 5:

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

10. The regulator viewed the disputed practice as a misapplication of the levelized commission guidance in SSAP No. 71 and that the reporting entity was underreporting its sales commission expense incurred and the related commission expense liability.

**DISCUSSION**

11. The accounting issue is whether levelized commission funding arrangements require the establishment of a liability for the full amount of the unpaid principal and accrued interest which is payable to a third party. The agenda item and the proposed revisions assert that guidance in SSAP No. 71, which has existed since prior to codification, requires accrual of the full amount that is repayable to the funding agent under the levelized commission agreement. It is important to highlight that the guidance in SSAP No. 71, nor the proposed clarifying edits, do not seek to prohibit funding agreements. The long-standing guidance simply requires full liability recognition to ensure continued consistent reporting across reporting entities of commission obligations.

12. During the discussion of the agenda item, it was identified that this disputed practice of not accruing the full liability for the commission expense was only employed by a small number of reporting entities that employ similar operational practices. It was identified that these limited number of insurers entered into third-party arrangements with the intent to defer the recognition of commission costs for surplus relief. This goes against long-standing statutory accounting guidance and results in those insurers presenting a better financial position than other reporting entities that applied the guidance in SSAP No. 71 when using third-parties to pay commission as well as reporting entities that pay commission directly to agents. The
application of this approach by the small number of reporting entities employing the practice resulted in significant differences impacting consistency and comparability in statutory financial statements. From information obtained, it is believed that a vast majority of companies are following the guidance in SSAP No. 71 as originally intended.

13. Research identified that some capital-funding companies were facilitating the practice, with marketing efforts to promote the surplus relief provided by using their structure as a third-party payer. These capital-funding companies were also active commenters in response to the proposed edits to clarify the guidance in SSAP No. 71. Throughout the Working Group discussion, it was identified that if the guidance is not clarified, then all reporting entities would need to contract with third-party agents to pay commissions to prevent competitive disadvantages in reporting financial results in the statutory financial statements. For the small number of companies that have engaged in this practice, these entities have benefited from lower expense recognition. It also results with a decrease in liabilities, resulting with a calculation that fewer assets are needed to meet obligations and improving overall RBC calculations. These results were identified as concerning as the financial statements do not accurately represent the obligations of the reporting entity from issued in-force policies and could hinder the proper assessment of whether there are appropriate assets available to satisfy policyholder claims and other contractual requirements of the reporting entity.

Development of Statutory Accounting Guidance

14. SSAP No. 71 was adopted in 1998 as part of base codification, which went into effect in 2001.

15. Issue Paper No. 71—Policy Acquisition Costs and Commissions, paragraph 10 identifies the pre-codification statutory accounting guidance that is the basis for the existing SSAP No. 71 guidance. The precodification guidance also notes the same concerns (reiterated in the agenda item 2019-24) if reporting entities use levelized commission arrangements which operate as funding agreements to inappropriately enhance surplus. Issue Paper No. 71—Policy Acquisition Costs and Commissions:

10. Chapter 17, Other Liabilities, of the Accounting Practices and Procedures Manual for Life and Accident and Health Insurance Companies contains the following guidance on levelized commissions:

Levelized Commission

The accounting treatment for certain transactions, characterized as levelized commissions, which results in enhancement of surplus, has been determined to be inappropriate for statutory reporting.

These transactions are, in fact, funding agreements between an insurer and a third party. Agents receive normal (non-level) commissions with payments made by the third party. It is intended, but not necessarily guaranteed, that the amounts paid to the agents would ultimately be repaid (with interest explicit or implied) to the third party by "levelized" payments (which are less than the normal first year commissions but exceed the normal renewal commissions) from the insurer. The continuance of the stream of payments specified in the levelized commission contract is a mechanism to bypass recognition of those expenses which are ordinarily charged to expense in the first year of the contract. Consequently, the normal link between the persistency of the policy, the continuance of premium payment or the maintenance of the agents license with the insurer is not maintained with respect to the payment stream.

The use of an arrangement where commission payments are not linked to traditional elements such as premium payments and policy persistency but rather are linked to the repayment of an advanced amount requires the establishment of a liability in the full amount of the unpaid principal and accrued interest.
16. The intent of SSAP No. 71 for levelized commissions is that repayment of an advance (by having a third party pay on the insurer’s behalf), requires the establishment of a liability for the full amount of unpaid principal and accrued interest.

**Contingent Commission versus Funding Agreement**

17. SSAP No. 71, paragraphs 3-5, which are excerpted in the relevant statutory accounting section of this issue paper, describes both contingent commission and levelized commission agreements.

18. Contingent commission: SSAP No. 71, paragraph 3 provides the following key points:
   a. Contingent Commission liabilities are to be determined in accordance with the terms of each individual commission agreement.
   b. Commission liabilities determined on the basis of a formula that relates to loss experience shall be established for the earned portion.
   c. Assumptions used to calculate the contingent commission liability shall be consistent with the terms of the policy contract and with the assumptions made in recording other assets and liabilities necessary to reflect underwriting results of the reporting entity, such as retrospective premium adjustments and loss reserves, including incurred but not reported.

19. Levelized commission: SSAP No. 71, paragraphs 4 and 5 discuss levelized commission with the following key points:
   a. Such transactions are noted as in substance to be a funding agreement or a loan between a reporting entity and a third party.
   b. Selling agents receive their normal commission from a third party and repayment of the commission amounts to the third party by the reporting entity are intended, but repayment (with interest explicit or implied) to the third party is not necessarily guaranteed.
   c. Commission repayment to the third party by the reporting entity is over time. The levelized commission payments are lower than normal first year (sales) commission, but higher than normal renewal commission.
   d. The levelized commission arrangements are described as an attempt to bypass the recognition of expenses, which are normally charged to expense in the first year of the insurance contract.
   e. This guidance also notes that the use of a levelized commission arrangement is an attempt to break the normal link between underlying policies and the expense recognition, by changing the timing of the payment stream.
   f. SSAP No. 71, paragraph 5 provides:

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

20. The key differences between traditional contingent commission paid directly to the selling agent and a levelized commission funding agreement that uses a third-party funding agent were a major
component of the discussion prior to adopting the clarifying edits. The example brought to the Working Group was identified, by the regulator as a levelized commission funding agreement. Key levelized commission features of this example were: 1) the direct selling agents were paid their sales commission for policies written on behalf of the insurance reporting entity for year one commission by the third party; 2) the third-party funding agent was being repaid over time with some contingency elements in the third party levelized commission contract; and 3) the third party had typically advanced the funds to the selling agents in the same year that the policies were written (however some direct selling agents could choose different payment patterns).

21. Rather than accruing the total expected payments to the third party who had made commission payments to the direct selling agents, the reporting entity was only accruing commission expense based on when the next annual payment was due to the third-party. This levelized commission arrangement attempts to de-link the timing of recognition for the initial sales commission by inserting a third party.

22. As recognition of commission expenses is driven by policy events (such as the issuing or renewing of an insurance policy), the commission expenses had already been incurred, therefore, the reporting entities employing the disputed practice were viewed as underreporting their incurred commission expense and commission liabilities. This was not viewed as consistent with the principle of expensing acquisition costs when incurred or with the treatment of levelized commission funding agreements in SSAP No. 71.

23. In addition, it was identified that waiting to accrue the subsequent expected payments because the underlying polices might lapse in the future reflects a 100% lapse assumption. Using a 100% lapse assumption was noted as being inconsistent with the other financial statement assumptions regarding the underlying policies used for reserving, incurred but not reported claims, etc.

**Contingent Commission versus Loan with Contingency Element**

24. Comments received often characterized the third-party funding agreements as a persistency commission as support for why the full commission expense should not be required. The use of the term “persistency” in these instances is not in line with the traditional use of this term as it pertains to insurance contracts. Fundamentally, a persistency commission is commission that is earned over time as a policy is renewed or remains in force. A persistency commission occurs subsequent to an initial sales commission, where the triggering event is either the continuation or renewal of a policy. With these terms, an additional commission (beyond what was earned from the initial sales commission) is owed once the policy ‘persists’ overtime. Persistency commissions are generally much smaller payments than initial sales commission.

25. The third-party funding agreements reference to persistency commission in their contracts is not referring to additional commission owed with the continuation or renewal of a policy. Rather, they have taken the position that deferring the initial sales commission overtime and requiring portions of that initial sales commission to be paid to the third-party as the contract remains in force is akin to a persistency commission. This is not an appropriate comparison. As detailed, commission liabilities and the recognition of commission expenses shall occur in accordance with policy events. As such, with the issuance of an initial policy, the initial sales commission shall be recognized, with a liability accrual until paid, and with the recognition of the commission expense. If a policy remains in force over time, the terms of the contract may require additional commission to be paid to the selling agent. These additional commission amounts are considered “persistency” commissions and are only recognized when the policy event occurs that triggers the commission to be owed.

26. The following examples are included to assist with illustrating these concepts:

   a. Single Premium Immediate Annuity (SPIA): On January 1, 2020, agent sells a SPIA insurance policy and is owed $1,000 in initial sales commission. Over the next 10 years, if the policy continues to be in force, on January 1, the selling agent is awarded a persistency commission.
commission of $10, per year. This is a reward to the agent for the policy not being churned/terminated.

b. Direct Agent Arrangement: On January 1, 2020, the reporting entity recognizes the $1,000 as commission expense. On January 1, 2021 (and subsequent years) as the policy continues in force, reporting entity recognizes the $10 persistency commission as incurred.

c. Funding Agreement Arrangement: Rather than the reporting entity paying the $1,000 initial sales commission directly to the agent upfront, the funding agent pays the initial $1,000 commission to the selling agent. The insurer and the funding agent have an expectation that the reporting entity will repay the funding agent this amount over time. Under SSAP No. 71, an insurer is not permitted to insert a third-party to delay commission expense recognition. As such, under this arrangement the reporting entity insurer shall also recognize the full $1,000 as commission expense on January 1, 2020. Additionally, the insurer should recognize the $10 persistency commission on January 1, 2021 (and each year subsequent) if the policy continues to be in force. (This example does not reflect the recognition of the fees / interest of the funding agreement arrangement, which would also be required to be recognized.)

27. To be overly clear, the key concepts within these illustrations are as follows:

a. The initial obligating event is the selling of the insurance contract. Commission expense for initial sales commission shall be recognized consistently by each insurer, regardless of third-party arrangements where a funding agent pays this on behalf of the insurer.

b. The second obligation event is the persistency threshold in which additional commission is owed to the selling agent (policy did not lapse). This is also required to be recognized consistently by insurer regardless of any third-party arrangement.

c. The small number of companies that have delayed recognition of initial commission expense due to the insertion of a funding agent have noted that their agreement allows them to avoid payment in the future even of policy cancellation (lapse). The proper accounting for commission in the event of policy lapse is to decrease the payable to the funding agent when the lapse occurs, not prior to the lapse.

d. In addition to not altering the triggering event (initial issuance of policy), this dynamic does not reflect a traditional “persistency” commission. This funding agreement and use of a finance agent is simply a financing mechanism that the insurer has paid additional fees and interest to obtain. The proper accounting is to recognize the obligation for the full commission expense at the time of policy issuance, and then derecognize the obligation if, and only if, the insurer is no longer obligated to the funding agent. It is also noted that a third party would not pay large sums of money on an insurer’s behalf in an arm’s length transaction without an expectation of repayment.

Actions of the Statutory Accounting Principles (E) Working Group

28. On August 3, 2019, the Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 71—Policy Acquisition Costs and Commissions to clarify levelized commissions guidance and provide additional direction regarding commissions that are based on policy persistency. The Working Group exposed initial revisions to paragraphs 2, 3, 4 and 5 which were intended to clarify both levelized and persistency commission because it was identified that some
entities were trying to characterize their funding agreements as persistency commission. Key points in the exposed guidance were that:

a. A levelized commission arrangement (whether linked to traditional or nontraditional elements) require the establishment of a liability for the full amount of the unpaid principal and accrued interest payable to a third party at the time the policy is issued.

b. The persistency commission is accrued proportionately over the policy period in which the commission relates to and is not deferred until fully earned.

29. The exposed revisions were consistent with the original intent of SSAP No. 71 as well as the Statutory Statement of Concepts focusing on Recognition (excerpts from Preamble, paragraphs 37 and 38).

a. Liabilities require recognition as they are incurred.

b. Accounting treatments which tend to defer expense recognition do not generally represent acceptable SAP treatment.

30. On December 7, 2019, the Working Group exposed nonsubstantive revisions to SSAP No. 71 to provide clarifications to the long-standing levelized commissions guidance and provide additional guidance regarding commission that is based on policy persistency. The revisions proposed to clarify that a levelized commission arrangement (whether linked to traditional or nontraditional elements) requires the establishment of a liability for unpaid principal and accrued interest payable, regardless of the timing of payments made to a third party. Additionally, the exposed guidance required accrual of persistency commission over the associated policy period.

31. The December 7, 2019, revisions were to address some of the comments received from interested parties and two capital funding companies. It was affirmed that the levelized commission repayment amount is owed to the funding agent who made the advance on the insurer’s behalf unless the policy has lapsed. It was noted that delaying payment to a third-party does not delay expense recognition. After this discussion, the guidance was exposed with the following revisions from the prior exposure:

a. Paragraph 2 - Removed previously exposed revisions regarding persistency commission. These provisions were initially included because the levelized commission example included contingency features regarding repayment. Commenters expressed concern that the exposed revisions could have an inadvertent impact on traditional renewal commissions, which was unrelated to a levelized commission arrangement.

b. Paragraph 3 - Added clarifying phrases regarding persistency commission accrual. The concept is that normal persistency commission is accrued for the period it relates to unless the policy is cancelled. This language was also added to address the industry comments regarding inadvertent impacts to traditional renewal commission.

c. Paragraph 4 - Added two clarifying phrases to assist with identifying levelized commission funding agreements.

d. Paragraph 5 - Added clarifying phrases to assist with identifying levelized commission funding agreements.

e. Footnote 1 - Redrafted to remove double negative wording.

32. The December 7, 2019, exposed nonsubstantive revisions were again intended to be consistent with the original intent of SSAP No. 71 as well as the Statutory Statement of Concepts focusing on Recognition (noted in the Preamble, paragraphs 37 and 38) stating that liabilities require recognition as they are incurred and accounting treatments which tend to defer expense recognition do not generally represent acceptable SAP treatment.

33. Notice of the December 7, 2019, exposure was also sent to the Life Actuarial (A) Task Force. The Working Group forwarded comments received at the 2019 Fall National Meeting inquiring whether there
is specific Valuation Manual language in VM-20, Requirements for Principle-Based Reserves for Life Products, and VM 21, Requirements for Principle-Based Reserves for Variable Annuities, that needs to be addressed in the coordination process as part of this agenda item. It was noted that the Principles-Based Reserving (PBR) methodology takes commission into account when projecting the present value of future cash flows. However, the projected future cash flows would not be accrued in duplicative if there is an existing liability.

34. On March 18, 2020, the Working Group, deferred discussion of this item for a subsequent call or meeting. This deferral occurred as the 2020 Spring National Meeting was cancelled for COVID-19, and the interim call held by the Working Group was limited in the topics to address.

35. During the July 30, 2020, meeting, the Working Group reviewed comments from interested parties and on behalf of two capital funding companies.

a. The proposed language from interested parties and one of the capital funding entities, as detailed in the following subparagraphs, was rejected by the Working Group as not viable and inconsistent with existing principles.

i. Interested parties’ proposed language recommended deleting most of the exposed revisions and adding guidance that would redefine a funding arrangement to only include those items where repayment is guaranteed. This proposal was noted as being in conflict with the long-standing guidance in SSAP No. 71, paragraph 4 which notes that “It is intended, but not necessarily guaranteed, that the amounts paid to the agents by the third party would ultimately be repaid…” It was also noted that the existing language in SSAP No. 71 seeks to look at the substance of the levelized commission arrangement noting that a third party would not prepay an entity’s commission expenses without an expectation of repayment.

ii. One of the capital funding companies sent comments through a legal firm. Their comments proposed only requiring levelized commission liability recognition if the third party, which prepays the commission, is under the control or has common control with the insurance reporting entity. The perception of that comment was that if an unrelated party were the third-party funding agent that paid the upfront sales commission expense, no liability recognition would be required by the insurance reporting entity. This recommendation was also rejected as the substance of the transaction is a loan and the accrual of a liability for a loan is the same under SSAP No. 5R for related and unrelated parties.

b. The Working Group also noted a concern with the capital funding company’s comments regarding assumption of lapse risk by noninsurance entities such as brokers and other third parties. The capital funding company’s comment letter (via the legal firm) asserted that the third-party broker, by virtue of their agreement, has assumed “lapse risk, mortality risk and the commission expense obligation.” The Working Group noted that some of the identified items which were noted as being transferred to the broker are insurance risks that can only be transferable to an insurance entity through a reinsurance agreement.

c. The comments from the other capital funding company focused on unintended consequences and potential impacts to various entities. It asserted that the clarifying edits to the existing language are a substantive change. The Working Group noted that the proposed revisions are trying to emphasize existing language that has been in effect prior to codification that is being ignored by some reporting entities in an attempt to defer
expense recognition. The Working Group affirmed that expensing acquisition costs when incurred is a long-standing principle in statutory accounting.

d. While commenters agreed that the commission obligations are ultimately liabilities/expenses, they noted that the issue is when to record the liability/expense. The discussion noted that the accrual of sales commission liabilities and the corresponding recognition of expenses are incurred when the insurance contract is written, not when the payment is due. It also noted that an insurer is responsible for the policy acquisition costs of its directly written policies.

36. After the discussion on July 30, 2020, the Working Group exposed additional nonsubstantive revisions to SSAP No. 71 to clarify the original levelized commission guidance and provide additional direction regarding commissions that are based on policy persistency. The exposed edits would require reporting entities that have not complied with the original intent of SSAP No. 71 to reflect the change as a correction of an error (as a mistake in the application of an accounting principle) pursuant to SSAP No. 3—Accounting Changes and Corrections of Errors in the December 31, 2020, financial statements. In accordance with SSAP No. 3, correction of accounting errors in previously issued financial statements, for which an amended financial statement was not filed, are to be reported as an adjustment to unassigned funds (surplus) in the period in which the error was detected. This guidance also requires disclosure in accordance with SSAP No 3. Part of the reason the exposure included correction of error guidance, as opposed to change in accounting principle, is that the Working Group identified that the practice was employed by a small number of reporting entities purposely for surplus relief and it was viewed as inconsistent with the long-standing guidance in SSAP No. 71. Further, it was identified that some funding companies were actively promoting the use of these third-party arrangements as a way to increase surplus by avoiding the recognition of commission expense when incurred.

37. On October 15, 2020, the Working Group held a hearing to receive comments from interested parties and from the American Institute of Certified Public Accountants’ NAIC Task Force (AICPA Task Force).

38. Both interested parties and the AICPA disagreed with the correction of an error treatment and stated a preference to have the classification as a change in accounting principle. It was noted that referring as a correction in error could result with issues in previously filed financial statements, prior exams, and previously issued audit opinions. The Working Group agreed to remove the previously exposed correction of error guidance in paragraph 7 and to revert to the change in accounting principle guidance. When making this decision, it was noted that the resulting financial statements would ultimately have a similar result. Under the change in accounting principle guidance, a reporting entity reflects the cumulative effect of the change as an adjustment to unassigned funds (surplus) in the period of change of the accounting principle. This guidance provides that the cumulative effect is the difference between the amount of capital and surplus at the beginning of the year and the amount of capital and surplus that would have been reported at that date as if the accounting principle had been applied retroactively to all prior periods. For a correction of error, domiciliary states may require entities to file corrected financial statements for all prior periods that reflected the error. If this direction does not occur, the change is required as an adjustment to unassigned funds in the period the error is detected. As such, by permitting this correction to be reported as a change in accounting principle, the impacted reported entities will not be subject to different treatment by domiciliary states with the resubmission of previously filed financial statements to correct the error. Rather, all impacted entities will have a consistent approach to update their financial statements accordingly.

39. The Working Group discussed the other comments and proposed revisions from interested parties regarding contingency commission. The Working Group did remove more of the contingent commission guidance that was previously exposed in paragraph 3 to address concerns regarding potential impacts on
traditional commission and renewals. This was viewed as addressing the remaining concerns about unintended impacts from the majority of industry that is not using funding agreements.

40. The Working Group also agreed to move the proposed effective date to January 1, 2021, to allow the small number of entities that are employing the practice the opportunity to consult with their domiciliary regulators.

41. With this discussion the Working Group again highlighted that the revisions are a nonsubstantive clarification of existing longstanding provisions of SSAP No. 71 which have been in place before 1998 and are only not being applied by a small number of reporting entities. As some commenters noted the materiality impact to the small number of entities that engaged in this practice, it was noted that under the *NAIC Policy Statement on Maintenance of Statutory Accounting Principles*, it is not the impact of a change on an individual entity that determines whether a change is substantive or nonsubstantive, but rather if the change alters original intent.

Excerpt from Policy Statement on Maintenance of Statutory Accounting Principles:

Nonsubstantive revisions to SAP will be developed to address, but will not be limited to: 1) clarification of the intent or application of existing SSAPs; 2) new disclosures and modification of existing disclosures; 3) revisions that do not change the intent of existing guidance; and 4) revisions to Appendix A—Excerpts of NAIC Model Laws to reflect amendments to NAIC adopted model laws and regulations.

42. After the discussion on October 15, 2020, the Working Group exposed updated revisions to SSAP No. 71 to clarify existing levelized commissions guidance, which requires full recognition of funding agreement liabilities incurred for commission expenses obligated when an insurance policy is written. (This guidance clarifies that writing the insurance policy is the obligating event for initial sales commission.) The exposed revisions have the following key changes from the prior exposure:

   a. Improved description of the funding agreements in paragraphs 4 and 5.

   b. Deletes the previously proposed revisions in paragraph 3 regarding other types of commission to address the comments received regarding unintended impacts on traditional renewal commission.

   c. Modifies the revisions in paragraph 7 to remove the language on correction of an error.

   d. Proposes the nonsubstantive revisions apply to contracts in effect on January 1, 2021.

43. On November 12, 2020, the Working Group held a hearing to receive comments on the October exposure. Comments were received from interested parties, the Mississippi Department of Insurance and a former New York state regulator. Key points from the review of comments were as follows:

   a. Given the year-end timing and the material impact to what is believed to be a very limited number of companies, the Working Group discussed having another exposure, with minor edits, to clarify that the revisions would apply to contracts in effect as of the effective date to later be specified by the Working Group. While the Working Group did not want to have the guidance in effect on January 1, 2021, a few members stated a preference to having the guidance effective upon adoption sometime in 2021.
b. The Working Group discussed the comments from the Mississippi Department of Insurance, interested parties and a former New York regulator that the changes appear to be substantive.

i. It was identified that the revisions have already had the due process required for either a substantive or a nonsubstantive change since it has had multiple exposures and public discussions.

ii. The Working Group affirmed that the proposed revisions are a nonsubstantive clarification of existing longstanding provisions of SSAP No. 71 which have been in place since prior to 1998. It was noted that under the *NAIC Policy Statement on Maintenance of Statutory Accounting Principles*, it is not the impact of a change on an individual entity that determines whether a change is substantive or nonsubstantive, but rather if the change alters original intent.

iii. It was also noted that the *NAIC Policy Statement on Maintenance of Statutory Accounting Principles* allows for drafting of an issue paper subsequent to the adoption of revisions. An issue paper can be drafted for either substantive or nonsubstantive revisions.

c. The former New York regulator generally opposed all of the revisions. He noted that the total commission paid will not change under this guidance, but rather only the timing of commission expense recognition will change. In response to these comments, Working Group members noted that the total commission expense is actually higher using these third-party arrangements because the funding agents charge interest and/or fees.

44. The Working Group also discussed and rejected the following revisions proposed by interested parties:

a. The proposed interested parties’ revisions would have allowed both a reduction in commission expense recognition and the delay in commission expense timing. The parties employing the disputed practice are trying to use persistency features in a funding agreement to defer and decrease the funding agreement liability. Interested parties’ comments advocated that the funding-agent fronting commission does not require recognition because of the insertion of a persistency contingency provision into the funding agreement. They noted that this persistency contingency provision might allow the reporting entity to avoid repayment of the past advance if the policy is subsequently cancelled. These proposed revisions were not incorporated as they are not in line with the original intent of the guidance and because it is not permissible to assume 100% lapse risk in recognition commission expense. It is only if a policy has been cancelled can a reporting entity derecognize the accrued liability/commission expenses.

b. Interested parties’ proposed revisions that commission funding agreements should only be accrued when repayment is guaranteed. This position has been previously rejected by the Working Group as it is in direct conflict with the existing guidance in SSAP No. 71, paragraph 4 which requires accrual of the full amount of a levelized commission agreement even when repayment is not guaranteed. It was noted that the purpose of the levelized commission guidance is to identify that the substance of the levelized commission is a funding arrangement. It identifies that a third party in an arm’s length transaction would not pay acquisition costs on behalf of an insurer without expectation of repayment and expectation of profit. The guidance requires recognition of the full amount of the funding agreement liability even if repayment is not guaranteed. The funding agreement is an...
attempt to de-link the relationship to the underlying policy from the normal day one accrual of sales commission. The funding agreement advance made by the third party is made with an expectation of repayment. Thus, the liability for amounts already advanced by the funding agent is not extinguished as a liability (under SSAP No. 5R or SSAP No. 103—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities) until it has either been repaid or the policy is cancelled.

c. The interested parties recommended revisions to recognize a reduced and delayed liability for the funding amount. They recommended ignoring the funding agreement nature of the advances and only recognizing the next payment because the policy might be cancelled in the future. It was again noted that this is the equivalent of assuming a 100% lapse rate on the policies. This position is similar to setting up the liability for a single payment on a loan instead of the entire principal balance. This proposed revision was rejected as inconsistent with the existing guidance in SSAP No. 71 which requires full accrual of the funding agreement liability.

d. Interested parties’ recommended revisions to add a new reference to SSAP No. 52—Deposit Type Contracts for the recognition of funding agreement liabilities. This was possibly an attempt to allow the funding agreement liability to be calculated using actuarial assumptions in the calculation of the liability. This would be inconsistent with SSAP No. 71 which does not allow discounting of such a liability.

e. Interested parties commented that “SSAP No. 71 is consistent in the application of persistency being part of the transfer of the risk (liability) to another party. If the lapse risk (persistency) is transferred to another party, the liability that the insurance company may have, is also transferred to that party and the insurance company has no liability.” However, it was noted that guidance in Appendix A-791 on Life and Health Reinsurance identifies that lapse risk, which is an insurance risk, can only be transferred via reinsurance. The Working Group disagreed that insurance risk liabilities can be extinguished with a commission agreement with a non-insurance entity, which seems to be the position of interested parties.

f. It was also noted that because of the persistency feature in the funding agreement, interested parties’ commenters were advocating to not recognize any commission expense in these arrangements until it is due to the third-party agent. Similar to other positions, this is the equivalent of a 100% lapse assumption. This assertion is not consistent with any other assertions reflected in the recognition of these insurance policies in their financial statements.

g. The Working Group did not support the comment by interested parties that under a levelized commission agreement another party is responsible for an insurer’s acquisition costs. It was noted that statutory accounting requires acquisition costs to be expensed as incurred, not shifted to a non-insurance entity. Interested parties were asserting that even though a third party prepaid their acquisition costs that they do not have to recognize an accrual for the levelized commission funding agreement. This position was rejected by the Working Group. The Working Group affirmed that a funding agreement is not the same as traditional persistency commission. The Working Group affirmed the original SSAP No. 71 guidance that the substance of a levelized commission agreement is a loan.

45. The Working Group discussed the overall statutory accounting concepts of conservatism and consistency which require that statutory financial statements reflect assets available for policyholder claims with comparable financial information. It was noted that allowing delayed expense recognition of initial policy commission expenses will contradict both statutory accounting concepts, as assets will be included that are not available for policyholder claims (as they are needed for non-recognized commission expenses).
and will result with financial statements that are not comparable to other insurance entities. Working Group members also expressed concerns with the competitive advantages that were occurring with companies that were employing these practices and stated a preference to have the guidance in effect in 2021.

46. After the discussion on November 12, 2020, the Working Group took the following actions:

   a. The proposed effective date of January 1, 2021 was changed to be effective upon adoption, and revised text was added to explicitly state that the proposed revisions will apply to contracts in effect as of the date of adoption.

   b. Determined that the revisions to SSAP No. 71 had met the due process for either a substantive or a nonsubstantive revision but concluded to keep the revision classified as nonsubstantive as the edits are in line with the original intent of SSAP No. 71. The Working Group reiterated that it is not the impact of a change on an individual entity that determines whether a change is substantive or nonsubstantive, but whether the revision is in line with the original intent of the SSAP. The Working Group noted that the proposed revisions to SSAP No. 71 are clarifications to the existing guidance consistent with original intent. Commissioner Donelon (LA) noted an objection to the classification as nonsubstantive.

   c. Directed NAIC Staff to draft an Issue Paper to document the discussion on this topic for historical purposes.

47. On March 15, 2021, the Working Group discussed written comments received from six parties including the 1) Montana Commissioner (now U.S. Representative) Matthew M. Rosendale, Sr., 2) a former North Carolina Commissioner 3) National Council of Insurance Legislators (NCOIL), 4) Interested parties, 5) one capital management company, and 6) a national conglomerate insurer. The key points from comments were summarized and draft responses were provided in the hearing materials for the meeting.

   a. Comments that there is no reason to change as current programs have been around for decades, been subject to external audits and insurance examinations and have not previously been noted of concern. (Montana commissioner, former North Carolina commissioner, capital company and the national conglomerate insurer).

      i. Materials response - It was noted that identifying levelized commission transactions is difficult, without an in-depth review. When this was identified on a 2017 state examination, the reporting entity refused to recognize the full liability, which is why this issue was brought to the Working Group. The guidance to recognize the full liability amount for a levelized commission transaction has been a statutory accounting requirement since before 1998. This guidance is in place to recognize that the substance of an arrangement that has a third party pay an insurer’s sales commission costs, is a loan. This is because a third party would not pay out large amounts of costs on another’s behalf without an expectation of repayment.

   b. Comments that the change is substantive based on impact and needs more study and review for unintended consequences. (Montana, former North Carolina commissioner, NCOIL, interested parties, the capital company and the national conglomerate insurer).

      i. Materials response - As noted in earlier meetings, under the NAIC Policy Statement on Maintenance of Statutory Accounting Principles, it is not the impact of a change on an individual entity that determines whether a change is substantive or nonsubstantive. To the extent this is a clarification of existing guidance, the revisions are consistent with the nonsubstantive classification.
ii. Materials response - Agenda item 2019-24 has been under discussion since August 2019, and the March 2021 meeting will be the sixth public discussion of this item. This item has been discussed: 1) August 2019; 2) December 2019; 3) July 2020; 4) October 2020; 5) November 2020 and 6) March 2021. It was noted that the underreporting of commission liabilities appears to be a practice employed by only a very small number of reporting entities.

c. Comments that there can be a negative RBC impact. The former North Carolina Commissioner, NCOIL, and the capital company all noted concern with the potential negative impact to risk-based capital which will result with the revisions requiring companies employing the disputed practice to recognize the full funding agreement.

i. Materials response - Reporting previously unrecognized liabilities can have negative RBC impacts; this is why the adoption of the agenda item was delayed from year-end 2020. The delay was to allow the small number of reporting entities which are employing the disputed practice to have an opportunity to have discussions with their regulators. However, it is highlighted that the unrecognized liability also resulted with improved financial statements (and better RBC) than what should have been recognized based on actual operations.

d. Possible consumer rate increases on guaranteed renewable long-term care were noted by the former NC commissioner and the capital company.

i. Materials response - The disputed practice is underreporting incurred commission expense and the obligation to repay it to a funding agent. This financing activity is being used to delay / under report incurred commissions. However, the total commission cost is typically slightly higher as the funding agents charge a fee and or interest (implicit or explicit ) for their services. As such, the full financial statement impact is not as clear cut as implied in this comment.

e. Effective date comments were varied. NCOIL was against a 2020 effective date, however that comment appeared to be related to the prior October exposure. NCOIL also requested a delay for the issue paper and recommended a five-year phase-in. The interested parties and the national insurance conglomerate advocated for an effective date no sooner than December 31, 2021, to allow time to work with regulators, auditors etc.

i. Materials response - Effective Date - The Working Group discussed proposed language which allows a December 31, 2021, effective date.

ii. Materials response - Phase-in - This is viewed as a practice employed by a small minority of reporting entities, but the potential impact is material. Some Working Group members and some members of industry have noted the unfair competitive advantage that entities which employ this practice are receiving, because it underrepresents the incurred liabilities. Prior Working Group discussions have indicated that a phase-in would need to be a permitted practice granted by the domiciliary regulator.

f. Interested parties’ comments asserted that lapse risk under the contracts had been transferred to a noninsurance entity, with the following comments “The existing SSAP No. 71 guidance is consistent in the application of persistency being part of the transfer of the risk (liability) to another party. If the lapse risk (persistency) is transferred to another party, the liability that the insurance company may have, is also transferred to that party and the insurance company has no liability. Removing persistency as a factor in the accrual of
commissions is a dangerous precedent. The differentiation between commissions based on real insurance risks versus payments based solely upon the passage of time in SSAP No. 71 goes directly to the risk transfer issue of one type of level commissions versus another. The proposed additional language eliminates this differentiation.”

i. Materials response - Statutory accounting guidance in Appendix A-791 on Life and Health Reinsurance identifies that lapse risk can be transferred via reinsurance. Transferring lapse related liabilities with a commission agreement with a noninsurance entity, was not viewed as a viable option under statutory accounting. The long-standing guidance in SSAP No. 71 requires full accrual of the funding agreement liability even if repayment is not guaranteed.

ii. Materials response - Because of the persistency feature in the funding agreement, interested parties’ commenters are advocating to not recognize any commission expense in these arrangements until it is due to the third-party agent. This is the equivalent of a 100% lapse assumption. This assumption would be inconsistent with any other assertions reflected in the recognition of these insurance policies in their financial statements. The overall statutory accounting concepts of conservatism and consistency require that financial statements reflect assets available for policyholder claims with comparable financial information. Allowing delayed expense recognition of initial policy commission expenses will contradict both statutory accounting concepts, as assets will be included that are not actually available for policyholder claims (as they are needed for non-recognized commission expenses) and will result with financial statements that are not comparable to other insurance entities.

g. Interested parties resubmitted some of the previously rejected proposed paragraph 4 revisions which seek to codify the industry position that funding agreements, which incorporate contingencies linked to traditional elements, should not be treated as a funding agreement (i.e. excluded from liability recognition).

i. Materials response - The proposed revisions were not incorporated as proposed language seeks to codify the treatment which has previously been rejected as inconsistent with the guidance in SSAP No. 71.

h. Interested parties resubmitted some of the previously rejected proposed paragraph 5 revisions to replace most of the exposed paragraph with language that is less detailed and which seeks to codify the industry position that funding agreements which incorporate contingencies linked to traditional elements should not be treated as a funding agreement (i.e. excluded from liability recognition).

i. Materials response - The proposed revisions were not incorporated as proposed language seeks to codify the treatment which has previously been rejected as inconsistent with the guidance in SSAP No. 71.

i. Interested parties commented that the exposed language which describes funding agreements, is too broad. Notes a concern that interim pay downs are not mentioned.

i. Materials response - Additional guidance regarding interim payments to paragraph 5, were not added because liabilities are always reduced when paid. This is detailed in SSAP No. 5R and SSAP No. 103R.
48. Interested parties commented that, “The current revisions require the accrual of a liability in situations that are inconsistent with the guidance SSAP No. 5R. Under a levelized commission program a third party has the obligation for the full initial sales commission. The insurer’s obligation under a levelized commission program that incorporates persistency should be accrued to the extent of legally contracted amounts owed. We do not believe the original intent of the SSAP required accruing for amounts that are not yet due and that may never be due. We strongly feel that the recognition of an obligation based on persistency is in accordance with the principles of SSAP 5R.”

a. Materials response - The comment by interested parties indicates that under a levelized commission agreement another party is responsible for an insurer’s acquisition costs. This is not appropriate as statutory accounting requires acquisition costs are expensed as incurred, not shifted to a non-insurance entity. The position of interested parties is that even though a third party prepaid an insurer’s acquisition costs that the insurer does not have to recognize an accrual for the levelized commission funding agreement because in some situations such as future policy cancellation, the insurer might not have to pay. This is rejected as inconsistent with SSAP No. 71 guidance and inconsistent with SSAP No. 5R.

b. Materials response - SSAP No. 5R incorporates an obligation to recognize contingent amounts that are probable and can be reasonably estimated. The difference is that a levelized commission arrangement is repaying a loan where in most cases the advance of the loan amount has already been made. The loan has contingency elements that may allow the loan repayment to be reduced in the future. Until the policy is cancelled there is a presumption that the amounts will be repaid. This is different from making a future commission payment on commission that has not yet been earned which occurs under traditional persistency commission. The elements of a liability under SSAP No. 5R:

i. Current obligation to pay for a past transaction - the insurer has a contract to repay the funding agent (current obligation). The service that is being paid for is the selling agent's sale of the insurance contract (past transaction). The guidance in SSAP No. 71 provides that related interest payments for the financing charges do not meet the definition of a liability until the passage of time for the interest has occurred. The insertion of a persistency element to the funding-agent funding agreement does not extinguish the entire pending liability. Such a liability would only be extinguished by payment or other legal release such as policy cancellation. The advance liability to the third party is for a past transaction- that is, the funding agent has paid commission to the direct agents for the sale of the policy.

ii. Payment probable of occurring - Payment of the obligation has to be probable of occurring. The only difference between the "persistency linked" funding arrangement and one where payment is guaranteed, is obviously the potential that principal will not be repaid due to lapse. However, the funding agents are not taking this risk without being compensated. The funding agreements are using a conservative estimate of expected lapses and factoring in a profit for the funding agent, hence the existing wording in SSAP No. 71 regarding interest explicit or implied. Therefore, a third-party funding agent would not be willing to provide financing if they did not think it was probable that they would have their full investment, plus a return on investment repaid. As such, the probable element of SSAP No. 5R is also met. The payment is probable and can be estimated and therefore meets the accrual requirements of SSAP No. 5R.
On March 15, 2021, the Working Group discussion included the following key points:

a. Mr. Bruggeman (OH) and Ms. Marcotte (NAIC) introduced agenda item 2019-24: Levelized and Persistency Commissions. The Working Group has been discussing this topic since August 2019 with this being the sixth public discussion. This agenda item was drafted in response to a specific state insurance regulator request to address an accounting practice identified during a financial examination. It was noted that a few insurers are utilizing a disputed practice by using third parties to pay policy acquisition costs, and they are not recognizing the full liability to repay those third parties. Not recognizing the full liability to repay the parties who are paying acquisition costs on an insurer’s behalf is inconsistent with the guidance in SSAP No. 71—Policy Acquisition Costs and Commissions. SSAP No. 71, which has been in place prior to 1998, provides statutory accounting guidance and identifies such agreements as funding agreements, which require full liability recognition. Mr. Bruggeman stated that NAIC staff have provided a summary of comments received, which includes a response to each position. Accordingly, NAIC staff are not recommending additional modifications.

b. Commissioner Mulready (OK) inquired as to whether actions taken by the Working Group regarding this project would go through the complete NAIC committee process, including reporting to the Accounting Practices and Procedures (E) Task Force and the Financial Condition (E) Committee and review by the Executive (EX) Committee and Plenary. Mr. Bruggeman stated that due to the controversial nature of this topic, this agenda item will be specifically considered through all levels of the committee process.

c. Commissioner Mulready further inquired regarding the expense recognition and payment of cashflows for using a third party to pay policy acquisition costs compared to insurers who directly pay commission expense. Mr. Bruggeman stated that traditional life insurance policies typically have a larger commission in the first year the policy is written. Through the use of a third party, some insurers have used a levelized repayment plan, so the first-year commission is repaid over several years. Additionally, the immediate expense recognition for this first-year commission, as required under SSAP No. 71, is not being properly recognized by some insurers in the year of acquisition. As a third party has remitted funds on behalf of an insurer, the insurer needs to properly recognize the loan as a liability.

d. Commissioner Mulready inquired about lapse risk, which is a common element built into these financing agreements. Mr. Bruggeman commented that lapse risk cannot be transferred to a noninsurance entity; and SSAP No. 71 still requires the liability to be recognized, even if repayment to the third party is not guaranteed. Mr. Bruggeman further stated that by not recognizing the full commission financing liability, an insurance company is asserting a 100% lapse rate, which is not an appropriate assumption and not consistent with the reserving methodology used for these products.

e. Ms. Nettleton (Guggenheim) stated that levelized commissions are not a new concept. She noted that a 2010 U.S. Securities and Exchange Commission (SEC) complaint against another carrier notes that levelized commissions were common practice. She stated that the concept of persistency remains a concern, as Guggenheim believes expense recognition will occur earlier than has traditionally been required. She stated that Guggenheim feels it is a dangerous practice to remove persistency in the treatment of levelized commission. Mr. Bruggeman stated that the concepts regarding traditional persistency commission are not a part of the proposed edits, as this agenda item is to clarify that initial acquisition costs should not be deferred through the use of a funding agreement.
Mr. Stolte (VA) stated that in 1991, Virginia had an insolvency in which the company participated in a structure where it utilized a levelized commission financing arrangement and did not properly recognize a liability for the amounts paid by the third party. However, as the insurer was liquidated, the third-party financier sought reimbursement for commission amounts previously forwarded on behalf of the insurer. Mr. Stolte stated that the insurer had not recorded the full amount of the liability, and this overstated surplus. He stated that if these amounts due are not recorded, they are in essence off-book, unrecorded liabilities. He stated that the concept of recognizing commission expenses when incurred has been a long-standing concept of statutory accounting, which was noted even prior to codification. He noted that acquisition costs are expensed as incurred upfront.

Commissioner Donelon responded that the insurer referenced by Mr. Stolte did a levelized commission practice; however, he perceived the accounting practice was fully transparent, and the $16 million amount of the off-balance sheet liability only represented a fraction of the $120 million insolvency. He stated that earlier exposures of this item, involved other large life insurers; however their earlier concerns appear to have been accommodated. He inquired regarding the nature of this accommodation. Mr. Bruggeman stated that this comment pertains to clarification involving true persistency commissions—i.e., subsequent year commissions—were not intended to be captured in the scope of levelized commissions revisions in SSAP No. 71. He said the initial revisions were perceived by the broader insurance industry as affecting traditional persistency commission and the Working Group subsequently clarified that that was not the intent of the revisions. Ms. Gann (NAIC) stated that SSAP No. 71 is a common area SSAP, so it is applicable to all insurer and product types. She stated that the intent of the SSAP No. 71 revisions is to capture initial acquisition costs and commissions from the issuance of a policy, not traditional persistency commissions that arise subsequent to initial commissions which are common in many insurance products.

Thomas B. Considine (National Council of Insurance Legislators—NCOIL) stated that NCOIL believes that the changes proposed are substantive in nature and the timing of an adoption is less than prudent, especially in light of the current economic environment. He noted that the revisions will have adverse capital consequences on some companies. Companies utilizing levelized commission structures have done so for decades, and in conjunction with this requiring a significant financial impact, NCOIL would recommend a four or five-year phase-in of expense recognition. Mr. Stolte stated that in response to a multi-year phase-in request, insurers affected could request a permitted practice from their state of domicile. In doing so, a multi-year phase-in could be granted; however, the financial and capital impact could be appropriately disclosed. Mr. Considine stated that permitted practices are not viewed as favorably as uniform treatment, and this would not be a preferred solution.

Lynn Kelley (Delaware Life), on behalf of interested parties, stated that they do not agree with the proposed edits, and they believe the edits are substantive in nature. She stated that interested parties believe that their accounting practices have been in compliance with SSAP No. 71 and have been subject to numerous insurance exams and independent financial audits. If adopted by the Working Group, an effective date no earlier than December 31, 2021, is requested. She stated her support also for a multi-year phase-in.

Mr. Bridgeland (Center for Insurance Research—CIR), NAIC consumer representative, stated that the most important function of statutory accounting is to ensure solvency and a level playing field among similar insurers. He stated that an insurer’s financial statements
should reflect capital available to pay policyholder claims and not permit off-balance sheet liabilities. Despite this requiring material adjustments to a few insurers, he stated that adoption was recommended to ensure that financial statements appropriately reflect an insurer’s financial position. He stated that if deferring the recognition of commissions is what is maintaining a company in the appropriate risk-based capital (RBC) range, then the company may warrant additional scrutiny for other areas as well.

k. Mr. Bruggeman stated that as the edits proposed do not change the original intent of SSAP No. 71, he views the edits as nonsubstantive in nature. He stated that the concept of requiring immediate expense recognition of initial acquisition costs meets the spirit of statutory accounting concepts, as well as the concept of conservatism as referenced in the preamble. Commissioner Donelon stated that he believes this issue to be substantive in nature, even if it is not in the technical accounting sense. He indicated that the reporting entity that contacted him indicated that it will not have a materially adverse impact on them. However, he has been told that there are reporting entities that will have a significant financial impact on some small companies, and it will jeopardize members of the ACLI and the National Alliance of Life Companies (NALC). He stated recommendation for grandfathering of existing practices or a multi-year phase-in of any recognition requirements. He stated his agreement with Mr. Considine that a permitted practice is not preferred. Mr. Smith stated that when referencing the definitions of substantive versus nonsubstantive in the Accounting Practices and Procedures Manual (AP&P Manual), the exposed edits are nonsubstantive in nature.

l. Commissioner Mulready stated that this practice has been in place for decades, and to classify this as nonsubstantive signifies to him that all prior insurance exams and independent audits are incorrect. Ms. Andersen (IL) stated that the proposed edits are only clarifying in nature, as they do not change the intent of SSAP No. 71. She stated that this practice has only been employed by a small number of insurance entities, and it results in liabilities that are not recorded in the financial statements. Mr. Stolte stated that commission financial arrangements are difficult to discover; in the prior insolvency example referenced, it was not until the company was in receivership that the issue was discovered. He noted that such arrangements create illusory surplus and violate the concepts of statutory accounting and audits do not review every single contract.

m. Mr. Bruggeman stated that nonsubstantive agenda items are generally effective immediately; however, due to the nature of this topic, it will need to be approved by the Accounting Practices and Procedures (E) Task Force, the Financial Condition (E) Committee, and the Executive (EX) Committee and Plenary. With the Executive (EX) Committee and Plenary not meeting until the Summer National Meeting, the earliest this adoption could take effect is likely the third quarter of 2021. Mr. Smith (VA) stated that due to the length that this agenda item has been discussed, they would support an immediate effective date. Ms. Belfi (CT), Mr. Fry (IL), Mr. Clark (IA) and Mr. Kim Hudson (CA) recommended a December 31, 2021, effective date, due to the likelihood of a significant financial impact combined with the requirement for adoption by the Executive (EX) Committee and Plenary. In an inquiry from Mr. Bruggeman, no Working Group member was opposed to a December 31, 2021, effective date, which is the effective date suggested by Delaware Life per the comments from Ms. Kelley.

n. As this agenda item directs that any adjustments be accounted for as a change in accounting principle under SSAP No. 3—Accounting Changes and Corrections of Errors, the effective date will not have a material impact, as any required cumulative adjustments calculated as of January 1, 2021, will impact unassigned funds (surplus). Mr. Bruggeman stated that
 upon adoption, insurers will be required to record a liability for outstanding amounts due to a third-party funding agent as a cumulative effect adjustment to surplus as of January 1. He noted that activities throughout the year after January 1 are recorded through income.

50. On March 15, 2021, the Working Group took the following actions with Louisiana voting in opposition.

   a. Directed NAIC staff to update this Issue paper for March 2021 and subsequent actions to allow for future exposure. It was noted that the non-authoritative issue paper does not need to be adopted prior to implementation of the SSAP No. 71 revisions.

   b. Supported an annual statement blanks proposal to provide a new general interrogatory to identify the use of a third party for the payment of commission expenses, which will be concurrently exposed with the Blanks (E) Working Group.

   c. Adopted the exposed revisions to SSAP No. 71 with a December 31, 2021, effective date. The Working Group affirmed the nonsubstantive classification of these revisions as consistent with the original intent of SSAP No. 71.

51. On March 23, 2021, the Accounting Practice and Procedures (E) Task Force adopted the report of the Working Group. The Task Force conducted a separate vote on the SSAP No. 71 revisions. The motion passed with 41 in favor and the states of Louisiana and Oklahoma opposed.

52. Key aspects of the March 23, 2021, Task Force discussion are provided below.

   a. Mr. Bruggeman provided an overview of agenda item 2019-24 regarding levelized commission, which affects SSAP No. 71—Policy Acquisition Costs and Commissions. He stated that the Working Group has been discussing this item since August 2019, when it was brought to the Working Group by a domiciliary state. Mr. Bruggeman stated that after six public discussions, the nonsubstantive revisions that clarify the guidance in SSAP No. 71 regarding levelized commissions were adopted on March 15, 2021, with a December 31, 2021, effective date. Thirteen Working Group members voted in favor of adoption, and one member was opposed.

   b. Mr. Bruggeman stated that both U.S. GAAP and SAP would calculate acquisition costs in a similar manner. However, one of the major financial reporting differences between SAP and GAAP is that GAAP capitalizes acquisition costs and expenses them over time to match revenue and expenses while SAP expenses policy acquisitions costs as incurred. Mr. Bruggeman stated that at the heart of this issue is that a small number of reporting entities are using third parties to pay their sales commission costs and not recognizing the full liability of what is in essence a loan to repay the third parties as required under SSAP No. 71. He said that the Working Group has had extensive discussion on this topic and has noted that the revisions clarify the long-standing principles in SSAP No. 71, which have existed since even prior to codification. He stated that the revisions were classified as nonsubstantive because the revisions emphasize the original principles regarding funding agreements and the impact to a minor number of companies do not determine the classification of the revisions.

   c. Mr. Bruggeman noted that state insurance regulators and consumer representatives also voiced concerns about the illusory surplus and unlevel playing field such arrangements create. He stated that because of the unfair competitive advantages that are perceived, the Working Group was not in favor of grandfathering the practices. He noted that the Working Group did discuss that companies could have discussions with their domiciliary states
regarding obtaining a permitted practice for phasing in the financial impact. Because the impact to the affected companies may vary.

d. Louisiana staff stated that Commissioner James J. Donelon could not attend the meeting, but he wanted his comments that this is a substantive change noted and also that he is in favor of a phase-in period. Oklahoma staff also noted that Oklahoma also supports the comments from Louisiana.

e. Ms. Kelley (Delaware Life) stated that their position is also that the revisions are substantive and that they appreciate the time that the Working Group has spent discussing this issue even if not all of the edits they submitted were incorporated. She also stated support for an effective date at least as late as December 31, 2021.

f. Elly Nettleton (Guggenheim Life and Annuity) highlighted two points from their prior comment letters: 1) levelized commissions are not a new concept and date back several decades. She noted that a 2010 U.S. Securities and Exchange Commission (SEC) complaint against another carrier identified levelized commissions as a common practice in the industry. She said Guggenheim is not aware that the accounting treatment was determined not to be in accordance with statutory accounting principles; and 2) traditional commissions such as those tied to policy persistency are carved out of the proposals. Ms. Nettleton said Guggenheim believes it is a dangerous precedent to remove persistency as a factor in the accrual of commissions as it is a key insurance element. Mr. Bruggeman noted that similar comments as Ms. Nettleton’s were made at the Working Group. He stated that the Working Group did hear the comments but did not agree with them.

g. Thomas Considine (National Council of Insurance Legislators—NCOIL) stated that NCOIL members feel strongly that the revisions are substantive but are willing to put that aside and do not feel the need to debate that classification again at this time. He stated that this is a practice that has been going on for decades. He stated that to implement this change during a period of great economic turmoil seems not only short-sighted, but also it is dangerous to require entities to make such a change in a period of a year. He stated that NCOIL recommends a significant phase-in period with a proposed effective date of December 31, 2025. He stated that a permitted practice does not reflect positively on the state granting the practice or the reporting entity receiving the practice. He stated that accreditation reviews note the permitted practices granted by a jurisdiction. He stated that the most fair and equitable solution and a way to avoid the debate of change classification is to add a four- or five-year phase-in.

h. Mr. Bruggeman stated that funding agreements to levelized commission costs are not prohibited. He said the issue is that the full liability for the funding agreement must be recognized for the inherent loan. In other words, it is a financing arrangement; it does not delay the timing of recognition of the acquisition costs. He stated that a permitted practice may not have a positive perception. However, permitted practice disclosure requirements allow state insurance regulators to understand the surplus impact of the arrangement. He stated that a permitted practice provides transparency and noted that if there were any decisions to extend the effective date beyond December 31, 2021, there would need to be a disclosure of the impact. Ms. Walker (TX) agreed, noting that consistency, meaning the ability to compare reporting entities’ financial positions, is a fundamental concept that statutory accounting is based on. She noted its importance for solvency regulation.

i. Mr. Considine noted that to address Mr. Bruggeman’s point about state insurance regulators’ information needs, he is confident that if there were a four- or five-year phase-
in, legislators would be supportive of a reasonably tailored data call. Mr. Rehagen (MO) asked if Mr. Considine envisioned a confidential data call or one that would be publicly produced. Mr. Considine indicated he assumed if it were for the state insurance regulators, then such a data call would be confidential. However, he said NCOIL would be open to discussion. Mr. Bruggeman stated his intent was for a disclosure to be part of the public statutory accounting filing.

j. Mr. Stolte stated that the Task Force is discussing noncompliant statutory accounting by a handful of companies. He stated that in 1991, Virginia had an insurance receivership of a large life insurance company that had a deferred commission funding arrangement. He said that the insurer had not booked the liability, but when the company was put into receivership, the funding entity/financier filed with the receivership a request for payment of $16 million. He said that the reporting entity prior to the receivership was reporting $120 million in surplus, but true surplus ended up being approximately $4 million. He said he disagreed with the statement that what the handful of companies are doing is an acceptable SAP practice. He said it is noncompliance with statutory accounting in SSAP No. 71, and also with the statutory accounting guidance that existed even prior to codification. He said from a level playing field perspective, he does not want to be forced to approve such agreements for his companies to be able to compete with reporting entities employing this practice. He stated that not recording the full liability for the funding agreements creates illusory surplus. He stated that if a reporting entity needs more time to implement the revisions, a permitted practice is what should be employed. He noted that he received notification of more than 100 permitted practices in an average year. He stated that the permitted practices are designed to provide transparent disclosure for all state insurance regulators.

k. Mr. Considine stated that what Mr. Stolte is terming “noncompliance” has been accepted in the regulatory community for 20 years. He said if reporting entities have been doing so for 20 years, it seems unreasonable to require a change in one year. Mr. Stole said that in Virginia, they have not accepted such practices. He noted that there may be some that they were unaware of, but they do not view it as an acceptable practice. He stated that this has been noted as problematic in a formal examination report, and he respectfully disagrees with Mr. Considine’s statement that it was an acceptable practice. Ms. Walker also noted that she has been a Texas state insurance regulator for 20 years and is not aware of any entities that are using funding agreements to defer the recognition of acquisition costs. She noted that she would also take exception to doing so if it were identified in an examination or other regulatory review.

l. Mr. Bridgeland (Center for Insurance Research—CIR) stated support for the proposal as adopted by the Working Group. He stated that one of the top priorities for state insurance regulators was ensuring that the insurers are solvent. He stated that part of that is also ensuring that there is a level playing field. He stated that in this case, there are a handful of companies using a technique that, by their own admission, is enhancing surplus. He noted that as a consumer advocate, he does not want to see insurers have illusory surplus.

53. On April 13, 2021, the Financial Condition (E) Committee, adopted the revisions with 11 in favor and the three states of Mississippi, New Mexico, and South Carolina dissenting. The following key comments were part of the discussion:

a. Commissioner White stated that the last item on the agenda is an issue that has received a considerable amount of discussion within the Statutory Accounting Principles (E) Working Group over the last couple years. He stated that unlike the premium refund issue from 2020,
where the Committee overturned the adoption of a position and suggested that the issue be redrafted, he does not believe that should occur for this particular issue. He stated that the reason for this was that it was his understanding that the vast majority of the life insurance industry is very much opposed to the practice that has apparently been used by what we think is a handful of companies. The reason being is they believe it gives those handful of companies an unfair competitive advantage over the rest of the industry that has been abiding by Statement of Statutory Accounting Principles (SSAP) No. 71—Policy Acquisition Costs and Commissions ever since its inception, as well as even dating back before at least the 1990s. He suggested that if the Committee does not adopt this item, his understanding is that it would force the Working Group to change the entire SSAP No. 71 to allow all commissions and related acquisition costs to be deferred and amortized over time. The reason this would be required is that is essentially what the handful of companies are doing today, while the rest of the industry expenses these costs at the inception of the contract in accordance with statutory accounting principles (SAP). Commissioner White summarized that this would require the Working Group to go back and basically adopt U.S. Generally Accepted Accounting Principles (GAAP) for this particular issue, even though this is one of the biggest differences between SAP and U.S. GAAP. He noted that even if the Committee adopts the issue, it still needs to be adopted by the Executive (EX) Committee and Plenary. He also noted that he already recommended that the Executive (EX) Committee and Plenary consider taking it up either at the Summer National Meeting or during an interim call of the Executive (EX) Committee and Plenary.

b. Ms. Walker noted that included in the materials is a document that provides an overview of the levelized commission agenda item 2019-24 from the Working Group, which modifies SSAP No. 71 through a clarification. She discussed how the Working Group began discussion on the issue in August 2019, and on March 15, 2021, the Working Group adopted nonsubstantive revisions illustrated at the end of the attachment, with an effective date of December 31, 2021. The Working Group vote was 13 states in favor and one state opposed. On March 23, 2021, the Accounting Practices and Procedures (E) Task Force adopted the Working Group’s revisions without modification. The vote was 41 members in favor and two opposed (Louisiana and Oklahoma).

c. Ms. Walker discussed that although U.S. GAAP and SAP calculate acquisition costs in a similar manner, one major financial reporting difference between the two is that U.S. GAAP capitalizes acquisition costs and expenses them over time to match revenues and expenses while SAP expenses policy acquisitions costs as incurred. This accounting treatment is in line with the SAP Statement of Concepts, particularly the recognition concept. This concept specifically identifies that accounting treatments that defer expense recognition are not generally acceptable under SAP.

d. Ms. Walker noted that this agenda item was initiated because some reporting entities are using third parties to pay their sales commission costs without recognizing the full liability to repay the third parties, as required under SSAP No. 71. These entities have taken the position that their agreements are not funding agreements, as they pass on lapse risk to the third party. Ms. Walker discussed how the Working Group has noted that the revisions clarify the long-standing principles in SSAP No. 71, which have existed since even prior to codification. The nonsubstantive revisions emphasize the original principles that require full liability recognition for the commission paid on an insurer’s behalf and any interest and fees incurred to date. Ms. Walker described how the Working Group noted that it is not permissible to pass insurance lapse risk to a non-insurance entity. Furthermore, as the commission is owed with the issuance of an insurance contract, the proper recognition shall continue to require recognition at the time the insurance contract is issued. Ms. Walker
indicated that the Working Group confirmed that it is not permissible to utilize a third-party payer of sales commission as a means to defer recognition of commission expenses.

e. Ms. Walker described how if the agenda item is adopted, a small number of companies will have a material financial impact. She emphasized that because of the unfair competitive advantages that are perceived, and as the guidance is in line with the original intent of SSAP No. 71, the Working Group did not adopt grandfathering or transition provisions. She discussed how the Working Group has recommended that affected companies speak to their domiciliary states regarding potential permitted practices, as needed, for phasing in the financial impact. This approach was favored because the impact to the affected companies may vary, and it provides disclosure in Note 1 to ensure the comparability of all insurers with SAP. Ms. Walker noted that it is her understanding that most companies are not employing this practice and will not be affected by the agenda item’s adoption.

f. Superintendent Toal (NM) suggested that the Committee should consider modifying the effective date from the current proposed year-end 2021 to year-end 2022. Ms. Walker stated that the Working Group had already delayed the effective date from its usual practice of effective upon adoption for nonsubstantive items such as this, but the Working Group wanted to allow time for domestic states to work with any of their companies affected. She also described how a further delay was considered, but since the vast majority of the industry is complying, such a suggestion was rejected by the Working Group. Superintendent Toal questioned whether having less than six months allows enough time for companies to make the changes necessary. Commissioner Donelon repeated a comment that he indicated he has made in the past, which was that even though this was not a substantive change, the real-world impact to some companies was to the tune of hundreds of millions of dollars; therefore, grandfathering of the old contracts, perhaps on a phased-in approach, should be allowed. He described that he had been directed to some communication from the U.S. Securities and Exchange Commission (SEC) where this practice was identified as far back as 30 years ago. He described how such companies therefore may have been using this practice in good faith, or at least one they believed was appropriate, and they are being asked to record hundreds of millions of changes in surplus from this practice. He stated that for this reason, he and other commissioners have interceded in this process. Mr. Slape (TX) stated that the reference to SEC action may not be accurate, as he believes the facts indicate that the company was in worse financial condition after entering into these transactions. In essence, these companies are borrowing money, paying interest on that borrowed money, then competing against other companies that are following the current accounting requirements. Mr. Slape noted that this is not a new issue; this is the first thing that a state insurance regulator learns about regarding the differences between SAP and U.S. GAAP.

g. Commissioner White indicated that everything he has been told is that this may have been taking place within a handful of companies, but that does not mean the state insurance regulators of those companies were aware of its existence in those companies. He described how this is not readable or identified in the financial statements since it is an unrecorded liability. He described how expensing these costs as incurred has been a bedrock principle within statutory accounting for years, even before SSAP No. 71 was adopted in 2001. He noted that he understands the argument for phasing in the impact, given that it could be material for some companies; however, the other side of that is the argument about the level playing field. He emphasized what Ms. Walker said earlier about affected companies working with their domestic regulator about a permitted practice, which is disclosed in Note 1 of the financial statements. Commissioner Donelon stated that he believes from his experience as a commissioner for so many years that the term “permitted practice” certainly
comes with a negative connotation. He stated that for the companies he has heard from, the affected companies are unwilling to pursue a permitted practice. However, he stated his appreciation for the time that the Committee and its subsidiary task forces and working groups have given to this issue.

h. Mr. Galbraith (AR) asked if it is possible to determine definitively if there were just a handful of companies and also whether the practice will definitively cease with all companies going forward on the same level playing field if the proposed changes are adopted. Commissioner White stated that he has heard no evidence to the contrary that it was anything more than a handful of companies since he believes state insurance regulators would have heard from those companies that are affected, and he noted that he is aware of companies in only three states where this is an issue. He described how this is a difficult practice to identify since it is not recorded in the financial statements. He also stated that with the significant discussion, the industry appears to be very aware of the issue, and the vast majority of the industry is supportive of the clarification to have a level playing field.

i. Commissioner Mulready stated his support for the comments made by Commissioner Donelon, noting that his concerns have never been about the issue but rather the implementation. He stated his understanding that grandfathering may be difficult, but a delayed effective date, as suggested by Superintendent Toal, should be considered. Commissioner White responded that he believes that point was debated at the Working Group and the Accounting Practices and Procedures (E) Task Force. Commissioner Mulready noted that as a result of these discussions, Oklahoma had sent communication to all of its domestices to determine if other insurers are affected, and he suggested that he is sure other states are likely doing the same thing. Commissioner White stated his support for that practice, noting that it allows the domestic regulator to determine what is best for any affected companies. Wayne Goodwin, former North Carolina Insurance Commissioner, stated that he had previously submitted comments on this issue, noting slippery slope concerns with what could happen if it is implemented as quickly as is suggested since those concerns affect consumers. He stated his support for comments from Commissioner Donelon, Commissioner Mulready and Mr. Galbraith, and he noted concern about the potential impact on smaller carriers.

j. Superintendent Toal stated that he wants to be clear in the idea of moving to a level playing field, and he is not objecting to the policy, rather his objection was with the limited time to implement, particularly given that state insurance regulators do not know the number of companies affected. Commissioner White responded that his deputy refers to the issue that arises from this practice as illusory surplus, and if in fact there are millions in unrecorded liabilities, that indicates information should be available to solvency regulators and indicates a level of concern. Ms. Walker stated that she believes this is a consumer protection issue, and her highest responsibility is ensuring that carriers can pay policyholder claims as they come due. She stated that when she hears some of the concerns that are being stated, as the domiciliary regulator, she needs the companies to come speak to her so that the two can work out a practice that takes care of consumers while considering the concerns of the company. She stated that the Accounting Practices and Procedures Task Force is trying to adopt some disclosures to gather information on companies, but that depends upon accurate completion by the company, something that may not occur given this particular accounting practice of expensing commissions as they are incurred, which is a fundamental bedrock of statutory accounting that differs from other standards. She noted that there was discussion of trying to obtain more data on the companies using this practice, but the companies did not come forward to their state insurance regulator even though that was requested. So, while a complete scope is not known, the Working Group
and the Task Force did not receive information from state insurance regulators that are on the Task Force or follow it. Ms. Walker also noted that the current proposed effective date of year-end 2021 is already a delay. Mr. Slape suggested that if this is going to have hundreds of millions of impacts on a handful of companies, that is illusory surplus, and that raises questions about the solvency of such insurers using this practice. Therefore, it could have an impact on this small number of companies.

k. Ms. Kelley (Delaware Life Insurance Company), on behalf of interested parties, stated that this is an issue that has been discussed for some time, and she appreciates the ongoing discussions of the Committee and NAIC staff that have worked with Delaware Life. She strongly advocated for additional time to work through this implementation because Delaware Life still believes there are unanswered questions with regard to the calculations. She stated that Delaware Life has advocated all along for an extended effective date. She stated that Delaware Life maintains that this is a substantive change and believes that it has applied SSAP No. 71 in good faith, with all prior financial statements subject to examination and audit. Mr. Corbett (Guggenheim Life and Annuity Company) stated that the accounting for levelized commissions has been presented as a solvency issue, whereby companies have unrecorded liabilities for future commission payments. If this is the case, the liability is deemed necessary for policyholder protection, so how would the Committee be comfortable with any persistency commissions being recorded over time when all insurers have policy experience to be used as a basis for estimating the liability for these future expected commission payments. Therefore, the obligating event, which is defined by one of three essential characteristics in SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets, has not occurred until the policy anniversary date. Mr. Corbett noted that paragraph 2 of SSAP No. 71, which contains no proposed modifications to the definition of a liability, determine when that liability has been incurred. The proposed changes to levelized commissions with a link to persistency are contradictory to paragraph 2. Commissions that are paid and earned according to persistency, which is a long-standing insurance element, should be treated in a consistent manner to ensure comparability among reporting entities. Guggenheim believes the proposed changes to SSAP No. 71 sets a dangerous precedence for the need to accrue for other liabilities for other predictable future expenses. Ms. Walker noted that the expense is incurred for the first year when the policy is written. So, even if the funding agreement allows the company to pay the sales agent in the future, that does not allow the company to defer expenses the first year of the policy. She stated that by deferring, and not recording the liability, and making the statement that it is not due until after the period is contrary and has a different assumption. The assumption that one does not have to book the liability until the policy is still in effect ignores the fact that the policy is currently in effect. As long as the policy is in effect, that amount will be owed. Therefore, you are not to adjust the liability down until the policy lapses or is cancelled. Using a funding agreement simply changes the timing of when the payment is due and does not affect if there should be an expense. Mr. Slape stated these are not persistency commissions because in those situations the agent is paid a commission in future years for when that policy stays in force. These are referred to as renewal commissions, and they are reported on the future anniversary date, but the first-year commission must be expensed immediately up front regardless of the existence of a funding agreement since that is a loan. Mr. Slape stated that he takes issue with the statement that these funding agreements provide for a persistency commission.

l. Roger Sevigny (Sevigny Consulting), as a former state insurance regulator, stated that what he keeps hearing is a lack of information, and he asked that the work be slowed down. Commissioner Donelon stated that with respect to the companies referred to, they are owned by wealthy owners and some of the largest insurers in the world.
White stated that the debate has been vigorous, and he reminded everyone that even if the Committee votes to adopt the proposal, it will still need to be considered by the Executive (EX) Committee and Plenary. at the Summer National Meeting or during an interim meeting before that date.

54. The revisions were adopted by the Executive (EX) Committee and Plenary on August 17, 2021, with 10 jurisdictions voting as opposed. The discussion primarily centered around whether to allow a one-year deferral of the effective date to December 31, 2022. The December 31, 2021, effective date was maintained.

RELEVANT STATUTORY ACCOUNTING

55. Existing guidance in SSAP No. 71—Policy Acquisition Costs and Commissions.

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

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

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

Effective Date

56. As issue papers are not represented in the Statutory Hierarchy (see Section IV of the Preamble), the subsequent consideration and adoption of this issue paper will not have any impact of the December 31, 2021, effective date of the nonsubstantive revisions adopted to SSAP No. 71 by the Working Group on March 15, 2021.
EXHIBIT A – NONSUBSTANTIVE REVISIONS TO SSAP NO. 71—POLICY ACQUISITION COSTS AND COMMISSIONS

Statement of Statutory Accounting Principles No. 71

Policy Acquisition Costs and Commissions

SCOPE OF STATEMENT

1. This statement establishes statutory accounting principles for policy acquisition costs and commissions.

SUMMARY CONCLUSION

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

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

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

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

Relevant Literature

6. This statement rejects ASU 2018-12, Targeted Improvements to the Accounting for Long-Duration Contracts, ASU 2010-26, Accounting for Costs Associated with Acquiring or Renewing Insurance Contracts, FASB Statement No. 60, Accounting and Reporting by Insurance Enterprises, FASB Statement No. 97, Accounting and Reporting by Insurance Enterprises for Certain Long-Duration Contracts and for Realized Gains and Losses from the Sale of Investments, and Statement of Position 05-1, Accounting by Insurance Enterprises for Deferred Acquisition Costs in Connection with Modifications or Exchanges of Insurance Contracts.

Effective Date and Transition

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

REFERENCES

Relevant Issue Papers

• Issue Paper No. 71—Policy Acquisition Costs and Commissions
• Issue Paper No. 165—Levelized Commission

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/Fall 2021/TF/App/SAP/Minutes/Att OneF_IP No. 165_Levelized Commission.docx
Interpretation of the Statutory Accounting Principles (E) Working Group

INT 20-10: Reporting Nonconforming Credit Tenant Loans

GUIDANCE DETERMINED TO BE NO LONGER RELEVANT

INT 20-10 Dates Discussed

November 18, 2020; December 18, 2020; December 28, 2020; December 11, 2021

INT 20-04 References

SSAP No. 43R—Loan-Backed and Structured Securities


INT 20-10 Issue

1. During the Statutory Accounting Principles (E) Working Group meeting on November 12, 2020, the Working Group discussed and deferred final decision on inconsistencies in the reporting of “nonconforming” credit tenant loans (CTLs) currently reported on Schedule D-1 and directed reporting exceptions for year-end 2020. Due to subsequent questions, this interpretation has been issued to detail the provisions provided and clarify the reporting of CTLs in the year-end 2020 statutory financial statements.

INT 20-10 Discussion

2. As detailed in agenda item 2020-24, some reporting entities have reported CTLs that do not qualify as “conforming” CTLs per the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) on Schedule D-1: Long-Term Bonds. CTLs that do not qualify under the P&P Manual structural requirements are noted as “nonconforming” CTLs. During the November 12 discussion, the Working Group deferred final guidance on the reporting of nonconforming CTLs. This deferral was supported as the Working Group has a separate project to assess investments that are captured on Schedule D-1. With this project, it was identified that it would be undesirable to require an investment that is currently being reported on Schedule D-1 to be moved to a different schedule if there was potential for that investment to subsequently qualify for Schedule D-1.

3. Although the Working Group deferred final conclusion on the reporting of nonconforming CTLs, it was identified that the long-standing guidance detailed in the P&P Manual only permits CTLs that meet certain structural criteria, which is verified by the SVO, to be reported on Schedule D-1. Under this existing guidance, these conforming CTLs are also prohibited from using CRP ratings in determining NAIC designation but are required to utilize SVO-assigned NAIC designations obtained after the SVO verifies compliance with the structural elements. As such, to ensure that nonconforming CTLs are not provided more favorable provisions than conforming CTLs that meet structural requirements, the Working Group confirmed that only CTLs that are filed with the NAIC SVO by February 15, 2021, shall be reported on Schedule D-1. Key aspects noted in this direction:

   a. This direction is a limited-time exception to the NAIC Policy Statement on Coordination of the Accounting Practices and Procedures Manual and the Purposes and Procedures Manual of the Investment Analysis Office and shall not be inferred to other investments. Pursuant to the noted Policy Statement, obtaining an NAIC designation does not change an investment’s applicable SSAP, annual or quarterly statement reporting schedule, or override other SSAP guidance required
for the investment to be an admitted asset. Although nonconforming CTLs will be permitted to be reported on Schedule D-1 when filed with the SVO for future receipt of an SVO-assigned NAIC designation (even without meeting structural requirements), this is strictly a limited-time exception to prevent reporting schedule changes while a larger project on the scope of Schedule D-1 is considered.

b. The requirement to file the nonconforming CTL for an SVO-assigned NAIC designation for Schedule D-1 applies to all investments that represent credit tenant loans. It is not permissible for a reporting entity to classify an investment, which meets the characteristics of a credit tenant loan, as a different type of investment (for example, as a form of leased-backed security) for purposes of reporting the investment on Schedule D-1 without filing for an SVO-assigned NAIC designation.

c. The Working Group direction intends to only address nonconforming CTLs that have previously been reported on Schedule D-1 although they did not comply with the requirements of the P&P Manual. This direction is not intended to require, or permit, nonconforming CTLs that have been previously reported as mortgage loans (on Schedule B – Mortgage Loans) or as other invested assets (on Schedule BA – Other Long-Term Invested Assets) to be moved to a different reporting schedule. Nonconforming CTLs that have previously been reported on Schedule B or BA shall remain on that reporting schedule for the duration of this INT.

**INT 20-10 Consensus**

4. The Working Group reached a consensus to provide a limited time exception allowing nonconforming CTLs to continue to be reported on Schedule D-1 for year-end 2020 provided they have filed for an SVO-assigned NAIC designation. With the issuance of this interpretation, the Working Group confirmed the provisions and limitations detailed in paragraph 3, and summarized the resulting provisions below:

a. CTLs that qualify per the provisions of the P&P Manual are considered to be “conforming” CTLs and shall be reported on Schedule D-1 with the NAIC designation obtained from the SVO.

b. CTLs that do not qualify per the provisions of the P&P Manual to be “conforming” CTLs shall follow the accounting and reporting provisions detailed in the following subparagraphs. These CTLs are noted as “nonconforming CTLs.”

i. Nonconforming CTLs that have previously been reported on Schedule D-1 may continue to be reported on Schedule D-1 for year-end 2020 if they have filed for an SVO-assigned NAIC designation. This provision only requires that an entity file the security with the SVO by February 15, 2021, not that the entity receive the SVO-assigned designation prior to submitting their 2020 annual statutory financial statements. If an entity does not file the security with the SVO by February 15, 2021, the investment shall be reported on Schedule BA. If reporting on Schedule BA, these CTLs shall not be reported with a credit-rating provider (CRP) determined NAIC designation. For nonconforming CTLs that have been filed with the SVO and retained on Schedule D-1, the reporting entity is required to disclose the total amount of nonconforming CTLs reported on Schedule D-1 on Note 1 as if it were a permitted practice. The reporting entity shall complete the permitted practice disclosures required by SSAP No. 1—Accounting Policies, Risks & Uncertainties, and Other Disclosures, with two separate entries that detail the nonconforming CTLs that were reported on D-1 on one line, and the nonconforming CTLs that were not reported on Schedule BA on a separate line within this disclosure. (These lines will likely net to a zero impact to statutory surplus; therefore, the separate line reporting is required.)
ii. Nonconforming CTLs that have been previously reported on a different reporting schedule (e.g., Schedule B or Schedule BA) shall remain on the prior reporting schedule. There is no requirement for reporting entities to pursue SVO-assigned designations for these CTLs or disclose these nonconforming CTLs in Note 1. Furthermore, reporting entities that have previously reported nonconforming CTLs on Schedule D-1 that do not want to file with the SVO or that do not want to disclose in Note 1 pursuant to paragraph 4.b.i. are permitted to reclassify these CTLs to Schedule B or Schedule BA without NAIC designations.

5. The exceptions granted in this interpretation are applicable for the year-end 2020 statutory financial statement only. Nonconforming CTLs that have been filed with the SVO and are reported on Schedule D-1 shall continue the Note 1 reporting for each 2021 quarterly financial statement until an SVO-assigned designation is received. The provisions within this INT, and the ability to continue reporting nonconforming CTLs on Schedule D-1 with an SVO-assigned NAIC designation, are limited time exceptions that extend only to October 1, 2021. The exceptions provided in this INT shall not be interpreted to indicate the likely conclusion of the Working Group in determining the appropriate reporting schedule for nonconforming CTLs. All reporting entities shall be prepared to make adjustments to comply with the reporting schedule utilized for nonconforming CTLs upon final conclusion by the Working Group.

INT 20-10 Status

6. On November 18, 2020, the Statutory Accounting Principles (E) Working Group exposed this interpretation to provide a limited-time exception on the reporting of nonconforming CTLs. On December 18, 2020, the Working Group exposed revisions to this interpretation to allow continued D-1 reporting of nonconforming CTLs if they are filed with the SVO by February 15, 2021. With this provision, nonconforming CTLs reported on Schedule D-1 that have not received an SVO-assigned designation shall be disclosed in Note 1 as if a permitted practice. On December 28, 2020, the Working Group finalized action, via evote, to adopt the interpretation exposed December 18, 2020.

7. On December 11, 2021, the Statutory Accounting Principles (E) Working Group explicitly nullified this interpretation due to actions taken in July 2021 by the Valuation of Securities (E) Task Force, which amended the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to define that credit tenant loans are specific to mortgage loans in scope of SSAP No. 37—Mortgage Loans. In addition, the edits to the P&P Manual clarify that security structures shall be assessed for accounting and reporting guidance in accordance with the provisions in SSAP No. 26R—Bonds and SSAP No. 43R—Loan-Backed and Structured Securities, thus the reporting exceptions provided in this INT were no longer required. The action to nullify occurred subsequent to the expiration date, but was done explicitly for historical documentation purposes.

7.8. No further discussion is planned.
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: SSAP No. 43R – Credit Tenant Loans - Scope

Check (applicable entity):

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Description of Issue: On July 15, 2021, the Valuation of Securities (E) Task Force adopted revisions to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to clarify that the definition of a credit tenant loan (CTL), which defines CTLs as mortgage loans, is specific to “mortgage loans in scope of SSAP No. 37.” This limited amendment to the P&P Manual was suggested by the chair and vice chair of the Statutory Accounting Principles (E) Working Group to clarify that the application of the structural assessment to identify CTLs is limited to direct mortgage loans and relates to the potential reclassification of investments from Schedule B (Mortgage Loans) to Schedule D (Bonds) for qualifying investments. The amendment also clarifies that security structures, which are excluded from SSAP No. 37, are not subject to the P&P Manual CTL structural assessments and should be captured for accounting and reporting in accordance with the applicable SSAP within the NAIC Accounting Practices and Procedures Manual. With this Task Force discussion, it was highlighted that there is a current Working Group project to define principal concepts for bond reporting.

With the adoption of the Task Force guidance, NAIC staff has assessed whether INT 20-10: Reporting Nonconforming CTLs should be nullified and whether other revisions should be incorporated into SSAP No. 43R prior to the adoption of guidance in advance of the principle-based bond proposal project.

Review of INT 20-10:
INT 20-10 was adopted Dec. 28, 2020, to provide reporting exceptions for year-end 2020. This interpretation permitted continued reporting on Schedule D for nonconforming CTLs (and other structures which met the characteristics of a CTL) if they had been filed for an SVO-assigned designation by Feb. 15, 2021. Although an SVO-assigned designation was not required to be received before filing the statutory financial statements, reporting entities were required to disclose the nonconforming CTLs captured on Schedule D with a CRP rating in Note 1. Once the SVO-assigned designation was received, then the reporting entity would begin reporting the SVO-assigned designation (instead of the CRP rating) and the Note 1 disclosure would no longer be required. This interpretation also clarified that there would be no requirement to move investments to Schedule D (and file them with the SVO) if they had previously been reported on a different schedule (such as Schedule B or Schedule BA). This interpretation was set to expire Oct. 1, 2021. This limited effective date was set to allow for further review and consideration of these structures prior to year-end 2021 reporting.

Assessment of INT 20-10:
With the adoption of the Task Force edits, which clarify that security structures shall be assessed for accounting and reporting in accordance with the provisions in SSAP No. 26R and SSAP No. 43R, NAIC staff does not believe there is a need to retain INT 20-10 as the reporting exception provided within would no longer be necessary for security structures. (The identification of nonconforming CTLs as of year-end 2020 solely encompassed security structures with underlying real estate risk and did not include any direct mortgage loans that had been reclassified from Schedule B to Schedule D without meeting the SVO structural analysis.) With the nullification of INT 20-10 and Task Force clarifications, only direct mortgage loans would be assessed for reclassification from mortgage
loans to bonds under the CTL structural provisions. With the limited focus on these specific structures, there is no perceived need to reconsider the current structural provisions that need to be met (namely the 5% residual risk threshold) for those investments to be reclassified from mortgage loans to bonds. With the nullification of INT 20-10, the following guidance would be applicable:

- Mortgage loans in scope of SSAP No. 37 will continue past practice, with reporting entities having the ability to file the structures with the SVO for a structural assessment to determine whether the mortgage loan can be reclassified from Schedule B to Schedule D as a CTL.

- Security structures that have underlying real estate risk, whether they are referred to as CTLs or by another named (e.g., lease-backed securities) that qualify in scope of SSAP No. 26R—Bonds or SSAP No. 43R—Loan-Backed and Structured Securities shall follow the accounting and reporting provisions of those SSAPs. Investments that qualify within these SSAPs are reported on Schedule D-1: Long-Term Bonds. This is consistent with past intent of the SSAPs as the highest level of the statutory hierarchy (pursuant to Section V – Statutory Hierarchy of the Preamble to the AP&P Manual) as well as guidance in the NAIC Policy Statement on Coordination of the AP&P Manual and the P&P Manual. Per that guidance, obtaining an NAIC designation does not change in investment’s applicable SSAP, annual or quarterly statement reporting schedule or override other SSAP guidance required for an investment to be an admitted asset. That guidance identifies that there are limited instances in which a SSAP specifically identifies within its scope, the inclusion of specific SVO-Identified investments based on structural assessments (such as SVO-Identified Bond ETFs in scope of SSAP No. 26R). However, that guidance is specific to the inclusion of qualifying investments into the scope of a specific SSAP and does not provide the ability to remove investments from a specific SSAP that qualify under the SSAP’s scope provisions.

**Assessment of SSAP No. 43R:**
NAIC staff has recognized that the scope guidance of SSAP No. 43R does not name mortgage loans that qualify as CTLs after an SVO structural assessment. Furthermore, it has been identified that there are examples of securities in paragraph 27.b that have been cited as structures that are in scope of SSAP No. 43R. Paragraph 27 is not a scope paragraph but is in the section of the SSAP that addresses determination of the designation based on whether the investment is subject to the financial modeling guidance. (The original source of these examples were in a paragraph that identified investments that would not be financially modeled or that did not receive CRP ratings subject to the “modified filing exempt” provisions. Since the “MFE” concept was removed in 2020, SSAP No. 43 investments are either financially modeled or captured as an “all other loan-backed or structured security.”) With the removal of the MFE guidance, paragraph 27.b is now applicable to all securities not subject to financial modeling, but these examples are still included. (Note: **NAIC staff has an impression that there could be industry concern with removing these examples as it will cause questions on whether they can be reported in scope of SSAP No. 43R.**)

Although there is current “bond project” to establish principal concepts in determining whether an investment qualifies as a bond, the finalization and implementation of that project is expected to take time to complete. To address immediate issues with regards to clarifying the reporting of mortgage loan CTLs and other securities, NAIC staff proposes nonsubstantive revisions to remove the examples from paragraph 27.b and explicitly incorporate applicable provisions in the scope paragraphs of SSAP No. 43R.

**Existing Authoritative Literature:**

1. This statement establishes statutory accounting principles for investments in loan-backed securities, structured securities and mortgage-referenced securities. In accordance with SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, retained beneficial interests from the sale of loan-backed securities and structured securities are accounted for in accordance with this statement. Items captured in scope of this statement are collectively referred to as loan-backed securities.
Designation Guidance

27. For RMBS/CMBS securities within the scope of this statement, the initial NAIC designation used to determine the carrying value method and the final NAIC designation for reporting purposes is determined using a multi-step process. The P&P Manual provides detailed guidance. A general description of the processes is as follows:

a. Financial Modeling: Pursuant to the P&P Manual, the NAIC identifies select securities where financial modeling must be used to determine the NAIC designation. NAIC designation based on financial modeling incorporates the insurers’ carrying value for the security. For those securities that are financially modeled, the insurer must use NAIC CUSIP specific modeled breakpoints provided by the modelers in determining initial and final designation for these identified securities. As specified in the P&P Manual, securities where modeling results in zero expected loss in all scenarios and that would be equivalent to an NAIC designation and NAIC designation category of NAIC 1 and NAIC 1.A. respectively, if the filing exemption process in the P&P Manual was applied, are automatically considered to have a final NAIC designation of NAIC 1 and NAIC designation category of NAIC 1.A., regardless of the carrying value. The three-step process for modeled securities is as follows:

i. Step 1: Determine Initial Designation – The current amortized cost (divided by remaining par amount) of a loan-backed or structured security is compared to the modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP to establish the initial NAIC designation.

ii. Step 2: Determine Carrying Value Method – The carrying value method, either the amortized cost method or the lower of amortized cost or fair value method, is then determined as described in paragraph 26 based upon the initial NAIC designation from Step 1.

iii. Step 3: Determine Final Designation – The final NAIC designation is determined by comparing the carrying value (divided by remaining par amount) of a security (based on paragraph 27.a.ii.) to the NAIC CUSIP specific modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP. The final designation is mapped to an NAIC designation category according to the instructions in the P&P Manual. This final NAIC designation shall be applicable for statutory accounting and reporting purposes and the NAIC designation category will be used for investment schedule reporting and establishing RBC and AVR charges. The final NAIC designation is not used for establishing the appropriate carrying value method in Step 2 (paragraph 27.a.ii.).

b. All Other Loan-Backed and Structured Securities: For securities not subject to paragraph 27.a. (financial modeling) follow the established designation procedures according to the appropriate section of the P&P Manual. The NAIC designation shall be applicable for statutory accounting and reporting purposes (including determining the carrying value method and establishing the AVR charges). The carrying value method is established as described in paragraph 26. Examples of these securities include, but are not limited to equipment trust certificates, credit tenant loans (CTL), 5*/6* securities, interest only (IO) securities, securities with CRP ratings (excluding RMBS/CMBS), loan-backed and structured securities, and mortgage-referenced securities with SVO assigned NAIC designations.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): Previous activity was summarized above, in the ‘Description of Issue’ section. A prior agenda item 2020-24: Accounting and Reporting of Credit Tenant Loans in response to a Task Force referral was also developed
Information or issues (included in Description of Issue) not previously contemplated by the Working Group:
None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and take the following action:

1) Nullify INT 20-10 as no longer applicable. (If preferred, rather than nullifying immediately, this INT could continue and expire automatically on Oct. 1, 2021, without consideration of further extension.)

2) Dispose agenda item 2020-24: Accounting and Reporting of Credit Tenant Loans without statutory revisions. This agenda item had two exposures regarding CTLs prior to the development of INT 20-10 and the SVO adoption that clarified the definition of CTLs.

3) Expose revisions to SSAP No. 43R—Loan-Backed and Structured Securities to explicitly identify the SVO-Identified CTLs in scope of SSAP No. 43R. These revisions also propose to delete the examples of “other LBSS” in paragraph 27.b. If there are concerns that this deletion inadvertently removes any specific investment from the scope of SSAP No. 43R, those comments are requested to be shared during the exposure period.

It is noted that these modifications are intended to simply clarify current guidance prior to the adoption of bond proposal.

Proposed edits to SSAP No. 43R:

1. This statement establishes statutory accounting principles for investments in loan-backed securities, structured securities and mortgage-referenced securities. In accordance with SSAP No. 103R—Transfers and Servicing of Financial Assets and Extinguishments of Liabilities, retained beneficial interests from the sale of loan-backed securities and structured securities are accounted for in accordance with this statement.

In addition, mortgage loans in scope of SSAP No. 37 that qualify under a SVO structural assessment are in scope of this statement as credit tenant loans (CTLs). Items captured in scope of this statement are collectively referred to as loan-backed securities

Designation Guidance

27. For RMBS/CMBS securities within the scope of this statement, the initial NAIC designation used to determine the carrying value method and the final NAIC designation for reporting purposes is determined using a multi-step process. The P&P Manual provides detailed guidance. A general description of the processes is as follows:

a. Financial Modeling: Pursuant to the P&P Manual, the NAIC identifies select securities where financial modeling must be used to determine the NAIC designation. NAIC designation based on financial modeling incorporates the insurers’ carrying value for the security. For those securities that are financially modeled, the insurer must use NAIC CUSIP specific modeled breakpoints provided by the modelers in determining initial and final designation for these identified securities. As specified in the P&P Manual, securities where modeling results in zero expected loss in all scenarios and that would be equivalent to an NAIC designation and NAIC designation category of NAIC 1 and NAIC 1.A., respectively, if the filing exemption process in the P&P Manual was applied, are automatically considered to have a final NAIC designation of NAIC 1 and NAIC designation category of NAIC 1.A., regardless of the carrying value. The three-step process for modeled securities is as follows:
i. Step 1: Determine Initial Designation – The current amortized cost (divided by remaining par amount) of a loan-backed or structured security is compared to the modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP to establish the initial NAIC designation.

ii. Step 2: Determine Carrying Value Method – The carrying value method, either the amortized cost method or the lower of amortized cost or fair value method, is then determined as described in paragraph 26 based upon the initial NAIC designation from Step 1.

iii. Step 3: Determine Final Designation – The final NAIC designation is determined by comparing the carrying value (divided by remaining par amount) of a security (based on paragraph 27.a.ii.) to the NAIC CUSIP specific modeled breakpoint values assigned to the six (6) NAIC designations for each CUSIP. The final designation is mapped to an NAIC designation category according to the instructions in the P&P Manual. This final NAIC designation shall be applicable for statutory accounting and reporting purposes and the NAIC designation category will be used for investment schedule reporting and establishing RBC and AVR charges. The final NAIC designation is not used for establishing the appropriate carrying value method in Step 2 (paragraph 27.a.ii.).

b. All Other Loan-Backed and Structured Securities: For securities not subject to paragraph 27.a. (financial modeling) follow the established designation procedures according to the appropriate section of the P&P Manual. The NAIC designation shall be applicable for statutory accounting and reporting purposes (including determining the carrying value method and establishing the AVR charges). The carrying value method is established as described in paragraph 26. Examples of these securities include, but are not limited to equipment trust certificates, credit tenant loans (CTL), 5*/6* securities, interest only (IO) securities, securities with CRP ratings (excluding RMBS/CMBS), loan-backed and structured securities, and mortgage-referenced securities with SVO assigned NAIC designations.

Staff Review Completed by: Julie Gann, NAIC Staff – July 2021

Status:
On August 26, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed the following:

1. Revisions to SSAP No. 43R—Loan-Backed and Structured Securities, as illustrated above, to explicitly identify the SVO-Identified CTLs are in scope of SSAP No. 43R. These revisions also propose to delete the examples of “other loan-backed and structured securities” in paragraph 27.b. Comments are requested if this deletion is perceived to remove investments from the scope of SSAP No. 43R.

2. Request for comment on the Working Group’s intent to nullify INT 20-10. (This INT nullifies automatically on Oct. 1, 2021, but it is anticipated that the explicit nullification will identify the revisions adopted by the VOSTF for historical reference.)

3. Disposal of agenda item 2020-24: Accounting and Reporting of Credit Tenant Loans without statutory revisions. This was the agenda item in response to the initial VOSTF referral and is no longer applicable with the adopted Task Force edits to clarify that CTLs are mortgage loans in scope of SSAP No. 37.

On December 11, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to SSAP No. 43R—Loan-Backed and Structured Securities, as illustrated above. The revisions 1) identify
that SVO-Identified credit tenant loans are in scope of SSAP No. 43R, and 2) delete various example references of “other loan-backed and structured securities” in paragraph 27.b. In addition, the Working Group nullified INT 20-10: Reporting Nonconforming CTLs and disposed agenda item 2020-24: Accounting and Reporting of Credit Tenant Loans without statutory revisions.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/Fall 2021/TF/App/SAP/Minutes/Att One-H_21-11_SSAP No. 43R_CTL_2021.docx
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: SSAP No. 30R – FHLB Disclosure – Blanks Referral

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Description of Issue: SSAP No. 30R—Unaffiliated Common Stock directs the accounting and reporting of capital stock held in Federal Home Loan Banks (FHLB). As holding capital stock in a FHLB is a requirement for FHLB borrowing, the disclosure requirement for said borrowings is also detailed in SSAP No. 30R - regardless of if the reporting entity classifies the borrowings as debt pursuant to SSAP No. 15—Debt and Holding Company Obligations or as a funding agreement per SSAP No. 52—Deposit-Type Contracts. (Note: if the debt is classified as a funding agreement, SSAP No. 52 directs reporting entities to SSAP No. 30 for applicable disclosure requirements).

If the debt is classified as a funding agreement within the scope of SSAP No. 52, its applicable activity is reported in Exhibit 7 – Deposit-Type Contracts. However, Exhibit 7 includes columnar reporting of various deposit-type contracts, including guaranteed interest contracts (GIC), annuities certain, supplemental contracts, etc. Due to the varied nature of reporting based on policy forms, FHLB borrowings classified as a deposit-type contract and reported on Exhibit 7 are not readily identifiable to financial statement users. While statutory accounting revisions are not proposed, this agenda item has been drafted to document a referral to the Blanks (E) Working Group regarding the specific identification of FHLB borrowings, which have been classified as funding agreements reported on Exhibit 7.

Existing Authoritative Literature: All applicable SSAP No. 30R references for the accounting and reporting of FHLB capital stock as well as the disclosure requirements of FHLB borrowings have been included in this section. Please note that for brevity, applicable footnotes have not been included.

FHLB Capital Stock

14. FHLB capital stock is held by reporting entities that are members of an FHLB. Each reporting entity must acquire FHLB capital stock for membership and maintain capital stock holding sufficient to support its business activity (borrowings) in accordance with the respective FHLB’s capital plan. The price of FHLB capital stock cannot fluctuate, and all FHLB capital stock must be purchased, repurchased or transferred at its par value. FHLB capital stock is restricted for redemption in accordance with the FHLB capital plan and shall be coded as restricted within the financial statements (e.g., investment schedules and general interrogatories).

15. Acquisition of FHLB capital stock allows members to conduct business activity (borrowings) from an FHLB. The amount of capital stock acquired determines the reporting entity’s eligible borrowing amount. At a minimum, all borrowings from an FHLB (regardless of structure) must also be fully collateralized in accordance with the FHLB capital plan, which determines the amount of collateral required by type of pledged instrument. Collateral pledged to an FHLB shall be coded as restricted within the financial statements (e.g., investments schedules and general interrogatories). Collateral pledged to
an FHLB by a reporting entity FHLB member is considered an admitted asset if all of the conditions in paragraphs 15.a. through 15.d. are met:

a. The asset would have been admitted under SSAP No. 4;

b. The pledging insurer continues to receive the income on the pledged collateral;

c. The pledging insurer can remove and substitute other securities with little or advance notice to the FHLB as long as the insurer complies with related investment quality and market value provisions; and

d. There has been no uncured default or event to indicate an impairment or loss contingency for the pledged assets.

16. The guidance in paragraph 14 and paragraph 15 is specific for reporting entities that are FHLB members. A reporting entity that engages with an FHLB through an “affiliate arrangement” (meaning an affiliate of the reporting entity is the FHLB member), is not considered an FHLB member. In those situations, any FHLB capital stock held by the non-FHLB member reporting entity or collateral pledged to an FHLB on behalf of an affiliate shall be nonadmitted. Detail of the affiliate FHLB arrangement, including any collateral pledged or funds received, shall be captured as a related party transaction (as if the activity occurred directly with the affiliate) under the provisions of SSAP No. 25—Affiliates and Other Related Parties.

FHLB Disclosures

18. For reporting entity FHLB members, the following information shall be disclosed in the financial statements for current and prior year and between general account and separate account activity. The information in the disclosures shall be presented gross even if a right to offset exists per SSAP No. 64—Offsetting and Netting of Assets and Liabilities.

a. General description of FHLB agreements, with information on the nature of the agreement, type of borrowing (advances, lines of credit, borrowed money, etc.) and use of the funding.

b. Amount of FHLB capital stock held, in aggregate, and classified as follows: i) membership stock (separated by Class A and Class B); ii) Activity Stock; and iii) Excess Stock. For membership stock, report the amount of FHLB capital stock eligible for redemption and the anticipated timeframe for redemption: i) less than 6 months, ii) 6 months to 1 year, iii) 1 year to 3 years, and iv) 3 to 5 years.

c. Amount (fair value and carrying value) of collateral pledged to the FHLB as of the reporting date. In addition, report the maximum amount of collateral pledged to the FHLB at any time during the current reporting period. (Maximum shall be determined on the basis of carrying value, but with fair value also reported)

d. Aggregate amount of borrowings at the reporting date from the FHLB, reflecting compilation of all advances, loans, funding agreements, repurchase agreements, securities lending, etc., outstanding with the FHLB, and classify whether the borrowing is in substance: i) debt (SSAP No. 15—Debt and Holding Company Obligations), ii) a funding agreement (SSAP No. 52—Deposit-Type Contracts), or iii) Other. For funding agreements, report the total reserves established. Report the maximum amount of aggregate borrowings from an FHLB at any time during the current reporting period, the actual or estimated maximum borrowing capacity as determined by the insurer, with a description of how the borrowing capacity was determined, and whether current borrowings are subject to prepayment penalties.
19. The disclosures in paragraphs 17.c. through 17.f. shall be included in the annual audited statutory financial reports only. The FHLB disclosures in paragraph 18 are required in all interim and annual financial statements regardless if the activity is materially different from the activity reported during the prior reporting period. Refer to the Preamble for further discussion regarding disclosure requirements.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
NAIC staff recommends that the Working Group forward a proposal to the Blanks (E) Working Group to supplement the identification of FHLB borrowings that are classified as a deposit-type contract and reported on Exhibit 7 - Deposit-Type Contracts. The supplemental data to be captured is consistent with current requirements in SSAP No. 30R—Unaffiliated Common Stock, however this improved reporting granularity will significantly assist financial statement users with the ability to identify FHLB borrowings captured in Exhibit 7. The proposed additions to Exhibit 7 are shown below.

ANNUAL STATEMENT BLANK – LIFE/FRATERNAL AND HEALTH (LIFE SUPPLEMENT)

EXHIBIT 7 – DEPOSIT-TYPE CONTRACTS

<table>
<thead>
<tr>
<th>Description of Issue</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tbody>
<tr>
<td>Total</td>
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<tr>
<td>1. Balance at the beginning of the year before reinsurance</td>
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<td>2. Deposits received during the year</td>
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<td>3. Investment earnings credited to the account</td>
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<td>4. Other net change in reserves</td>
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<td></td>
<td></td>
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<tr>
<td>5. Fees and other charges assessed</td>
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<td>6. Surrender charges</td>
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<td>7. Net surrender or withdrawal payments</td>
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<tr>
<td>8. Other net transfers to or (from) Separate Accounts</td>
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<tr>
<td>9. Balance at the end of current year before reinsurance (a) (Lines 1+2+3+4+5+6-7-8)</td>
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<tr>
<td>10. Reinsurance balance at the beginning of the year</td>
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<tr>
<td>11. Net change in reinsurance assumed</td>
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<tr>
<td>12. Net change in reinsurance ceded</td>
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<td>13. Reinsurance balance at the end of the year (Lines 10+11-12)</td>
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<tr>
<td>14. Net balance at the end of current year after reinsurance (Lines 9+13)</td>
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</tr>
</tbody>
</table>

(a) FHLB Funding Agreements

1. Reported as a GICs (captured in column 2): ................................................................. $  
2. Reported as an Annuities Certain (captured in column 3): ........................................ $  
3. Reported as Supplemental Contracts (captured in column 4): .................................. $  
4. Reported as Dividend Accumulations or Refunds (captured in column 5):................ $  
5. Issued as Premium or Other Deposit Funds (captured in column 6): .......................... $  
6. Total Issued as Deposit-Type Contracts (captured in column 1): (Sum of Lines 1 through 6)........ $  

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Staff Review Completed by: Jim Pinegar, NAIC Staff – October 2021

Status:
On October 25, 2021, in response to an e-vote to expose, the Statutory Accounting Principles (E) Working Group exposed this agenda item for public comment. This agenda item does not propose statutory accounting revisions, however resulted in a referral to the Blanks (E) Working Group to include a supplemental data capture footnote for FHLB borrowings that are classified as a deposit-type contract and reported on Exhibit 7 – Deposit-Type Contracts.

On December 11, 2021, the Statutory Accounting Principles (E) Working Group adopted this agenda item, which did not result in statutory accounting revisions, however the adoption expressed support of the corresponding Blanks (E) Working Group agenda item (2021-15BWG). The blanks agenda item includes a supplemental data capture footnote for FHLB borrowings that are classified as a deposit-type contract and reported on Exhibit 7 – Deposit-Type Contracts.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/Fall 2021/TF/App/SAP/Minutes/Att One-I_21-16_SSAP No. 30R_FHLB Disclosure_Blanks Referral.docx
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: SSAP No. 32R – Permitted Valuation Methods

Check (applicable entity):

<table>
<thead>
<tr>
<th>Modification of Existing SSAP</th>
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<th>Health</th>
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Description of Issue: This agenda item’s primary purpose is to propose minor revisions to SSAP No. 32R to clarify the applicable measurement methods for preferred stock. For a brief historical context, in July 2020, the Working Group adopted Issue Paper No. 164—Preferred Stock and substantively revised SSAP No. 32R—Preferred Stock. The substantively revised SSAP No. 32R was effective January 1, 2021, however in October 2020, agenda item 2020-31, permitted early application of the newly revised standard.

As described in Issue Paper No. 164, paragraph 17, the historical guidance in SSAP No. 32 captured different accounting and reporting provisions based on whether the preferred stock was classified as redeemable or perpetual, and whether the reporting entity maintained an Asset Valuation Reserve. Although these classifications were still considered appropriate, in 2020, the Statutory Accounting Principles (E) Working Group reviewed the permissible valuation methods for redeemable preferred stock – specifically the prior guidance in SSAP No. 32 that permitted “historical cost” as an applicable measurement method. During the development of SSAP No. 32R, and consistent with prior conclusions from U.S. GAAP, the Working Group concluded that “historical cost” is generally not an acceptable measurement method for this type of instrument. However, during the implementation of SSAP No. 32R, it was discovered that a lingering reference to “cost” being a permissible reporting value remained in the authoritative literature.

This agenda item has been drafted to 1) remove lingering references which indicate that cost is a permissible valuation method, and 2) remove descriptive language regarding redeemable preferred stock to ensure consistency with other identical edits made when SSAP No. 30 was substantively revised.

Existing Authoritative Literature: The primary outstanding reference to “cost” is found in paragraph 11 of SSAP No. 32R - relevant items have been bolded for emphasis.

Balance Sheet Amount

11. Preferred stock shall be valued based on (a) the underlying characteristics (redeemable, perpetual or mandatory convertible), (b) the quality rating expressed as an NAIC designation, and (c) whether an asset valuation reserve (AVR) is maintained by the reporting entity:

a. For reporting entities that do not maintain an AVR:

i. Highest-quality or high-quality redeemable preferred stocks (NAIC designations 1 and 2), which have characteristics of debt securities, shall be valued at cost or amortized cost. All other redeemable preferred stocks (NAIC designations 3 to 6) shall be reported at the lower of cost, amortized cost, or fair value.

ii. Perpetual preferred stock and publicly traded preferred stock warrants shall be reported at fair value, not to exceed any currently effective call price.
ii. Mandatory convertible preferred stocks (regardless if the preferred stock is redeemable or perpetual) shall be reported at fair value, not to exceed any currently effective call price, in the periods prior to conversion. Upon conversion to common stock, these securities shall be in scope of SSAP No. 30R.

iv. For preferred stocks reported at fair value, unrealized gains and losses shall be recorded as a direct credit or charge to unassigned funds (surplus).

b. For reporting entities that maintain an AVR:

i. Highest-quality, high-quality or medium quality redeemable preferred stocks (NAIC designations 1 to 3) shall be valued at amortized cost. All other redeemable preferred stocks (NAIC designations 4 to 6) shall be reported at the lower of amortized cost or fair value.

ii. Perpetual preferred stock and publicly preferred stock warrants shall be valued at fair value, not to exceed any currently effective call price.

iii. Mandatory convertible preferred stocks (regardless if the preferred stock is redeemable or perpetual) shall be reported at fair value, not to exceed any currently effective call price, in the periods prior to conversion. Upon conversion to common stock, these securities shall be in scope of SSAP No. 30R.

iv. For preferred stocks reported at fair value, the accounting for unrealized gains and losses shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): In addition to the previous activity that was summarized in the “Description of Issue” section, in Aug. 2021, the Working Group adopted revisions from agenda item 2021-10: SSAP No. 32R – Clarification of Effective Call Price. Adopted revisions clarified that the “effective call price” valuation limitation for instruments with outstanding call provisions shall only apply if the call is currently exercisable by the issuer or if the issuer has announced that the instrument will be redeemed/called.

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 32R—Preferred Stock to remove lingering references indicating that cost is an allowable valuation method. Note that the additional proposed edits in SSAP No. 32R, paragraph 11.a.i., regarding removing the reference to “characteristics of debt securities” was proposed to ensure consistency with prior approved edits to yield what is now SSAP No. 32R, paragraph 11.b.i.
**Proposed edits to SSAP No. 32R:**

**Balance Sheet Amount**

11. Preferred stock shall be valued based on (a) the underlying characteristics (redeemable, perpetual or mandatory convertible), (b) the quality rating expressed as an NAIC designation, and (c) whether an asset valuation reserve (AVR) is maintained by the reporting entity:

   a. For reporting entities that do not maintain an AVR:
      
      i. Highest-quality or high-quality redeemable preferred stocks (NAIC designations 1 and 2), which have characteristics of debt securities, shall be valued at cost or amortized cost. All other redeemable preferred stocks (NAIC designations 3 to 6) shall be reported at the lower of cost, amortized cost, or fair value.
      
      ii. Perpetual preferred stock and publicly traded preferred stock warrants shall be reported at fair value, not to exceed any currently effective call price.
      
      iii. Mandatory convertible preferred stocks (regardless if the preferred stock is redeemable or perpetual) shall be reported at fair value, not to exceed any currently effective call price, in the periods prior to conversion. Upon conversion to common stock, these securities shall be in scope of SSAP No. 30R.
      
      iv. For preferred stocks reported at fair value, unrealized gains and losses shall be recorded as a direct credit or charge to unassigned funds (surplus)

   b. For reporting entities that maintain an AVR:
      
      i. Highest-quality, high-quality or medium quality redeemable preferred stocks (NAIC designations 1 to 3) shall be valued at amortized cost. All other redeemable preferred stocks (NAIC designations 4 to 6) shall be reported at the lower of amortized cost or fair value.
      
      ii. Perpetual preferred stock and publicly preferred stock warrants shall be valued at fair value, not to exceed any currently effective call price.
      
      iii. Mandatory convertible preferred stocks (regardless if the preferred stock is redeemable or perpetual) shall be reported at fair value, not to exceed any currently effective call price, in the periods prior to conversion. Upon conversion to common stock, these securities shall be in scope of SSAP No. 30R.
      
      iv. For preferred stocks reported at fair value, the accounting for unrealized gains and losses shall be in accordance with SSAP No. 7—Asset Valuation Reserve and Interest Maintenance Reserve.

**Staff Review Completed by:** Jim Pinegar, NAIC Staff – September 2021

**Status:**

On October 25, 2021, in response to an e-vote to expose, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to SSAP No. 32R—Preferred Stock to remove lingering references which indicate that cost is an allowable valuation method for redeemable preferred stock.
On December 11, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to SSAP No. 32R—Preferred Stock, as illustrated above. The revisions remove lingering references which indicate that cost is an allowable valuation method for redeemable preferred stock. The revisions also included other minor updates to ensure consistent phraseology with prior modifications.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/Fall 2021/TF/App/SAP/Minutes/Att One-J_21-17_SSAP No. 32R_Permitted Valuation Methods.docx
NAIC Accounting Practices and Procedures Manual
Editorial and Maintenance Update
October 25, 2021

Maintenance updates provide revisions to the *Accounting Practices and Procedures Manual* (AP&P Manual), such as editorial corrections, reference changes and formatting.

<table>
<thead>
<tr>
<th>SSAP/Appendix</th>
<th>Description/Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSAP No. 16R</td>
<td>Correct cross paragraph references in paragraphs 11.b and 12.b of SSAP No. 16R – <em>Electronic Data Processing Equipment and Software</em></td>
</tr>
<tr>
<td>SSAP No. 43R</td>
<td>Removes outdated references to guidance which was previously deleted in Oct. 2017 (agenda item 2017-22).</td>
</tr>
</tbody>
</table>

**Recommendation:**
NAIC staff recommend that the Statutory Accounting Principles (E) Working Group move this agenda item to the active listing, categorize as nonsubstantive, and expose editorial revisions as illustrated below.

**Status:**
On October 25, 2021, in response to an e-vote, the Statutory Accounting Principles (E) Working Group exposed the editorial revisions, shown below, for public comment.

On December 11, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed editorial revisions as shown below.

**SSAP No. 16R – Electronic Data Processing Equipment and Software**

11. This statement also adopts with modification the guidance reflected in ASC 350-40 for cloud computing arrangements as modified by ASU 2018-15, *Customer’s Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract* and in this statement. Consistent with U.S. GAAP, the guidance in this statement for cloud computing hosting arrangements varies based on whether the cloud computing arrangement is a service contract:

   a. An arrangement that is not a service contract applies to internal-use software if the 1) reporting entity has the contractual right to take possession of the software at any time during the hosting period without significant penalty; and 2) it is feasible for the reporting entity to either run the software on its own hardware or contract with another party unrelated to the vendor to host the software.

   b. If both conditions in paragraph 11.a. are not met, then the arrangement for internal-use software is considered a service contract.

12. For hosting arrangements that are not service contracts, reporting entities shall account for any internal-use software as follows:

   a. The reporting entity shall recognize an operating or non-operating system software asset for the costs incurred for the software license in accordance with paragraph 3 of this statement. This is a modification from U.S. GAAP in which the asset is recognized as an intangible asset. A liability shall also be recognized if payments for the software license are still required.
b. If the reporting entity has a hosting arrangement that includes both the acquisition of a software asset (pursuant to paragraph 112.a.) and an ongoing hosting arrangement, the reporting entity shall allocate the costs of the arrangement to the different elements. Costs for the ongoing hosting arrangement shall be accounted for in accordance with SSAP No. 22R—Leases.

SSAP No. 43R – Loan-Backed and Structured Securities

31. If the fair value of a loan-backed or structured security is less than its amortized cost basis at the balance sheet date, an entity shall assess whether the impairment is other than temporary. Amortized cost basis includes adjustments made to the cost of an investment for accretion, amortization, collection of cash, previous other-than-temporary impairments recognized as a realized loss (including any cumulative-effect adjustments recognized in accordance with paragraphs 58-60 of this statement).
Statutory Accounting Principles (E) Working Group
Maintenance Agenda Submission Form
Form A

Issue: Policy Statement Terminology Change – Substantive & Nonsubstantive

Check (applicable entity):

<table>
<thead>
<tr>
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</tr>
<tr>
<td>Interpretation</td>
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Description of Issue: Pursuant to the Aug. 14, 2021 referral from the Financial Condition (E) Committee, the discussion involving SSAP No. 71—Policy Acquisition Costs and Commissions, has highlighted that the statutory accounting terminology of “substantive” and “nonsubstantive” to describe statutory accounting revisions being considered by the Statutory Accounting Principles (E) Working Group to the Accounting Practices and Procedures Manual (AP&P Manual) could be misunderstood by users that are not familiar with the specific definitions and intended application of those terms. To avoid the incorrect perception that these terms may reflect the degree of financial impact to companies based on their common usage, the Financial Condition (E) Committee requests that the Statutory Accounting Principles consider updating these terms to prevent future misunderstandings.

Additional Referral Excerpts:

The Financial Condition (E) Committee understands the terms “substantive” and “nonsubstantive” were crafted as part of the statutory accounting principles (SAP) codification, which was finalized in 1998, and were intended to be simple, concise terms to differentiate whether proposed revisions reflect new SAP concepts (substantive) or clarification of existing SAP concepts (nonsubstantive). The source location for the definitions and classification criteria of these terms is the NAIC Policy Statement on Maintenance of Statutory Accounting Principles, but it is noted that the terms and definitions are referred to throughout SAP guidance, other policy statements, issue papers, and agenda items.

The Working Group should consider eliminating “substantive” and “nonsubstantive” and instead refer to the type of revisions in accordance with the general nature in which those terms were intended to reflect. As such a revision that would have previously been considered “substantive” could be referred to as a “New SAP Concept” and a revision that would have previously been considered as “nonsubstantive” could be referred to as a “SAP Clarification.” The Committee is not proposing that the Working Group reassess the classification criteria but is simply requesting terminology changes to prevent future misinterpretations or assessments by others. As such, unless the Working Group believes further revisions are necessary, statutory revisions that would have been previously classified as “nonsubstantive” are anticipated to continue to fall within that definition and be captured under the new terminology as a “SAP Clarification.”

The referral also includes proposed revisions to the NAIC Policy Statement on Maintenance of Statutory Accounting Principles as potential suggestions to incorporate the proposed guidance change. (These proposed edits are shown in the Aug. 26, 2021, proposed edits for exposure.)
Existing Authoritative Literature:

Although the terms “substantive” and “nonsubstantive” are used throughout the AP&P Manual, the source location for the definitions of these terms is the **NAIC Policy Statement on Maintenance of Statutory Accounting Principles**:

**NAIC Policy Statement on Maintenance of Statutory Accounting Principles**

1. Statutory accounting principles (SAP) provide the basis for insurers to prepare financial statements to be filed with and utilized by state insurance departments for financial regulation purposes. Accuracy and completeness of such filings are critical to meaningful solvency monitoring. Accordingly, maintenance of SAP guidance for changes in the industry and changes in regulatory concerns is vital to preserving the usefulness of SAP financial statements.

2. The promulgation of new or revised SAP guidance by the NAIC ultimately requires action of the entire NAIC membership. Responsibility for proposing new or revised SAP guidance will be delegated through the NAIC committee structure to the Accounting Practices and Procedures (E) Task Force (Task Force). The Task Force will charge the Statutory Accounting Principles (E) Working Group (Working Group) with the exclusive responsibility to develop and propose new statements of statutory accounting principles (SSAPs), to revise existing SSAPs, and to issue interpretations.

**Composition of the Statutory Accounting Principles (E) Working Group**

3. The chair of the Task Force shall determine membership of the Working Group subject to approval by the Financial Condition (E) Committee. The Working Group shall be limited in size to no more than 15 members and will include representation from the four zones of the NAIC. Membership shall be vested in the state (until such time as the membership may be changed) but continuity of individuals, to the extent possible, is extremely desirable.

**Development of New or Substantively Revised SSAPs**

4. New SSAPs will be developed to address, but will not be limited to: 1) concepts not previously addressed by a SSAP and that do not fit within the scope of an existing SSAP; 2) concepts that fit within the scope of an existing SSAP, but the Working Group elects to supersede existing SSAPs; and 3) existing concepts that warrant significant revisions. Substantively-revised SSAPs will be developed to address, but will not be limited to: 1) concepts that fit within the accounting topic of an existing SSAP, but have not been addressed by the Working Group; 2) changes to the valuation and/or measurement of an existing SSAP; and 3) modifications to the overall application of existing SSAPs. The decision to undertake development of a new or substantively revised SSAP will rest with the Working Group. New or substantively revised SSAPs will have a specified effective date.

5. Research and drafting of new or substantially revised SSAPs will be performed by NAIC staff under the direction and supervision of the Working Group which may enlist the assistance of interested parties and/or consultants with requisite technical expertise as needed or desired. The first step in developing new and substantially revised SSAPs will commonly be the drafting of an issue paper, which will contain a summary of the issue, a summary conclusion, discussion, and a relevant literature section. Public comments will be solicited on an issue paper (at least one exposure period), and at least one public hearing will be held before the issue paper is converted to a SSAP. Upon approval by the Working Group, all proposed SSAPs will be exposed for public comment for a period commensurate with the length of the draft and the complexities of the issue(s). After a hearing of comments, adoption of new or substantively revised SSAPs (including any amendments from exposure) may be made by simple majority. If no comments are received during the public comment period, the Working Group may adopt the proposal collectively (one motion/vote) with other non-contested positions after the opportunity is given during the hearing to separately discuss the proposal. All new and substantively revised SSAPs must be on the agenda for at least one public hearing before presentation to the Task Force for consideration. Adoption by the Task Force, its parent and the NAIC membership shall be governed by the NAIC bylaws.
6. The Working Group may, by a super majority vote (7 out of 10 members, 8 out of 11 or 12, 9 out of 13, 10 out of 14, and 11 out of 15) elect to: 1) combine the IP and SSAP process, resulting in concurrent exposure of the two documents; 2) expose and adopt revisions to a SSAP prior to the drafting/adoption of the related IP; and/or 3) forego completion of an IP and only proceed with revisions to a substantively revised SSAP.

7. If accounting guidance, reserving standards, asset valuation standards, or any other standards or rules affecting accounting practices and procedures are first developed by other NAIC working groups, task forces, subcommittees, or committees, such proposed guidance, standards or rules shall be presented to the Working Group for consideration. In cases where such guidance has already been subjected to substantial due process (e.g., public comment periods and/or public hearings), the Working Group may elect to shorten comment periods and/or eliminate public hearings, and in such cases, will notify the Task Force of these actions.

Development of Nonsubstantive Revisions to SSAPs

8. Nonsubstantive revisions to SSAP will be developed to address, but will not be limited to: 1) clarification of the intent or application of existing SSAPs; 2) new disclosures and modification of existing disclosures; 3) revisions that do not change the intent of existing guidance; and 4) revisions to Appendix A—Excerpts of NAIC Model Laws to reflect amendments to NAIC adopted model laws and regulations. Research and drafting of nonsubstantive revisions will be performed by NAIC staff under the direction and supervision of the Working Group. Public comment will be solicited on nonsubstantive revisions, and the item will be included on the agenda for at least one public hearing before the Working Group adopts nonsubstantive revisions. Nonsubstantive revisions are considered effective immediately after adoption by the Working Group, unless the Working Group incorporates a specific effective date. If comments are not received during the public comment period, the Working Group may adopt the proposal collectively (one motion/vote) with other “non-contested” positions after opportunity is given during the hearing to separately discuss the proposal. At its discretion, the Working Group may request that an issue paper be drafted for nonsubstantive revisions in order to capture historical discussion and adopted revisions. Adoption of nonsubstantive revisions by the Task Force, its parent and the NAIC membership shall be governed by the NAIC bylaws.

Development of Interpretations to SSAPs and Referencing Interpretations Within SSAPs

Interpretations Which DO NOT Amend, Supersede or Conflict with Existing SSAPs

9. Interpretations may be developed to address issues requiring timely application or clarification of existing SSAP, which shall not amend, supersede or conflict with effective SSAPs. Issues being considered as an interpretation must be discussed at no less than two open meetings. (Original introduction of the issue when the Working Group identifies the intent to address the issue as an “interpretation” during a public discussion is considered the first open meeting discussion.) The process must allow opportunity for interested parties to provide comments, but as interpretations are intended to provide timely responses to questions of application or interpretation and clarification of guidance, no minimum exposure timeframe is required.

10. As these interpretations do not amend, supersede or conflict with existing SSAP guidance, the interpretation is effective upon Working Group adoption unless specifically stated otherwise. The voting requirement to adopt an interpretation of this type is a simple majority. The Working Group shall report the adopted interpretation to the Accounting Practices and Procedures (E) Task Force as part of its public report during the next NAIC national meeting (or earlier if applicable). Interpretations can be overturned, amended or deferred by a two-thirds majority of the Task Force membership. For clarification, a two-thirds majority of the Task Force requires two-thirds of the entire Task Force membership, not just those electing to vote. Additionally, interpretations can be overturned, amended, deferred, or referred to either the Task Force and/or the Working Group by a simple majority of the Financial Condition (E) Committee.
Interpretations Which Amend, Supersede or Conflict with Existing SSAPs

11. In certain circumstances such as catastrophes and other time-sensitive issues requiring immediate, temporary statutory accounting guidance, the Working Group may adopt an interpretation which creates new SAP or conflicts with existing SSAPs. Historically, these interpretations temporarily modified statutory accounting principles and/or specific disclosures were developed in response to nationally significant events (e.g., Hurricane Sandy, September 11, 2001). (Examples of time-sensitive issues that have previously provided INT exceptions to SAP include the transition from LIBOR and special situations such as the federal TALF program.) Interpretations that conflict with existing SSAPs shall be temporary and restricted to circumstances arising from the need to issue guidance for circumstances requiring immediate guidance. In order to adopt an interpretation that creates new SAP or conflicts with existing SSAPs, the Working Group must have 67% of its members voting (10 out of 15 members) with a super majority (7 out of 10, 8 out of 11 or 12, 9 out of 13, 10 out of 14, or 11 out of 15) supporting adoption.

   a. These interpretations are effective upon Working Group adoption, unless stated otherwise, and shall be reported to the Accounting Practices and Procedures (E) Task Force as part of its public report during the next NAIC national meeting (or earlier if applicable). In circumstances where the Working Group adopts an interpretation (which creates new SAP or conflicts with existing SSAPs) that is controversial in nature (i.e., due to regulator or industry feedback or could have a policy level impact), the Working Group may elect to postpone the effective date until the item has been discussed by the Task Force and the Financial Condition (E) Committee and both have had an opportunity to review the interpretation.

   b. These interpretations can be overturned, amended or deferred by a two-thirds majority of the Task Force membership. For clarification, a two-thirds majority of the Task Force requires two-thirds of the entire Task Force membership, not just those electing to vote. Additionally, interpretations can be overturned, amended, deferred, or referred to either the Task Force and/or the Working Group by a simple majority of the Financial Condition (E) Committee.

12. As new SSAPs are developed, it is essential to review and, if necessary, update the status of interpretations related to SSAPs that are being replaced and/or new SSAPs being developed. The following options are available to the Working Group when a SSAP with existing interpretations is replaced:

   a. Interpretation of the new SSAP - If the Working Group would like to maintain the interpretation, the new SSAP can be added to the list of statements interpreted by the interpretation. In addition, the status section of the new SSAP will list the interpretation number next to the heading “Interpreted by.”

   b. Nullification - When an interpretation is nullified by a subsequent SSAP or superseded by another interpretation, the interpretation is deemed no longer technically helpful, is shaded and moved to Appendix H (Superseded SSAPs and Nullified Interpretations), and the reason for the change is noted beneath the interpretation title. The status section of the SSAP describes the impact of the new guidance and the effect on the interpretation (for example, nullifies, incorporated in the new SSAP with paragraph reference, etc.).

   c. Incorporation - When an interpretation is incorporated into a new SSAP, the Working Group can choose from the following two options:

      i. If the interpretation only interprets one SSAP, then the interpretation is listed as being nullified under the “affects” section of the SSAP and is not referenced under the “interpreted by” section of the status page of the SSAP.
ii. If the interpretation references additional SSAPs, and the Working Group intends to maintain the guidance, the interpretation is unchanged (no nullification). The new SSAP (Summary of Issue section) reflects that the interpretation issue has been incorporated into the new statement.

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None

Information or issues (included in Description of Issue) not previously contemplated by the Working Group: None

Convergence with International Financial Reporting Standards (IFRS): N/A

Staff Recommendation:
NAIC staff recommends that the Working Group move this item to the active listing and expose revisions to the NAIC Policy Statement on Maintenance of Statutory Accounting Principles, as suggested by the Financial Condition (E) Committee in their Aug. 14, 2021, referral, to alter the terminology used when discussing types of statutory accounting revisions.

Due to the extent that these terms are currently used throughout the AP&P Manual, upon adoption of this terminology change, NAIC staff will utilize the new terminology on a go-forward basis. These updates will be limited to the guidance that describes the use of these terms and will not capture previously adopted SSAPs, issue papers or agenda items. The terms used in previously adopted guidance will remain, with the new terms being used prospectively when considering future revisions to statutory accounting.


NAIC Policy Statement on Maintenance of Statutory Accounting Principles

1. Statutory accounting principles (SAP) provide the basis for insurers to prepare financial statements to be filed with and utilized by state insurance departments for financial regulation purposes. Accuracy and completeness of such filings are critical to meaningful solvency monitoring. Accordingly, maintenance of SAP guidance for changes in the industry and changes in regulatory concerns is vital to preserving the usefulness of SAP financial statements.

2. The promulgation of new or revised SAP guidance by the NAIC ultimately requires action of the entire NAIC membership. Responsibility for proposing new or revised SAP guidance will be delegated through the NAIC committee structure to the Accounting Practices and Procedures (E) Task Force (Task Force). The Task Force will charge the Statutory Accounting Principles (E) Working Group (Working Group) with the exclusive responsibility to develop and propose new statements of statutory accounting principles (SSAPs), to revise existing SSAPs, and to issue interpretations.

Composition of the Statutory Accounting Principles (E) Working Group

3. The chair of the Task Force shall determine membership of the Working Group subject to approval by the Financial Condition (E) Committee. The Working Group shall be limited in size to no more than 15 members and will include representation from the four zones of the NAIC. Membership shall be vested in the state (until such time as the membership may be changed) but continuity of individuals, to the extent possible, is extremely desirable.
Development of New **SSAPs** or **New SAP Concepts** in an Existing SSAP

### Development of New SSAPs or New SAP Concepts in an Existing SSAP

4. New SSAPs will be developed to address, but will not be limited to: 1) concepts not previously addressed by a SSAP and that do not fit within the scope of an existing SSAP; 2) concepts that fit within the scope of an existing SSAP, but the Working Group elects to supersede existing SSAPs and 3) existing concepts that warrant significant revisions. Substantively revised New SAP concepts to existing SSAPs will be developed to address, but will not be limited to: 1) concepts that fit within the accounting topic of an existing SSAP, but have not been addressed by the Working Group; 2) changes to the valuation and/or measurement of an existing SSAP; and 3) modifications to the overall application of existing SSAPs. The decision to undertake development of a new SSAP or substantively a new SAP concept in an existing revised SSAP will rest with the Working Group. New SSAPs or substantively new SAP concept in an existing revised SSAPs will have a specified effective date.

5. Research and drafting of a new SSAP or substantially a new SAP concept in an existing revised SSAP will be performed by NAIC staff under the direction and supervision of the Working Group which may enlist the assistance of interested parties and/or consultants with requisite technical expertise as needed or desired. The first step in developing new SSAPs and substantively new SAP concepts in existing revised SSAPs will commonly be the drafting of an issue paper, which will contain a summary of the issue, a summary conclusion, discussion, and a relevant literature section. Public comments will be solicited on an issue paper (at least one exposure period), and at least one public hearing will be held before the issue paper is converted to a SSAP. Upon approval by the Working Group, all proposed SSAPs will be exposed for public comment for a period commensurate with the length of the draft and the complexities of the issue(s). After a hearing of comments, adoption of new SSAPs or new SAP concepts in existing substantially revised SSAPs (including any amendments from exposure) may be made by simple majority. If no comments are received during the public comment period, the Working Group may adopt the proposal collectively (one motion/vote) with other non-contested positions after the opportunity is given during the hearing to separately discuss the proposal. All new SSAPs and substantively revised new SAP concepts in existing SSAPs must be on the agenda for at least one public hearing before presentation to the Task Force for consideration. Adoption by the Task Force, its parent and the NAIC membership shall be governed by the NAIC bylaws.

6. The Working Group may, by a super majority vote (7 out of 10 members, 8 out of 11 or 12, 9 out of 13, 10 out of 14, and 11 out of 15) elect to: 1) combine the IP and SSAP process, resulting in concurrent exposure of the two documents; 2) expose and adopt revisions to a SSAP prior to the drafting/adoption of the related IP; and/or 3) forego completion of an IP and only proceed with a new SSAP or new SAP concepts in an existing revisions to a substantially revised SSAP.

7. If accounting guidance, reserving standards, asset valuation standards, or any other standards or rules affecting accounting practices and procedures are first developed by other NAIC working groups, task forces, subcommittees, or committees, such proposed guidance, standards or rules shall be presented to the Working Group for consideration. In cases where such guidance has already been subjected to substantial due process (e.g., public comment periods and/or public hearings), the Working Group may elect to shorten comment periods and/or eliminate public hearings, and in such cases, will notify the Task Force of these actions.

### Development of SAP Clarifications Nonsubstantive Revisions to SSAPs

8. **SAP clarifications** Nonsubstantive revisions to SAP will be developed to address, but will not be limited to: 1) clarification of the intent or application of existing SSAPs; 2) new disclosures and modification of existing disclosures; 3) revisions that do not change the intent of existing guidance; and 4) revisions to Appendix A—Excerpts of NAIC Model Laws to reflect amendments to NAIC adopted model laws and regulations. Research and drafting of SAP clarification nonsubstantive revisions will be performed by NAIC staff under the direction and supervision of the Working Group. Public comment will be solicited on
nonsubstantive these revisions, and the item will be included on the agenda for at least one public hearing before the Working Group adopts nonsubstantive revisions. Nonsubstantive SAP clarification revisions are considered effective immediately after adoption by the Working Group, unless the Working Group incorporates a specific effective date. If comments are not received during the public comment period, the Working Group may adopt the proposal collectively (one motion/vote) with other “non-contested” positions after opportunity is given during the hearing to separately discuss the proposal. At its discretion, the Working Group may request that an issue paper be drafted for nonsubstantive SAP clarification revisions in order to capture historical discussion and adopted revisions. Adoption of nonsubstantive these revisions by the Task Force, its parent and the NAIC membership shall be governed by the NAIC bylaws.

New Footnote 1: Prior to (adoption date), the term used to describe a new SAP concept was “substantive” and the term used to describe a SAP clarification was “nonsubstantive.” The new terms will be reflected in materials to describe revisions to statutory accounting principles on a prospective basis and historical documents will not be updated to reflect the revised terms.

Development of Interpretations to SSAPs and Referencing Interpretations Within SSAPs

Interpretations Which DO NOT Amend, Supersede or Conflict with Existing SSAPs

9. Interpretations may be developed to address issues requiring timely application or clarification of existing SAP, which shall not amend, supersede or conflict with effective SSAPs. Issues being considered as an interpretation must be discussed at no less than two open meetings. (Original introduction of the issue when the Working Group identifies the intent to address the issue as an “interpretation” during a public discussion is considered the first open meeting discussion.) The process must allow opportunity for interested parties to provide comments, but as interpretations are intended to provide timely responses to questions of application or interpretation and clarification of guidance, no minimum exposure timeframe is required.

10. As these interpretations do not amend, supersede or conflict with existing SSAP guidance, the interpretation is effective upon Working Group adoption unless specifically stated otherwise. The voting requirement to adopt an interpretation of this type is a simple majority. The Working Group shall report the adopted interpretation to the Accounting Practices and Procedures (E) Task Force as part of its public report during the next NAIC national meeting (or earlier if applicable). Interpretations can be overturned, amended or deferred by a two-thirds majority of the Task Force membership. For clarification, a two-thirds majority of the Task Force requires two-thirds of the entire Task Force membership, not just those electing to vote. Additionally, interpretations can be overturned, amended, deferred, or referred to either the Task Force and/or the Working Group by a simple majority of the Financial Condition (E) Committee.

Interpretations Which Amend, Supersede or Conflict with Existing SSAPs

11. In certain circumstances such as catastrophes and other time-sensitive issues requiring immediate, temporary statutory accounting guidance, the Working Group may adopt an interpretation which creates new SAP or conflicts with existing SSAPs. Historically, these interpretations temporarily modified statutory accounting principles and/or specific disclosures were developed in response to nationally significant events (e.g., Hurricane Sandy, September 11, 2001). (Examples of time-sensitive issues that have previously provided INT exceptions to SAP include the transition from LIBOR and special situations such as the federal TALF program.) Interpretations that conflict with existing SSAPs shall be temporary and restricted to circumstances arising from the need to issue guidance for circumstances requiring immediate guidance. In order to adopt an interpretation that creates new SAP or conflicts with existing SSAPs, the Working Group must have 67% of its members voting (10 out of 15 members) with a super majority (7 out of 10, 8 out of 11 or 12, 9 out of 13, 10 out of 14, or 11 out of 15) supporting adoption.
Ref #2021-14

a. These interpretations are effective upon Working Group adoption, unless stated otherwise, and shall be reported to the Accounting Practices and Procedures (E) Task Force as part of its public report during the next NAIC national meeting (or earlier if applicable). In circumstances where the Working Group adopts an interpretation (which creates new SAP or conflicts with existing SSAPs) that is controversial in nature (i.e., due to regulator or industry feedback or could have a policy level impact), the Working Group may elect to postpone the effective date until the item has been discussed by the Task Force and the Financial Condition (E) Committee and both have had an opportunity to review the interpretation.

b. These interpretations can be overturned, amended or deferred by a two-thirds majority of the Task Force membership. For clarification, a two-thirds majority of the Task Force requires two-thirds of the entire Task Force membership, not just those electing to vote. Additionally, interpretations can be overturned, amended, deferred, or referred to either the Task Force and/or the Working Group by a simple majority of the Financial Condition (E) Committee.

12. As new SSAPs are developed, it is essential to review and, if necessary, update the status of interpretations related to SSAPs that are being replaced and/or new SSAPs being developed. The following options are available to the Working Group when a SSAP with existing interpretations is replaced:

a. Interpretation of the new SSAP - If the Working Group would like to maintain the interpretation, the new SSAP can be added to the list of statements interpreted by the interpretation. In addition, the status section of the new SSAP will list the interpretation number next to the heading “Interpreted by.”

b. Nullification - When an interpretation is nullified by a subsequent SSAP or superseded by another interpretation, the interpretation is deemed no longer technically helpful, is shaded and moved to Appendix H (Superseded SSAPs and Nullified Interpretations), and the reason for the change is noted beneath the interpretation title. The status section of the SSAP describes the impact of the new guidance and the effect on the interpretation (for example, nullifies, incorporated in the new SSAP with paragraph reference, etc.).

c. Incorporation - When an interpretation is incorporated into a new SSAP, the Working Group can choose from the following two options:

i. If the interpretation only interprets one SSAP, then the interpretation is listed as being nullified under the “affects” section of the SSAP and is not referenced under the “interpreted by” section of the status page of the SSAP.

ii. If the interpretation references additional SSAPs, and the Working Group intends to maintain the guidance, the interpretation is unchanged (no nullification). The new SSAP (Summary of Issue section) reflects that the interpretation issue has been incorporated into the new statement.

Staff Review Completed by: Julie Gann, NAIC Staff – August 2021

Status:
On August 26, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to the NAIC Policy Statement on Maintenance of Statutory Accounting Principles, as illustrated above and suggested by the Financial Condition (E) Committee in their Aug. 14, 2021, referral, to alter the terminology used when discussing types of statutory accounting revisions.
On December 11, 2021, the Statutory Accounting Principles (E) Working Group adopted, as final, the exposed revisions to the *NAIC Policy Statement on Maintenance of Statutory Accounting Principles*, as illustrated above and suggested by the Financial Condition (E) Committee in their Aug. 14, 2021, referral. The revisions alter the terminology used when discussing types of statutory accounting revisions and are effective Jan. 1, 2022. Editorial revisions to update the use of the terms in other areas of the AP&P Manual, on a prospective basis, are being addressed separately in agenda item 2021-26EP.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member Meetings/Fall 2021/TF/App/SAP/Minutes/Att One-L_21-14_SAP Terminology.docx
The Blanks (E) Working Group of the Accounting Practices and Procedures (E) Task Force met Nov. 16, 2021. The following Working Group members participated: Jake Garn, Chair (UT); Kim Hudson, Vice Chair (CA); William Arfanis (CT); N. Kevin Brown (DC); Tom Hudson (DE); Carolyn Morgan (FL); Daniel Mathis (IA); Roy Eft (IN); Judy Weaver (MI); Debbie Doggett (MO); Justin Schrader (NE); Patricia Gosselin (NH); Dale Bruggeman and Tracy Snow (OH); Diane Carter (OK); Melissa Greiner and Kimberly Rankin (PA); Trey Hancock (TN); Shawn Frederick and Jamie Walker (TX); Steve Drutz (WA); Adrian Jaramillo (WI); and Jamie Taylor (WV).

1. **Adopted its July 22 Minutes**

Mr. Garn said the Blanks (E) Working Group met July 22 and took the following action: 1) adopted proposal 2021-10BWG removing language in quarterly General Interrogatories Part 1, line 4.1 that requires filing of a quarterly merger/history form while still requiring the annual form; 2) adopted its editorial listing; 3) adopted the Health Actuarial Statement of Opinion Guidance for the 2021 reporting year; and 4) deferred four proposals for additional discussion for a 90-day public comment period ending Oct. 22.

Mr. Hudson made a motion, seconded by Ms. Gosselin, to adopt the Working Group’s July 22 minutes (see *NAIC Proceedings – Summer 2021, Accounting Practices and Procedures (E) Task Force, Attachment Two*). The motion passed unanimously.

2. **Withdraw an Item Previously Deferred**

a. **Agenda Item 2021-12BWG**

Mr. Drutz stated that this proposal makes changes to the Analysis of Operations by Lines of Business - Accident and Health for Life/Fraternal to capture health specific data captured on the Heath Analysis of Operations by Lines of Business but not on the Life/Fraternal Analysis of Operations page and add new crosschecks for the new lines.

Mr. Drutz stated that there were a lot of comments and discussions with interested parties on this proposal during the comment period. This proposal was modified from its original presentation but not modified during this latest comment period. Mr. Drutz stated that since he is proposing a replacement proposal—2021-17BWG—to be exposed at this meeting, he asked to withdraw this proposal. Mr. Garn stated that since Mr. Drutz is the proposal sponsor, he can withdraw without the need for a motion.

3. **Deferred a Proposal**

a. **Agenda Item 2021-13BWG**

Ms. Gosselin stated that this proposal adds a new supplement—Exhibit of Premiums and Losses (State Page) – Other Liability—to the property/casualty (P/C) blank to capture premium and loss data for annual statement line 17.1, line 17.2, and line 17.3. The purpose is to provide state insurance regulators with greater detail on business reported in the aggregate “other liability” category. The anticipated effective date is annual 2022. Ms. Gosselin stated that the proposal was modified from its original presentation at the last meeting to change incurred but not reported (IBNR) to “case reserves” and re-exposed to allow additional time for comments and discussion.

Ms. Gosselin stated that there were two comment letters received during the deferral/re-exposure period. Some of the comments included concerns over the cost to prepare versus benefits, recommendations to reduce format rationale for a reduction in the number of columns, and the basis of the category lines used in the proposal. Interested parties provided comments on how products are constructed in the data captured by industry. Ms. Gosselin stated that interested parties asked for deferral of this item and another re-exposure to allow additional time to evaluate the proposed alternative changes to the P/C annual statement.

Tip Tipton (Thrivent Financial) stated that interested parties have held a couple of meetings with state insurance regulators and NAIC staff to discuss this proposal. He stated that interested parties would appreciate being given additional time to determine an optimal solution to identify the inherent risks associated with the other liability category.
Ms. Gosselin made a motion, seconded by Mr. Hudson, to defer the proposal to allow for additional discussion. The motion passed unanimously.

4. **Adopted a Proposal Previously Deferred**
   
   a. **Agenda Item 2021-14BWG**
   
   Mr. Frederick stated that this proposal expands the number of lines of business reported on Schedule H to match the lines of business reported on the Health Statement. It modifies the instructions to be uniform between life/fraternal and P/C. Mr. Frederick stated that this proposal was modified with some line and column editorial corrections identified during the comment period.

   Mr. Frederick made a motion, seconded by Mr. Hudson, to adopt the proposal with the editorial revisions (Attachment Two-A). The motion passed unanimously.

5. **Rejected a Proposal Previously Deferred**
   
   a. **Agenda Item 2021-11BWG**
   
   This proposal adds the data capture elements of direct written exposures and direct earned exposures for the personal lines of business of homeowners and private passenger auto (PPA) to the P/C annual and quarterly statements. Birny Birnbaum (Center for Economic Justice—CEJ) stated that during the re-exposure/deferral period, interested parties reiterated their concerns expressed at the Working Group’s July 22 meeting. He stated that since the deferral, a memorandum has been received from the Financial Analysis (E) Working Group in which it states that there to be no value for financial analysts. He stated that there was no opportunity for stakeholders to participate in that discussion, so he is unclear as to how that decision was reached.

   Mr. Birnbaum stated that the Casualty Actuarial and Statistical (C) Task Force provided feedback on the proposal, as well as looked at alternatives for calculating the average premium in a more timely manner. He stated that these are not viable alternatives because what they propose is merely an add-on to an antiquated statistical reporting system. It does not leverage the world class financial system. This proposal is consistent with the initiatives of the NAIC State Ahead strategic plan. The current process does not provide company-specific analysis and does not meet the same time frames by a large margin.

   Mr. Birnbaum stated that he disagrees with the interested parties’ comments referring to this as statistical data and not financial data. He stated that there is a variety of information in the financial statements that are not explicit financial data but used indirectly for financial analysis. This proposal adds two measures of exposures that are similar to those found in the life financial statements in terms of covered lives or policies in force, as well as those referenced in other exhibits and schedules within the P/C statement. Mr. Birnbaum stated that this proposal would provide useful and relevant information not just to the regulatory analysts, but also to the public and policymakers.

   Mr. Garn stated that the Blanks (E) Working Group does not typically make policy decisions. The Working Group generally follows the direction of policymaking groups such as the Statutory Accounting Principles (E) Working Group, the Casualty Actuarial and Statistical (C) Task Force, or similar groups. Mr. Garn stated that absent clear direction from a policymaking group, the Blanks (E) Working Group has various options. He stated that it can vote to defer the proposal to allow additional time for discussion or propose a vote and see if a motion, second, and vote results in adoption, rejection, or the proposal not move forward for lack of a motion.

   Mr. Birnbaum stated that the NAIC has a policy that supports this proposal. First, the NAIC publishes average premium for homeowners and automobile coverage in the Casualty Actuarial and Statistical (C) Task Force reports. He states that as a matter of policy, the NAIC has determined that the information is relevant and useful for the public, state insurance regulators, and policymakers. This proposal takes that same policy but makes it more effective by speeding up the access to that information in a way that makes the data useful and usable. Second, this proposal is supported by the NAIC State Ahead initiatives and its broader policy. Mr. Birnbaum stated that the referral to the Task Force was not the relevant entity to ask for an opinion on the policy issue but rather to comment on whether the data conflicted with its statistical reports. He stated that the Market Analysis Procedures (D) Working Group would be the more appropriate group to review this request, as it would be the group that would use the data. He stated that while he would prefer that the Blanks (E) Working Group vote to adopt the proposal, he stated that he is willing to hear suggestions from state insurance regulators that might make the information more useful.
Ms. Walker stated that this proposal appears to be requesting the implementation of a policy change. She suggested that this proposal be referred to the Financial Condition (E) Committee and Property and Casualty Insurance (C) Committee to decide the policy issue and provide direction on whether the Working Group should continue to refine this particular proposal. Ms. Walker made a motion to refer this proposal to the Financial Condition (E) Committee and Property and Casualty Insurance (C) Committee. The motion died for lack of a second. Ms. Walker made a motion to reject the proposal. She suggested that a new proposal could be resubmitted at a later time when there is a policy decision with consensus from a technical committee.

Mr. Tipton stated that he heard collectively from interested parties confirming the opinion that the Working Group is not the appropriate group to decide on this data. He stated that with the comments received from the Casualty Actuarial and Statistical (C) Task Force and Financial Analysis (E) Working Group indicating the lack of support for the proposal, interested parties agree that rejection of this proposal is appropriate at this time.

Rachel Underwood (Cincinnati Insurance Companies) stated that the proposal sponsor agreed that the change would not be needed if the Casualty Actuarial and Statistical (C) Task Force could produce the reports faster. She stated that the Task Force indicated that it is not in favor of quarterly reports, and the averages per exposure do not change quickly nor significantly year-to-year. For historical averages, she has found that the average annual change in auto average premium per exposure from 2009 to 2018 was 3.1% or $32. In looking at a more narrow time range from 2014 to 2018, the average annual change was 4.9% or $52. For homeowners, the average premium exposure from 2013 to 2018 showed an average annual change of 3% or $33. For tenants policies of the same period, there was a decrease of 0.2% or $1. Ms. Underwood stated that the materiality does not justify the expense of having companies report the additional data. She stated that this level of detail is not used in the rate and forms filings. She stated that her company sends their data files to a third-party statistical agent, who is also a data contributor to the Task Force reports, which calculates the exposure counts.

Ms. Underwood indicated that the implementation project is estimated at approximately $300,000 over at least a six-month period. Over 2,500 P/C company statements are rolled into hundreds of filing groups. Assuming this would affect even 200 of these groups, she suggested the estimated cost to the industry being $60 million. She expressed concerns with the quality of the data.

Mr. Birnbaum stated that he has concerns with the accuracy of the figures quoted by Ms. Underwood. Mr. Garn stated that those discussions should be held at a technical group level and not with the Blanks (E) Working Group.

Ms. Walker made a motion, seconded by Mr. Mathis, to reject the proposal. The motion passed with Mr. Hudson and Mr. Arfanis opposed.

6. Exposed New Items

a. Agenda Item 2021-15BWG

Mr. Bruggeman stated that this blanks proposal is in response to the Statutory Accounting Principles (E) Working Group agenda item 2021-16. This agenda item was exposed by the Working Group and will be considered for adoption at the Fall National Meeting. The agenda item is in direct response to state insurance regulator comments stating that it is not feasible to identify where Federal Home Loan Bank (FHLB) funding agreements are captured in Exhibit 7: Deposit Type Contracts. As FHLB funding agreements can be captured on different types of deposit-type contract policy forms (e.g., as a guaranteed investment contracts, annuity certain, or other deposit funds), funding agreements can be reported differently on Exhibit 7 among reporting entities. Mr. Bruggeman stated that to preserve the current reporting on Exhibit 7 by type of policy form and obtain information on where FHLB funding agreements are captured, this blanks proposal proposes a new footnote to capture the FHLB funding agreement in each reporting category. He stated that although exposure of the blanks proposal is occurring before the Working Group considers adoption of agenda item 2021-16, any changes that might be made to its agenda item at the Fall National Meeting will be communicated to the Blanks (E) Working Group prior to it considering adoption of this item.

Hearing no objection from the Blanks (E) Working Group, the proposal was exposed for a public comment period ending March 4, 2022.

b. Agenda Item 2021-16BWG

Mr. Bruggeman stated that this blanks proposal is not in response to any current revisions nor issues being considered by the Statutory Accounting Principles (E) Working Group, but it reflects clarification to existing disclosures captured in Statement...
of Statutory Accounting Principles (SSAP) No. 101—Income Taxes and SSAP No. 22R—Leases. Revisions to the blanks only intend to clarify the instructions for reporting, result in consistency between the data-capture disclosure and the portable document format (PDF) submission, clarify the reporting of future lease payments.

Hearing no objection from the Blanks (E) Working Group, the proposal was exposed for a public comment period ending March 4, 2022.

c. **Agenda Item 2021-17BWG**

Mr. Drutz stated that this proposal replaces 2021-12BWG and modifies the Analysis of Operations by Lines of Business in the Health Blank to include all of health lines of business included in the Life/Fraternal Analysis of Operations by Lines of Business – Accident and Health. He stated that the proposal adds instructions for the new columns and adjusts the column references. It adds the Health Blank Analysis of Operations by Lines of Business as a supplement to the Life/Fraternal Blank with the appropriate instructions and crosschecks. It adds crosschecks to the Health Blank Analysis of Operations by Lines of Business to the Life/Fraternal Analysis of Operations by Lines of Business – Accident and Health instructions.

Hearing no objection from the Blanks (E) Working Group, the proposal was exposed for a public comment period ending March 4, 2022.

d. **Agenda Item 2021-18BWG**

Ms. Walker stated that this proposal modifies the Life Insurance exhibit (State Page) to include the line of business detail reported on the Analysis of Operations by Lines of Business pages. Two new Schedule T style pages, Exhibit of Claims Settled During the Current Year and Policy Exhibit, are created to include detail captured by state on the existing Life Insurance exhibit (State Page) that could not be included due to space restrictions. It adds definitions for life and annuity products to the lines of business definitions in the health appendix.

Hearing no objection from the Blanks (E) Working Group, the proposal was exposed for a public comment period ending March 4, 2022.

e. **Agenda Item 2021-19BWG**

Mr. Drutz stated that this proposal adds columns and lines to Underwriting and Investment Exhibits, Parts 1, 2, 2A, 2B, and 2D and the Exhibit of Premiums, Enrollment, and Utilization in the annual statement, bringing the lines of business reporting in line with Life/Fraternal and P/C. It adds columns and lines to the Exhibit of Premiums, Enrollment, and Utilization and Underwriting and Investment analysis of Claims Unpaid quarterly pages. The appropriate adjustments to the instructions are also being made.

Hearing no objection from the Blanks (E) Working Group, the proposal was exposed for a public comment period ending March 4, 2022.

f. **Agenda Item 2021-20BWG**

Mr. Garn stated that this proposal, beginning at line 72 of the Life/Fraternal Five-Year Historical, adds or deletes lines that do not pull in the specific lines of business reported on the Life/Fraternal Analysis of Operations by Lines of Business detail pages for life (individual and group), annuities (individual and group), and Accident and Health for line 33 of those pages.

Hearing no objection from the Blanks (E) Working Group, the proposal was exposed for a public comment period ending March 4, 2022.

g. **Agenda Item 2021-21BWG**

Mr. Bruggeman stated that this blanks proposal is sponsored by the Statutory Accounting Principles (E) Working Group and coincides with the revisions adopted at its Nov. 10 meeting to clarify the reporting of residual tranches. He stated that a residual tranche, pursuant to the definition adopted in SSAP No. 43R—Loan-Backed and Structured Securities, intends to capture securitization tranches and beneficial interests as well as other structures captured in scope of SSAP No. 43R, that reflect loss layers without any contractual payments, whether principal or interest, or both. He stated that payments to holders of these
investments occur after contractual interest and principal payments have been made to other tranches or interests and are based on the remaining available funds. Although payments to holders can occur throughout an investment’s duration and not just at maturity, such instances still reflect the residual amount permitted to be distributed after other holders have received contractual interest and principal payments.

Mr. Bruggeman stated that the revisions adopted by the Statutory Accounting Principles (E) Working Group at its Nov. 10 meeting confirm that residual tranches, although in scope of SSAP No. 43R, are required to be reported on Schedule BA and not Schedule D Part 1 beginning Dec. 31, 2022. This guidance permits reporting entities to continue reporting residual tranches on Schedule BA and permits entities that have historically reported on Schedule D Part 1, to move residual tranches to Schedule BA in advance of the effective date.

Mr. Bruggeman stated that this blanks proposal requests the establishment of specific reporting lines on Schedule BA to capture residual tranches for year-end 2022. As detailed in the proposal, it is requested that reporting lines separate residual tranches based on the type of underlying characteristics of fixed income, common stock, real estate, mortgage loans, or other. These categories are consistent with what is used for investments in scope of SSAP No. 48—Joint Ventures, Partnerships and Limited Liability Companies.

Mr. Bruggeman stated that reporting entities that already report residual tranches on Schedule BA are permitted to continue using the prior reporting location already utilized, and entities that elect to move residual tranches to Schedule BA for year-end 2021 are also permitted to utilize the reporting line currently available on Schedule BA in determining the best reporting location based on the characteristics of the instrument. Effective Dec. 31, 2022, all residual tranches will be expected to be captured on the distinct reporting lines created for these items.

Mr. Bruggeman stated that the blanks proposal included in the meeting materials was developed before the adoption of agenda item 2021-15 by the Statutory Accountings Principles (E) Working Group. With adoption, the Working Group considered industry-requested editorial changes to the SSAP No. 43R definition of residual tranches. These revisions include deleting the reference to “non-rated” when describing residual interests and the removal of “interests of structured finance investments” from the definition. These revisions are considered editorial in nature, and it is requested that corresponding edits be reflected in the blanks proposal prior to exposure.

Hearing no objection from the Blanks (E) Working Group, the proposal was exposed for a public comment period ending March 4, 2022.

7. Adopted the Editorial Listing

Mr. Hudson made a motion, seconded by Ms. Gosselin, to adopt the Blanks (E) Working Group editorial listing (Attachment Two-B). The motion passed unanimously.

8. Approved the State Filing Checklists

Ms. Greiner made a motion, seconded by Ms. Doggett, to approve the State Filing Checklist templates (Attachment Two-C). The motion passed unanimously.

9. Discussed Other Matters

Mr. Tipton stated that there is a group of interested parties, especially on the health side, evaluating what is perceived to be a redundancy of health data, not only within the life blank but also in the P/C and health blanks. This group is putting together a document to begin this discussion between industry and state insurance regulators.

Mr. Bruggeman referenced a Nov. 10 memorandum from the Statutory Accounting Principles (E) Working Group and Valuation of Securities (E) Task Force to the Blanks (E) Working Group intending to notify the Blanks (E) Working Group and interested parties on the reporting of residual tranches retained on Schedule D-1: Long-Term Bonds for year-end 2021. As part of the bond proposal project, it was identified that there is inconsistency in practice with how residual tranches or interests are reported within the investment schedules, with some entities reporting on Schedule BA: Other Invested Assets and other entities reporting on Schedule D-1, with either a self-assigned NAIC 5GI or NAIC 6 designation. The Working Group confirmed with the Securities Valuation Office (SVO) that use of the NAIC 5GI process for residual tranches is an inaccurate application, and residual tranches or interests reported on Schedule D-1 shall be reported with an NAIC 6 designation.
The NAIC 5GI process, noted in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual), permits entities to self-assign an NAIC 5 when they can certify the following three components: 1) documentation necessary to permit a full credit analysis of the security does not exist, or an NAIC credit rating provider (CRP) rating for a filing exempt (FE) or private letter (PL) security is not available; 2) the issuer or obligor is current on all contracted interest and principal payments; and 3) the insurer has an actual expectation of ultimate payment of all contracted interest and principal payments. Mr. Bruggeman stated that use of the NAIC 5GI process for residual investments is an incorrect application of the guidance, as: 1) there are no contracted interest and principal payments to certify as current; and 2) the insurer cannot have an actual expectation of receiving all contractual principal and interest of the underlying collateral, as these tranches absorb the losses first for the securitization structure. Although cash flows may pass through to these holders at periodic intervals in the waterfall, ultimate returns depend on continued performance; therefore, there can be no actual expectation that future payments will be received. The Valuation of Securities (E) Task Force is currently incorporating edits to mitigate future misapplication of the NAIC 5GI process for residual tranches.

Mr. Bruggeman stated that although the action taken by the Statutory Accounting Principles (E) Working Group will require residual tranches or interests to be reported on Schedule BA for year-end 2022, these items can be retained on Schedule D Part 1 for year-end 2021. However, if retained on Schedule D Part 1, the reporting entity should record an NAIC 6 designation.

Mr. Garn stated that he would be resigning his position as chair of the Blanks (E) Working Group, effective Dec. 31. He stated that after serving a 14-year term, it is time for someone new to assume the chair position. He named his replacement as Ms. Gosselin.

Having no further business, the Blanks (E) Working Group adjourned.
NAIC BLANKS (E) WORKING GROUP

Blanks Agenda Item Submission Form

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**BLANK(S) TO WHICH PROPOSAL APPLIES**

| [ X ] ANNUAL STATEMENT |
| [ ] QUARTERLY STATEMENT |
| [ X ] Instructions |
| [ X ] CROSSCHECKS |

[ X ] Life, Accident & Health/Fraternal
[ X ] Property/Casualty
[ ] Health
[ ] Separate Accounts
[ ] Protected Cell
[ ] Health (Life Supplement)

Anticipated Effective Date: Annual 2022

**IDENTIFICATION OF ITEM(S) TO CHANGE**

Expanded the number of lines of business reported on Schedule H to match the lines of business reported on the Health Statement. Modified the instructions so they will be uniform between life/fraternal and property.

**REASON, JUSTIFICATION FOR AND/OR BENEFIT OF CHANGE**

The purpose of the proposal is to bring uniformity in the accident and health lines of business used on Schedule H with other schedules and exhibits in the annual statement.

**NAIC STAFF COMMENTS**

Comment on Effective Reporting Date: ________________________________

Other Comments:

** This section must be completed on all forms.
ANNUAL STATEMENT INSTRUCTIONS – LIFE\FRATERNAL

SCHEDULE H

ACCIDENT AND HEALTH EXHIBIT

Life/Fraternal: “Appropriately” where used in the Instructions for Schedule H, means the appropriate accident and health portions of referenced data. Reconciliation with figures drawn from other parts of the statement may only be possible with respect to Group Accident and Health (Column 3), Credit (Group and Individual) Accident and Health (Column 5) and Other Accident and Health (the combination of Columns 7 through 17), and, in some cases, may only be possible with respect to Total Accident and Health (Column 1) of Schedule H – Accident and Health Exhibit.

For definitions of lines of business, see the appendix of these instructions.

All amounts reportable in Parts 1 through 3 are net of reinsurance ceded, i.e., reinsurance assumed should be included, reinsurance ceded should be deducted, and net figures entered in the statement. Part 4, “Reinsurance,” displays the reinsurance assumed and ceded components.

Column 5 ——— Credit Accident and Health (Group and Individual)

Include: Business not exceeding 120 months duration.

This column is not applicable to Fraternal Benefit Societies.

Column 7 ——— Collectively Renewable

Include: Amounts pertaining to policies/certificates that are made available to groups of persons under a plan sponsored by an employer, or an association or a union of affiliated associations or unions, or a group of individuals supplying materials to a central point of collection or handling a common product or commodity, under which the reporting entity has agreed with respect to such policies/certificates that renewal will not be refused, subject to any specified age limit, while the reporting entity remains a member of the group specified in the agreement unless the reporting entity simultaneously refuses renewal to all other policies/certificates in the same group. A sponsored plan shall not include any arrangement where a reporting entity’s customary individual policies/certificates are made available without special underwriting considerations, and where the employer’s participation is limited to arranging for salary allotment premium payments with or without contribution by the employer. Such plans are sometimes referred to as payroll budget or salary allotment plans. A sponsored plan may be administered by an agent or trustee.

Amounts pertaining to policies/certificates issued by a company or group of companies under a plan, other than a group insurance plan, authorized by special legislation for the exclusive benefit of the aged through mass enrollment.

Amounts pertaining to policies/certificates issued under mass enrollment procedures to older people, such as those age 65 and over, in some geographic region or regions under which the reporting entity has agreed with respect to such policies/certificates that renewal will not be refused unless the reporting entity simultaneously refuses renewal to all other policies/certificates specified in the agreement.
Column 9 — Non-cancelable

Include: Amounts pertaining to policies/certificates that are guaranteed renewable for life or to a specified age, such as 60 or 65, at guaranteed premium rates.

Column 11 — Guaranteed Renewable

Include: Amounts pertaining to policies/certificates that are guaranteed renewable for life or to a specified age, such as 60 or 65, but under which the reporting entity reserves the right to change the scale of premium rates.

Column 13 — Non-renewable for Stated Reasons Only

Include: Amounts pertaining to policies/certificates in which the reporting entity has reserved the right to cancel or refuse renewal for one or more stated reasons, but has agreed implicitly or explicitly that, prior to a specified time or age, it will not cancel or decline renewal solely because of deterioration of health after issue.

Column 17 — All Other

Include: Any other accident and health coverages not specifically required in other columns. All Medicare Part D Prescription Drug Coverage, whether sold on a stand-alone basis or through a Medicare Advantage product and whether sold directly to an individual or through a group.

PART 1 – ANALYSIS OF UNDERWRITING OPERATIONS

In each % column of Part 1, show the percentage of Line 2 for Lines 3 through 14 inclusive.

Line 1 — Premiums Written

Life/Fraternal: Column 1 should agree with Schedule T, Column 4 Line 97 minus Line 98 if prepared on a written basis.

Property: Column 1 should agree with Underwriting and Investment Exhibit, Part 1B sum of Lines 13 through 15 (Column 1 + 2 + 3).

Columns 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, 23 and 25 should agree with Underwriting and Investment Exhibit, Part 1B Column 1 + 2 + 3 Lines 13.1, 13.2, 14, 15.1, 15.2, 15.3, 15.4, 15.5, 15.6, 15.7, 15.8 and 15.9 respectively.

Should agree with “Total (All Business) minus Reinsurance Ceded” Line of Column 4, Schedule T, if prepared on a written basis.

Line 2 — Premiums Earned

Refer to SSAP No. 54R—Individual and Group Accident and Health Contracts for accounting guidance.

Should agree with Line 1 plus the change in unearned premiums and reserve for rate credits included in Part 2, Section A.
Line 3 – Incurred Claims

Report cash settlements during the year plus the change in claim liabilities, reserves and amounts recoverable from reinsurers.

**Life/Fraternal:** Should agree appropriately with both Exhibit 8, Part 2, Line 6.4 and also with Analysis of Operations by Lines of Business – Summary, Column 6, Line 13, in each case adjusted for the change in Exhibit 6 of Aggregate Accident and Health Reserves, Line 16 reserves.

**Property:** Column 1 should agree with Underwriting and Investment Exhibit, Part 2 sum of Lines 13 through 15 (Column 7).


Line 4 – Cost Containment Expenses

Report cost containment expenses in accordance with SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses.

**Life/Fraternal:** Should agree with Exhibit 2, Column 2, Line 10.

**Property:** Column 1 (Line 4 plus Line 8) should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29) sum of Lines 13 through 15.

Column 3 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29), Lines 13.1.

Column 5 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29), Lines 13.2.

Column 7 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29), Lines 15.4.

Column 9 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29), Lines 15.15

Column 11 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29), Lines 15.2.

Column 13 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29), Lines 15.8.
Column 15 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and 29), Lines 15.6.

Column 17 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and 29), Lines 15.5.

Column 19 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and 29), Lines 14.

Column 21 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and 29), Lines 15.3.

Column 23 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and 29), Lines 15.7.

Column 25 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and 29), Lines 15.9.

Line 5 – Incurred Claims and Cost Containment Expenses

Should agree with the sum of Lines 3 and 4.

Line 6 – Increase in Contract Reserves

Should agree with Part 2, Section B, Line 5.

Line 7 – Commissions

Report incurred commissions and expense allowances on reinsurance.

Life/Fraternal: Should agree appropriately with the net of Exhibit 1, Part 2, Line 31 minus Line 26.3 and also with the net of Analysis of Operations by Lines of Business – Summary, Column 6, Line 21 plus Line 22, minus Line 6, Accident and Health columns.

Property: Column 1 should agree with Insurance Expense Exhibit, Part II sum of Lines 13 through 15 (Column 23).


Column 5 – Should agree with the Insurance Expense Exhibit, Part II, Column 23, Line 13.2.

Column 7 – Should agree with the Insurance Expense Exhibit, Part II, Column 23, Line 15.4.
Line 8  – Other General Insurance Expenses

Report general insurance expenses incurred and provision for claim expenses incurred in connection with pending and incurred but unreported claims not included in Cost Containment Expenses on Line 4 above.

**Life/Fraternal:** Should agree appropriately with Exhibit 2, Column 3, Line 10.

Line 9  – Taxes, Licenses and Fees

Report total taxes (excluding federal income taxes) plus state insurance department licenses and fees.

**Life/Fraternal:** Should agree appropriately with Exhibit 3, Column 2, Line 7 and also with Analysis of Operations by Lines of Business – Summary, Column 6, Line 24, Accident and Health columns.

**Property:** Column 1 should agree with Insurance Expense Exhibit, Part II sum of Lines 13 through 15 (Column 25).

**Column 3**  – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 13.1.

**Column 5**  – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 13.2.

**Column 7**  – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.4.
Column 9 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.15.

Column 11 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.2.

Column 13 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.8.

Column 15 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.6.

Column 17 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.5.

Column 19 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.4.

Column 21 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.3.

Column 23 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.7.

Column 25 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.9.

Line 10 – Total Other Expenses Incurred
Sum of Lines 7, 8 and 9.

Line 11 – Aggregate Write-ins for Deductions
Enter the total of the write-ins listed in schedule “Details of Write-ins Aggregated at Line 11 for Deductions.”

Line 12 – Gain from Underwriting Before Dividends or Refunds
Report premiums earned less incurred claims, less increase in policy reserves and less total expenses incurred. Line 2 less the sum of Lines 5, 6, 10 and 11.

Line 13 – Dividends or Refunds

*Life/Fraternal:* Should agree appropriately with Analysis of Operations by Lines of Business – Summary, Column 6, Line 30, Accident and Health columns, and also with Exhibit 4, Dividends or Refunds, Column 2, Line 17.

*Property:* Column 1 should agree with Insurance Expense Exhibit, Part II sum of Lines 13 through 15 (Column 5).


Column 5 – Should agree with the Insurance Expense Exhibit, Part II, Column 5, Lines 13.2.
Column 7 – Should agree with the Insurance Expense Exhibit, Part II, Column 5, Lines 15.4.

Column 9 – Should agree with the Insurance Expense Exhibit, Part II, Column 5, Lines 15.15.

Column 11 – Should agree with the Insurance Expense Exhibit, Part II, Column 5, Lines 15.2.

Column 13 – Should agree with the Insurance Expense Exhibit, Part II, Column 5, Lines 15.8.

Column 15 – Should agree with the Insurance Expense Exhibit, Part II, Column 5, Lines 15.6.

Column 17 – Should agree with the Insurance Expense Exhibit, Part II, Column 5, Lines 15.5.


Column 21 – Should agree with the Insurance Expense Exhibit, Part II, Column 5, Lines 15.3.

Column 23 – Should agree with the Insurance Expense Exhibit, Part II, Column 5, Lines 15.7.

Column 25 – Should agree with the Insurance Expense Exhibit, Part II, Column 5, Lines 15.9.

Line 14 – Gain From Underwriting After Dividends or Refunds

Line 12 minus Line 13.

Details of Write-ins Aggregated on Line 11 for Deductions

List separately all deductions for which there is no pre-printed line on Schedule H – Part 1.

Include: Group conversions, transfers on account of group package policies and contracts, etc.
PART 2 – RESERVES AND LIABILITIES

SECTION A – PREMIUM RESERVES

Line 1  –  Unearned Premiums

**Life/Fratal:** Should agree appropriately with Exhibit 6, Line 1, net of applicable reinsurance ceded.

Line 2  –  Advance Premiums

**Life/Fratal:** Should agree appropriately with the sum of Exhibit 1, Part 1, Lines 4 and 14.

**Property:** Column 1 should agree with Underwriting and Investment Exhibit, Part 1A, Column 1 plus Column 2, sum of Lines 13, 14 and 15.

Line 3  –  Reserve for Rate Credits

**Life/Fratal:** Should agree appropriately with the net of Exhibit 6, Line 5, net of applicable reinsurance ceded, plus Page 3, Line 9.2 parenthetical amount #1 minus Page 2, Line 15.3, Column 3, accident and health portion.

**Not applicable to Fraternal Benefit Societies.**

**Property:** Column 1 should agree with Underwriting and Investment Exhibit, Part 1A, Column 4, sum of Lines 13, 14 and 15.

  **Column 2**  –  Should agree with the Underwriting and Investment Exhibit, Part 1A, Column 4, Line 13.1.

  **Column 3**  –  Should agree with the Underwriting and Investment Exhibit, Part 1A, Column 4, Line 13.2.

  **Column 4**  –  Should agree with the Underwriting and Investment Exhibit, Part 1A, Column 4, Line 15.4.

  **Column 5**  –  Should agree with the Underwriting and Investment Exhibit, Part 1A, Column 4, Line 15.5.

  **Column 6**  –  Should agree with the Underwriting and Investment Exhibit, Part 1A, Column 4, Line 15.2.

  **Column 7**  –  Should agree with the Underwriting and Investment Exhibit, Part 1A, Column 4, Line 15.8.

  **Column 8**  –  Should agree with the Underwriting and Investment Exhibit, Part 1A, Column 4, Line 15.6.

  **Column 9**  –  Should agree with the Underwriting and Investment Exhibit, Part 1A, Column 4, Line 15.5.

  **Column 10**  –  Should agree with the Underwriting and Investment Exhibit, Part 1A, Column 4, Line 14.
**SECTION B – CONTRACT RESERVES**

**Line 1** – Additional Reserves

Refer to *SSAP No. 54R—Individual and Group Accident and Health Contracts* for accounting guidance.

Include: Premium deficiency reserve.

Companies must carry a reserve in this line for any policy or block of policies:

(i) With which level premiums are used, or

(ii) With respect to which, due to the gross premium structure at issue, the value of future benefits exceeds the value of appropriate future valuation net premiums.

Companies must carry a reserve for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.

**Line 2** – Reserve for Future Contingent Benefits

Companies must carry a reserve on this line that provides for the extension of benefits after termination of the policy or of any insurance thereunder. Such benefits, that actually accrue and are payable at some future date, are predicated on a condition or actual disability that exists at the termination of the insurance and that is usually not known to the insurance company. These benefits are normally provided by contract provision but may be payable because of court decisions or of departmental rulings.

An example of the type of benefit for which a reserve must be carried is the coverage for hospital confinement after the termination of an employee’s certificate but prior to the expiration of a stated period. This example is illustrative only and is not intended to limit the reserve to the benefits.
Some individual Accident and Health policies may also provide benefits similar to those under the “Extension of Benefits” section of a group policy.

Line 3 – Total Contract Reserves, Current Year
Sum of Lines 1 and 2.

Line 4 – Total Contract Reserves, Prior Year
Line 3 from prior year. [For 2022 this only applies to Column 1. For 2023 it applies to all columns.]

Line 5 – Increase in Contract Reserves
Line 3 minus Line 4.

SECTION C – CLAIM RESERVES AND LIABILITIES

Line 1 – Total Current Year
Life/Fraterna l: Should agree appropriately with the sum of Exhibit 6, Line 16 and Exhibit 8, Part 1, Line 4.4.

Property: Column 1 should agree with Underwriting and Investment Exhibit, Part 2 sum of Lines 13 through 15 (Column 5).

Also should agree with Part 3, Line 2.1 plus Part 3, Line 2.2 below.

Line 2 – Total Prior Year
Line 1 from prior year. [For 2022 this only applies to Column 1. For 2023 it applies to all columns.]

Should agree with Part 3, Line 3.2 below.

Property: Column 13 should agree with Underwriting and Investment Exhibit, Part 2, Column 6, sum of Lines 13, 14 and 15.

Line 3 – Increase
Line 1 minus Line 2.
PART 3 – TEST OF PRIOR YEAR’S CLAIM RESERVES AND LIABILITIES

Lines 1.1 and 1.2 – Claims Paid During the Year on Claims Incurred Prior to and During Current Year

Represents net payments made during the year less the change in amounts still recoverable from reinsurance.

Life/Fraternal: The sum of Lines 1.1 and 1.2 should agree appropriately with Exhibit 8, Part 2, Lines 1.4 minus Line 3 plus Line 5.

Lines 2.1, 2.2 and 3.2 – Claim Reserves and Liabilities, December 31 on Claims Incurred Prior to and During Current Year.

The sum of Lines 2.1 and 2.2 should equal Line C1 of Part 2 of this schedule and Line 3.2 should equal Line C2 of Part 2 of this Schedule. Line 3.3 represents the result of the test for adequacy of claim provisions. A negative figure will normally indicate a favorable reserve development.

PART 4 – REINSURANCE

Represents the reinsurance assumed and ceded components of Part 1, Lines 1, 2, 3 and 7 of this schedule.

SECTIONS A AND B

Line 2 – Premiums Earned

Premiums earned are before adjustment for the increase in policy reserves that has been treated as a separate deduction.

SECTION A—REINSURANCE ASSUMED

Line 2 – Premiums Earned

Premiums earned are before adjustment for the increase in policy reserves that has been treated as a separate deduction.

SECTION B—REINSURANCE CEDED

Line 2 – Premiums Earned

Premiums earned are before adjustment for the increase in policy reserves that has been treated as a separate deduction.
PART 5 – HEALTH CLAIMS

Companies with less than 5% of premiums in Accident and Health business should not complete this schedule.

Column 3 = Other

Include: All Medicare Part D Prescription Drug Coverage, whether sold on a stand-alone basis or through a Medicare Advantage product and whether sold directly to an individual or through a group.

A. DIRECT

Line 1 – Incurred Claims

Should agree with Line 3 plus Line 4 minus Line 2.

Line 2 – Beginning Claim Reserves and Liabilities

Life/Fraternal: Should agree with Exhibit 8, Part 2, Line 4.1, sum of Columns 9, 10 and 11, plus direct portion of Exhibit 6, Line 14, Column 1, Prior Year.

Line 3 – Ending Claim Reserves and Liabilities

Life/Fraternal: Should agree with Exhibit 8, Part 2, Line 2.1, sum of Columns 9, 10 and 11, plus direct portion of Exhibit 6, Line 14, Column 1.

Line 4 – Claims Paid

Life/Fraternal: Should agree with Exhibit 8, Part 2, Line 1.1, sum of Columns 9, 10 and 11.

Property: Should agree with Underwriting and Investment Exhibit, Part 2, Column 1, sum of Lines 13, 14 and 15.

Column 1 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 13.1

Column 2 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 13.2

Column 3 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.4

Column 4 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.15

Column 5 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.2

Column 6 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.8

Column 7 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.6

Column 8 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.5
### Column 9 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 14.

### Column 10 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.3.

### Column 11 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.7.

### Column 12 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.9.

## B. ASSUMED REINSURANCE

### Line 15 – Incurred Claims

Columns 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13 should agree with Schedule H, Part 4, Line A3, Columns 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 1, respectively. Should also agree with Line 37 plus Line 48, minus Line 26.

### Line 26 – Beginning Claim Reserves and Liabilities

**Life/Fraternal:** Column 13 should agree with Exhibit 8, Part 2, Line 4.2, sum of Columns 9, 10 and 11 plus assumed portion of Exhibit 6, Line 14, Column 1, Prior Year.

### Line 37 – Ending Claim Reserves and Liabilities

**Life/Fraternal:** Column 13 should agree with Exhibit 8, Part 2, Line 2.2, sum of Columns 9, 10 and 11, plus assumed portion of Exhibit 6, Line 14, Column 1.

### Line 48 – Claims Paid

**Life/Fraternal:** Column 13 should agree with Exhibit 8, Part 2, Line 1.2, sum of Columns 9, 10 and 11.

**Property:** Column 13 should agree with Underwriting and Investment Exhibit, Part 2, Column 2, sum of Lines 13, 14 and 15.

Columns 1 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 13.1.

Columns 2 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 13.2.

Columns 3 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.4.

Columns 4 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.15.

Columns 5 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.2.

Columns 6 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.8.
Column 7 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.6.

Column 8 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.5.

Column 9 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 14.

Column 10 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.3.

Column 11 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.7.

Column 12 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.9.

C. **CEDED REINSURANCE**

Line 19 – Incurred Claims

Columns 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13 should agree with Schedule H, Part 4, Line B3, Columns 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 1, respectively.

Should also agree with Line 113, plus Line 124, minus Line 102.

Line 210 – Beginning Claim Reserves and Liabilities

Include: Amounts recoverable from reinsurers.

*Life/Fraternal:* Column 13 should agree with Exhibit 8, Part 2, Line 1.3, sum of Columns 9, 10 and 11.

Line 311 – Ending Claim Reserves and Liabilities

Include: Amounts recoverable from reinsurers.

*Life/Fraternal:* Column 13 should agree with Exhibit 8, Part 2, Line 2.3, sum of Columns 9, 10 and 11.

Line 412 – Claims Paid

*Life/Fraternal:* Column 13 should agree with Exhibit 8, Part 2, Line 1.3, sum of Columns 9, 10 and 11.

*Property:* Column 13 should agree with Underwriting and Investment Exhibit, Part 2, Column 3, sum of Lines 13, 14 and 15.

Column 1 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line 13.1.

Column 2 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line 13.2.
<table>
<thead>
<tr>
<th>Column 3</th>
<th>Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line 15.4.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 4</td>
<td>Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line 15.15</td>
</tr>
<tr>
<td>Column 5</td>
<td>Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line 15.2</td>
</tr>
<tr>
<td>Column 6</td>
<td>Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line 15.8</td>
</tr>
<tr>
<td>Column 7</td>
<td>Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line 15.6</td>
</tr>
<tr>
<td>Column 8</td>
<td>Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line 15.5</td>
</tr>
<tr>
<td>Column 9</td>
<td>Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line 14</td>
</tr>
<tr>
<td>Column 10</td>
<td>Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line 15.3</td>
</tr>
<tr>
<td>Column 11</td>
<td>Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line 15.7</td>
</tr>
<tr>
<td>Column 12</td>
<td>Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line 15.9</td>
</tr>
</tbody>
</table>

**D. NET**

<table>
<thead>
<tr>
<th>Line 143</th>
<th>Incurred Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Columns 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13 should agree with Schedule H, Part 1, Line 3, Columns 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, 23, 25 and 1.</strong></td>
<td></td>
</tr>
<tr>
<td>Should also agree with Line 145, plus Line 144, minus Line 142</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Line 244</th>
<th>Beginning Claim Reserves and Liabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life/Fraternal:</strong> Column 13, should agree with Schedule H, Part 2, Line C2, Column 1, minus Exhibit 8, Part 2, Line 5, sum of Columns 9, 10 and 11.</td>
<td></td>
</tr>
<tr>
<td><strong>Property:</strong> Columns 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13 should agree with Schedule H, Part 2, Line C2, Columns 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 1, respectively.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Line 345</th>
<th>Ending Claim Reserves and Liabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclude: Amounts recoverable from reinsurers.</td>
<td></td>
</tr>
<tr>
<td><strong>Life/Fraternal:</strong> Column 13, should agree with Schedule H, Part 2, Line C1, Column 1, minus Exhibit 8, Part 2, Line 3, sum of Columns 9, 10 and 11.</td>
<td></td>
</tr>
<tr>
<td><strong>Property:</strong> Columns 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13 should agree with Schedule H, Part 2, Line C1, Columns 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 1, respectively.</td>
<td></td>
</tr>
</tbody>
</table>
Line 416 – Claims Paid

**Life/Fraternal:** Column 13 should agree with Exhibit 8, Part 2, Line 1.4, sum of Columns 9, 10 and 11.

**Property:** Column 13 should agree with Underwriting and Investment Exhibit, Part 2, Column 4, sum of Lines 13, 14 and 15.

- **Column 1** – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 13.1.
- **Column 2** – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 13.2.
- **Column 3** – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.4.
- **Column 4** – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.5.
- **Column 5** – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.8.
- **Column 6** – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.6.
- **Column 7** – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.5.
- **Column 8** – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.4.
- **Column 9** – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 14.
- **Column 10** – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.3.
- **Column 11** – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.7.
- **Column 12** – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.9.
E. NET INCURRED CLAIMS AND COST CONTAINMENT EXPENSES

Line 142 - Incurred Claims and Cost Containment Expenses
Should agree with Schedule H, Part 1, Line 5, Column 1.

Line 218 - Beginning Reserves and Liabilities

Life/Fraternal: Column 13 should agree with Exhibit 2, Column 2, Line 11 plus Line 214 above.

Property: Should agree with Underwriting and Investment Exhibit, Part 3, Column 1 (in part), plus Line 214 above.

Line 319 - Ending Reserves and Liabilities

Life/Fraternal: Column 13 should agree with Exhibit 2, Column 2, Line 12 plus Line 315 above.

Property: Should agree with Underwriting and Investment Exhibit, Part 3, Column 1 (in part), plus Line 315 above.

Line 420 - Paid Claims and Cost Containment Expenses
Line 471 plus Line 482 minus Line 493.
ANNUAL STATEMENT INSTRUCTIONS –PROPERTY

SCHEDULE H

ACCIDENT AND HEALTH EXHIBIT

**Life/Fraternal:** “ Appropriately” where used in the Instructions for Schedule H, means the appropriate accident and health portions of referenced data. Reconciliation with figures drawn from other parts of the statement may only be possible with respect to Group Accident and Health (Column 3), Credit (Group and Individual) Accident and Health (Column 5) and Other Accident and Health (the combination of Columns 7 through 17), and, in some cases, may only be possible with respect to Total Accident and Health (Column 1) of Schedule H – Accident and Health Exhibit.

For definitions of lines of business, see the appendix of these instructions.

All amounts reportable in Parts 1 through 3 are net of reinsurance; (i.e., reinsurance assumed should be included, reinsurance ceded should be deducted, and net figures entered in the statement.) Part 4, Reinsurance displays the reinsurance assumed and ceded components.

Column 5 — Credit A & H (Group and Individual)

Include: __________ Business not exceeding 120 months duration.

Column 7 — Collectively Renewable

Include: __________ Amounts pertaining to policies that are made available to groups of persons under a plan sponsored by an employer, or an association or a union or affiliated associations or unions or a group of individuals supplying materials to a central point of collection or handling a common product or commodity, under which the reporting entity has agreed with respect to such policies that renewal will not be refused, subject to any specified age limit, while the insured remains a member of the group specified in the agreement unless the reporting entity simultaneously refuses renewal to all other policies in the same group. A sponsored plan shall not include any arrangement where a reporting entity’s customary individual policies are made available without special underwriting considerations and where the employer’s participation is limited to arranging for salary allotment premium payments with or without contribution by the employer. Such plans are sometimes referred to as payroll budget or salary allotment plans. A sponsored plan may be administered by an agent or trustee.

Amounts pertaining to policies issued by a company or group of companies under a plan, other than a group insurance plan, authorized by special legislation for the exclusive benefit of the aged through mass enrollment.

Amounts pertaining to policies issued under mass enrollment procedures to older people, such as those age 65 and over, in some geographic region or regions under which the reporting entity has agreed with respect to such policies that renewal will not be refused unless the reporting entity simultaneously refuses renewal to all other policies specified in the agreement.

Column 9 — Non-Cancelable

Include: __________ Amounts pertaining to policies, which are guaranteed renewable for life or to a specified age, such as 60 or 65, at guaranteed premium rates.
**Column 11 — Guaranteed Renewable**

Include: Amounts pertaining to policies that are guaranteed renewable for life or to a specified age, such as 60 or 65, but under which the reporting entity reserves the right to change the scale of premium rates.

**Column 13 — Non-Renewable for Stated Reasons Only**

Include: Amounts pertaining to policies in which the reporting entity has reserved the right to cancel or refuse renewal for one or more stated reasons, but has agreed implicitly or explicitly that, prior to a specified time or age, it will not cancel or decline renewal solely because of deterioration of health after issue.

**Column 17 — All Other**

Include: Any other accident and health coverages not specifically required in other columns. All Medicare Part D Prescription Drug Coverage, whether sold on a stand alone basis or through a Medicare Advantage product and whether sold directly to an individual or through a group.

---

**PART 1 – ANALYSIS OF UNDERWRITING OPERATIONS**

In each “%” column of Part 1, show the percentages of Line 2 for Lines 3 through 14 inclusive.

**Line 1 — Premiums Written**

- **Life/Fraternal:** Column 1 should agree with Schedule T, Column 4 Line 97 minus Line 98 if prepared on a written basis.
- **Property:** Column 1 should agree with Underwriting and Investment Exhibit, Part 1B sum of Lines 13 through 15 (Column 6).

Should agree appropriately with those shown in the Underwriting and Investment Exhibit, Part 1B.

**Line 2 — Premiums Earned**

Refer to SSAP No. 54R—Individual and Group Accident and Health Contracts for accounting guidance.

Should agree with Line 1 plus the change in unearned premiums and reserve for rate credits included in Part 2, Section A.

Should agree appropriately with those shown in the Underwriting and Investment Exhibit, Part 1.

**Line 3 — Incurred Claims**

Report cash settlements during the year plus the change in claim liabilities, reserves and amounts recoverable from reinsurers.

- **Life/Fraternal:** Should agree appropriately with both Exhibit 8, Part 2, Line 6.4 and also with Analysis of Operations by Lines of Business – Summary, Column 6, Line 13, in each case adjusted for the change in Exhibit 6 of Aggregate Accident and Health Reserves, Line 16 reserves.
Should agree appropriately with losses incurred as shown in the Underwriting and Investment Exhibit, Part 2.

Property: Column 1 should agree with Underwriting and Investment Exhibit, Part 2 sum of Lines 13 through 15 (Column 7).


Line 4 – Cost Containment Expenses

Report cost containment expenses in accordance with SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses.

Life/Frataln: Should agree with Exhibit 2, Column 2, Line 10.

Line 4 plus Line 8 should agree appropriately with the sum of Columns 9, 11, 27 and 29 of the Insurance Expense Exhibit, Part II.

Property: Column 1 (Line 4 plus Line 8) should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29) sum of Lines 13 through 15.

Column 3 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29), Lines 13.1.

Column 5 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29), Lines 13.2.

Column 7 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29), Lines 15.4.

Column 9 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29), Lines 15.8.

Column 11 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29), Lines 15.2.

Column 13 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29), Lines 15.8.

Column 15 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29), Lines 15.6.

Column 17 – Line 4 plus Line 8 should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and + 29), Lines 15.5.
<table>
<thead>
<tr>
<th>Column</th>
<th>Line</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 19</td>
<td>4 plus 8</td>
<td>Line 14. Should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and 29).</td>
</tr>
<tr>
<td>Column 21</td>
<td>4 plus 8</td>
<td>Line 15. Should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and 29).</td>
</tr>
<tr>
<td>Column 23</td>
<td>4 plus 8</td>
<td>Line 15.7. Should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and 29).</td>
</tr>
<tr>
<td>Column 25</td>
<td>4 plus 8</td>
<td>Line 15.9. Should agree with the Insurance Expense Exhibit, Part II (Columns 9 + Column 11 + Column 27 and 29).</td>
</tr>
</tbody>
</table>

Line 5  – Incurred Claims and Cost Containment Expenses

Sum of Lines 3 and 4.

Line 6  – Increase in Contract Reserves

Should agree with Schedule H, Part 2, Section B, Line 5.

Line 7  – Commissions

Report incurred commissions and expense allowances on reinsurance.

**Life/Fraternity:**

Should agree appropriately with the net of Exhibit 1, Part 2, Line 31 minus Line 26.3 and also with the net of Analysis of Operations by Lines of Business – Summary, Column 6, Line 21 plus Line 22, minus Line 6, Accident and Health columns.

**Property:**

Column 1 should agree with Insurance Expense Exhibit, Part II sum of Lines 13 through 15 (Column 23).


Column 5  – Should agree with the Insurance Expense Exhibit, Part II, Column 23, Line 13.2.

Column 7  – Should agree with the Insurance Expense Exhibit, Part II, Column 23, Line 15.4.

Column 9  – Should agree with the Insurance Expense Exhibit, Part II, Column 23, Line 15.5.

Column 11  – Should agree with the Insurance Expense Exhibit, Part II, Column 23, Line 15.2.


Column 17 – Should agree with the Insurance Expense Exhibit, Part II, Column 23, Lines 15.5.


Column 21 – Should agree with the Insurance Expense Exhibit, Part II, Column 23, Lines 15.3.

Column 23 – Should agree with the Insurance Expense Exhibit, Part II, Column 23, Lines 15.7.


Line 8 – Other General Insurance Expenses

Report general insurance expenses incurred and provision for claim expenses incurred in connection with pending and incurred but unreported claims not included in Cost Containment Expenses on Line 4 above.

Life/Fraternal: Should agree appropriately with Exhibit 2, Column 3, Line 10.

Line 4 plus Line 8 should agree appropriately with the sum of Columns 9, 11, 27 and 29 of the Insurance Expense Exhibit, Part II.

Line 9 – Taxes, Licenses and Fees

Report total taxes (excluding federal income taxes) plus state insurance department licenses and fees.

Life/Fraternal: Should agree appropriately with Exhibit 3, Column 2, Line 7 and also with Analysis of Operations by Lines of Business – Summary, Column 6, Line 24, Accident and Health columns.

Should agree appropriately with Column 25 of the Insurance Expense Exhibit, Part II.

Property: Column 1 should agree with Insurance Expense Exhibit, Part II sum of Lines 13 through 15 (Column 25).


Column 5 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 13.2.

Column 7 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.4.
Column 9 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.9.

Column 11 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.2.

Column 13 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.8.

Column 15 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.6.

Column 17 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.5.


Column 21 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.3.

Column 23 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.7.

Column 25 – Should agree with the Insurance Expense Exhibit, Part II, Column 25, Lines 15.9.

Line 10 – Total Other Expenses Incurred

Sum of Lines 7, 8 and 9.

Line 11 – Aggregate Write-ins for Deductions

Enter the total of the write-ins listed in Schedule Detail of Write-ins Aggregated at Line 11 for Deductions.

Line 12 – Gain From Underwriting Before Dividends or Refunds

Report premiums earned less incurred claims, less increase in policy reserves and less total expenses incurred. Line 2 minus the sum of Lines 5, 6, 10 and 11.

Line 13 – Dividends or Refunds

Life/Fraternals: Should agree appropriately with Analysis of Operations by Lines of Business – Summary, Column 6, Line 30, Accident and Health columns, and also with Exhibit 4, Dividends or Refunds, Column 2, Line 17.

Should agree appropriately with Column 5 of the Insurance Expense Exhibit, Part II.

Property: Column 1 should agree with Insurance Expense Exhibit, Part II sum of Lines 13 through 15 (Column 5).


Column 5 – Should agree with the Insurance Expense Exhibit, Part II, Column 5, Lines 13.2.
| Column 7 | Should agree with the Insurance Expense Exhibit, Part II, Column 5, Line 15.4 |
| Column 9 | Should agree with the Insurance Expense Exhibit, Part II, Column 5, Line 15.5 |
| Column 11 | Should agree with the Insurance Expense Exhibit, Part II, Column 5, Line 15.2 |
| Column 13 | Should agree with the Insurance Expense Exhibit, Part II, Column 5, Line 15.8 |
| Column 15 | Should agree with the Insurance Expense Exhibit, Part II, Column 5, Line 15.6 |
| Column 17 | Should agree with the Insurance Expense Exhibit, Part II, Column 5, Line 15.5 |
| Column 19 | Should agree with the Insurance Expense Exhibit, Part II, Column 5, Line 14 |
| Column 21 | Should agree with the Insurance Expense Exhibit, Part II, Column 5, Line 15.3 |
| Column 23 | Should agree with the Insurance Expense Exhibit, Part II, Column 5, Line 15.7 |
| Column 25 | Should agree with the Insurance Expense Exhibit, Part II, Column 5, Line 15.9 |

**Line 14**  
Gain From Underwriting After Dividends or Refunds

Line 12 minus Line 13.

**Details of Write-ins Aggregated at Line 11 for Deductions**

List separately each category of deductions for which there is no pre-printed line on Schedule H, Part 1.

Include: Group conversions, transfers on account of group package policies and contracts, etc.
PART 2 – RESERVES AND LIABILITIES

SECTION A – PREMIUM RESERVES

Should agree appropriately with those in the Underwriting and Investment Exhibit, Part 1A minus amounts reported as contract reserves in Schedule H, Part 2, Section B, below.

Line 1 – Unearned Premiums

Life/Fraternal: Should agree appropriately with Exhibit 6, Line 1, net of applicable reinsurance ceded.

Property: Column 1 should agree with Underwriting and Investment Exhibit, Part 1A, Column 1 plus Column 2, sum of Lines 13, 14 and 15.

Line 2 – Advance Premiums

Life/Fraternal: Should agree appropriately with the sum of Exhibit 1, Part 1, Lines 4 and 14.

Line 3 – Reserve for Rate Credits

Life/Fraternal: Should agree appropriately with the net of Exhibit 6, Line 5, net of applicable reinsurance ceded, plus Page 3, Line 9.2 parenthetical amount #1 minus Page 2, Line 15.3, Column 3, accident and health portion.

Not applicable to Fraternal Benefit Societies.

Property: Column 1 should agree with Underwriting and Investment Exhibit, Part 1A, Column 4, sum of Lines 13, 14 and 15:


Column 3 – Should agree with Underwriting and Investment Exhibit, Part 1A, Column 4, Lines 13.2.

Column 4 – Should agree with Underwriting and Investment Exhibit, Part 1A, Column 4, Lines 15.4.

Column 5 – Should agree with Underwriting and Investment Exhibit, Part 1A, Column 4, Lines 15.5.

Column 6 – Should agree with Underwriting and Investment Exhibit, Part 1A, Column 4, Lines 15.2.

Column 7 – Should agree with Underwriting and Investment Exhibit, Part 1A, Column 4, Lines 15.8.

Column 8 – Should agree with Underwriting and Investment Exhibit, Part 1A, Column 4, Lines 15.6.

Column 9 – Should agree with Underwriting and Investment Exhibit, Part 1A, Column 4, Lines 15.5.

Column 10 – Should agree with Underwriting and Investment Exhibit, Part 1A, Column 4, Lines 14.
**SECTION B – CONTRACT RESERVES**

**Line 1** – Additional Reserves

Refer to *SSAP No. 54R—Individual and Group Accident and Health Contracts* for accounting guidance.

Include: Premium deficiency reserve.

Companies must carry a reserve in this line for any policy or block of policies:

(i) With which level premiums are used, or
(ii) With respect to which, due to the gross premium structure at issue, the value of future benefits exceeds the value of appropriate future valuation net premiums.

Companies must carry a reserve for any block of contracts for which future gross premiums when reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims or services.

**Line 2** – Reserve for Future Contingent Benefits

Companies must carry a reserve on this line that provides for the extension of benefits after termination of the policy or of any insurance thereunder. Such benefits, that actually accrue and are payable at some future date, are predicated on a condition or actual disability that exists at the termination of the insurance and that is usually not known to the insurance company. These benefits are normally provided by contract provision but may be payable because of court decisions or of departmental rulings.

An example of the type of benefit for which a reserve must be carried is the coverage for hospital confinement after the termination of an employee’s certificate but prior to the expiration of a stated period. This example is illustrative only and is not intended to limit the reserve to the benefits described. Some individual Accident and Health policies may also provide benefits similar to those under the “Extension of Benefits” section of a group policy.
<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Total Contract Reserves, Current Year</td>
<td>Sum of Lines 1 and 2.</td>
</tr>
<tr>
<td>4</td>
<td>Total Contract Reserves, Prior Year</td>
<td>Line 3 from prior year. <em>(For 2022 this only applies to Column 1. For 2023 it applies to all columns.)</em></td>
</tr>
<tr>
<td>5</td>
<td>Increase in Contract Reserves</td>
<td>Line 3 minus Line 4.</td>
</tr>
</tbody>
</table>

**SECTION C – CLAIM RESERVES AND LIABILITIES**

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Total Current Year</td>
<td>Life/Fraternal: Should agree appropriately with the sum of Exhibit 6, Line 16 and Exhibit 8, Part 1, Line 4.4. Property: Column 1 should agree with Underwriting and Investment Exhibit, Part 2 sum of Lines 13 through 15 (Column 5). Should agree appropriately with Net Losses Unpaid shown in the Underwriting and Investment Exhibit, Part 2, Column 5. Also should agree with Schedule H, Part 3, Line 2.1; plus Schedule H, Part 3, Line 2.2 below.</td>
</tr>
<tr>
<td>2</td>
<td>Total Prior Year</td>
<td>Line 1 from prior year. <em>(For 2022 this only applies to Column 1. For 2023 it applies to all columns.)</em> Should agree with Schedule H, Part 3, Line 3.2 below. Property: Column 13 should agree with Underwriting and Investment Exhibit, Part 2, Column 6, sum of Lines 13, 14 and 15.</td>
</tr>
<tr>
<td>3</td>
<td>Increase</td>
<td>Line 1 minus Line 2.</td>
</tr>
</tbody>
</table>
PART 3 – TEST OF PRIOR YEAR’S CLAIM RESERVES AND LIABILITIES

Lines 1.1 and 1.2 – Claims Paid During the Year on Claims Incurred Prior to and During Current Year

Represents net payments made during the year less the change in amounts still recoverable from reinsurance.

Life/Fratal: The sum of Lines 1.1 and 1.2 should agree appropriately with Exhibit 8, Part 2, Lines 1.4 minus Line 3 plus Line 5.

Lines 2.1, 2.2 and 3.2 – Claim Reserves and Liabilities, December 31 on Claims Incurred Prior to and During Current Year

The sum of lines 2.1 and 2.2 should equal Line C1 of Part 2 of this schedule and Line 3.2 should equal Line C2 of Part 2 of this schedule. Line 3.3 represents the result of the test for adequacy of claim provisions. A negative figure will normally indicate a favorable reserve development.

PART 4 – REINSURANCE

Represents the reinsurance assumed and ceded components of Part 1, Lines 1, 2, 3 and 7 of this schedule.

SECTIONS A AND B

Line 2 – Premiums Earned

Premiums earned are before adjustment for the increase in policy reserves that has been treated as a separate deduction.

PART 5 – HEALTH CLAIMS

Companies with less than 5% of premiums in Accident and Health business should not complete this schedule.

Column 3 Other

Include: All Medicare Part D Prescription Drug Coverage, whether sold on a stand-alone basis or through a Medicare Advantage product and whether sold directly to an individual or through a group.

A. DIRECT

Line 1 – Incurred Claims

Should agree with Line 3 plus Line 4 minus Line 2.

Line 2 – Beginning Claim Reserves and Liabilities

Life/Fratal: Column 13 should agree with Exhibit 8, Part 2, Line 4.1, sum of Columns 9, 10 and 11, plus direct portion of Exhibit 6, Line 14, Column 1, Prior Year.
<table>
<thead>
<tr>
<th>Line</th>
<th>Ending Claim Reserves and Liabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Life/Fraternal:</strong> Column 13 should agree with Exhibit 8, Part 2, Line 2.1, sum of Columns 9, 10 and 11, plus direct portion of Exhibit 6, Line 14, Column 1.</td>
</tr>
<tr>
<td></td>
<td><strong>Claims Paid</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Life/Fraternal:</strong> Column 13 should agree with Exhibit 8, Part 2, Line 1.1, sum of Columns 9, 10 and 11.</td>
</tr>
<tr>
<td></td>
<td><strong>Property:</strong> Column 13 should agree with Underwriting and Investment Exhibit, Part 2, Column 1, sum of Lines 13, 14 and 15.</td>
</tr>
<tr>
<td></td>
<td>Column 1  —  Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 13.1.</td>
</tr>
<tr>
<td></td>
<td>Column 2  —  Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 13.2.</td>
</tr>
<tr>
<td></td>
<td>Column 3  —  Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.4.</td>
</tr>
<tr>
<td></td>
<td>Column 4  —  Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.5.</td>
</tr>
<tr>
<td></td>
<td>Column 5  —  Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.2.</td>
</tr>
<tr>
<td></td>
<td>Column 6  —  Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.8.</td>
</tr>
<tr>
<td></td>
<td>Column 7  —  Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.6.</td>
</tr>
<tr>
<td></td>
<td>Column 8  —  Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.5.</td>
</tr>
<tr>
<td></td>
<td>Column 9  —  Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 14.</td>
</tr>
<tr>
<td></td>
<td>Column 10 —  Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.3.</td>
</tr>
<tr>
<td></td>
<td>Column 11 —  Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.7.</td>
</tr>
<tr>
<td></td>
<td>Column 12 —  Should agree with the Underwriting and Investment Exhibit, Part 2, Column 1, Line 15.9.</td>
</tr>
</tbody>
</table>
B. ASSUMED REINSURANCE

Line 15 – Incurred Claims

Columns 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13 should **should** agree with Schedule H, Part 4, Line A3, Columns 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 1, respectively.

**Should also agree with Line 37 plus Line 48, minus Line 26.**

Line 26 – Beginning Claim Reserves and Liabilities

**Life/Fraternal:** Column 13S should agree with Exhibit 8, Part 2, Line 4.2, sum of Columns 9, 10 and 11 plus assumed portion of Exhibit 6, Line 14, Column 1, Prior Year.

**Line 37 – Ending Claim Reserves and Liabilities**

**Life/Fraternal:** Column 13S should agree with Exhibit 8, Part 2, Line 2.2, sum of Columns 9, 10 and 11, plus assumed portion of Exhibit 6, Line 14, Column 1.

**Line 48 – Claims Paid**

**Life/Fraternal:** Column 13S should agree with Exhibit 8, Part 2, Line 1.2, sum of Columns 9, 10 and 11.

**Property:** Column 13S should agree with Underwriting and Investment Exhibit, Part 2, Column 2, sum of Lines 13, 14 and 15.

**Column 1 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 13.1.**

**Column 2 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 13.2.**

**Column 3 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.4.**

**Column 4 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.5.**

**Column 5 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.6.**

**Column 6 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.8.**

**Column 7 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.6.**

**Column 8 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.5.**

**Column 9 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 14.**

**Column 10 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 2, Line 15.3.**
C. **Ceded Reinsurance**

Line **19** – Incurred Claims

Columns 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13 should agree with Schedule H, Part 4, Line B3, Columns 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 1, respectively. Should also agree with Line **211**, plus Line **312**, minus Line **210**.

Line **210** – Beginning Claim Reserves and Liabilities

Include: Amounts recoverable from reinsurers.

Life/Fraternal: Column **13S** should agree with Exhibit 8, Part 2, Line 4.3, plus Line 5, sum of Columns 9, 10 and 11, plus Exhibit 6, Line 15, Column 1, Prior Year.

Line **312** – Ending Claim Reserves and Liabilities

Include: Amounts recoverable from reinsurers.

Life/Fraternal: Column **13S** should agree with Exhibit 8, Part 2, Line 2.3, plus Line 3, sum of Columns 9, 10 and 11, plus Exhibit 6, Line 15, Column 1.

Line **412** – Claims Paid

Life/Fraternal: Column **13S** should agree with Exhibit 8, Part 2, Line 1.3, sum of Columns 9, 10 and 11.

Property: Column **13** should agree with Underwriting and Investment Exhibit, Part 2, Column 3, sum of Lines 13, 14 and 15.

Column 1 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line **13.1**.

Column 2 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line **13.2**.

Column 3 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line **15.4**.

Column 4 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line **15.5**.

Column 5 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line **15.2**.

Column 6 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line **15.8**.

Column 7 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 3, Line **15.6**.
**D. NET**

**Incurred Claims**

Columns 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13 should agree with Schedule H, Part 1, Line 3, Columns 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, 23, 25 and 1.

Should also agree with Line 315, plus Line 416, minus Line 214.

Should agree with Underwriting and Investment Exhibit, Part 2, Column 7, sum of Lines 13, 14 and 15 and Schedule H, Part 1, Line 3, Column 1.

**Beginning Claim Reserves and Liabilities**

Life/Fraternal: Column 13 should agree with Schedule H, Part 2, Line C2, Column 1, minus Exhibit 8, Part 2, Line 3, sum of Columns 9, 10 and 11.

Property: Columns 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13 should agree with Schedule H, Part 2, Line C2, Columns 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 1, respectively.

Should agree with Underwriting and Investment Exhibit, Part 2, Column 6, sum of Lines 13, 14 and 15 and Schedule H, Part 2, Line C2, Column 1.

**Ending Claim Reserves and Liabilities**

Exclude: Amounts recoverable from reinsurers.

Life/Fraternal: Column 13 should agree with Exhibit 8, Part 2, Line 1.4, sum of Columns 9, 10 and 11.

Property: Columns 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13 should agree with Schedule H, Part 2, Line C1, Columns 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 1, respectively.

Should agree with Underwriting and Investment Exhibit, Part 2, Column 5, sum of Lines 13, 14 and 15 and Schedule H, Part 2, Line C1, Column 1.

**Claims Paid**

Life/Fraternal: Column 13 should agree with Exhibit 8, Part 2, Line 1.4, sum of Columns 9, 10 and 11.
Property: Column 13 Should should agree with Underwriting and Investment Exhibit, Part 2, Column 4, sum of Lines 13, 14 and 15.

Column 1 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 13.1.

Column 2 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 13.2.

Column 3 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.4.

Column 4 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.51

Column 5 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.2.

Column 6 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.8.

Column 7 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.6.

Column 8 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.5.

Column 9 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 14.

Column 10 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.3.

Column 11 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.7.

Column 12 – Should agree with the Underwriting and Investment Exhibit, Part 2, Column 4, Line 15.9.

E. NET INCURRED CLAIMS AND COST CONTAINMENT EXPENSES

Line 147 Incurred Claims and Cost Containment Expenses

Should agree with Schedule H, Part 1, Line 5, Column 1.

Line 248 Beginning Reserves and Liabilities

Life/Fraternal: Column 13 Should agree with Exhibit 2, Column 2, Line 11 plus Line 14 above.

Property: Should agree with Underwriting and Investment Exhibit, Part 3, Column 1 (in part), plus Line 14 above.

Line 319 Ending Reserves and Liabilities

Life/Fraternal: Column 13 Should agree with Exhibit 2, Column 2, Line 12 plus Line 15 above.
Property: Should agree with Underwriting and Investment Exhibit, Part 3, Column 1 (in part), plus Line 15 above.

Line 420 - Paid Claims and Cost Containment Expenses

Line 117 plus Line 218 minus Line 319.
### UNDERWRITING AND INVESTMENT EXHIBIT

#### PART 1 – PREMIUMS EARNED

<table>
<thead>
<tr>
<th>Column 1</th>
<th>– Net Premiums Written</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The amounts reported for the lines in this column should agree with the amounts reported for the identical line in Column 6 of the Underwriting and Investment Exhibit, Part 1B.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 2</th>
<th>– Unearned Premiums December 31 Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The amounts reported for the lines in this column should agree with the amounts reported for the identical line in Column 3 of the prior year Underwriting and Investment Exhibit, Part 1.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 3</th>
<th>– Unearned Premiums December 31 Current Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The amounts reported for the lines in this column should agree with the amounts reported for the identical line in Column 5 of the Underwriting and Investment Exhibit, Part 1A.</td>
</tr>
<tr>
<td></td>
<td>Refer to SSAP No. 53—Property-Casualty Contracts – Premiums for accounting guidance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column 4</th>
<th>– Premiums Earned During Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sum of Lines 13 through 15 should agree with Schedule H, Part 1, Column 1 (Line 2 minus Line 6).</td>
</tr>
</tbody>
</table>

| Line 15 | Should agree with Schedule H, Part 1, Line 2 – Line 6, Columns 7 through 17. |
| Line 35 | Should agree with Page 4, Line 1, Column 1. |

| Line 13.1 | Comprehensive (Hospital and Medical) Individual |
| Line 13.2 | Comprehensive (Hospital and Medical) Group |
| Line 14   | Credit A&H (Group and Individual) |
| Line 15.1 | Vision Only |
| Line 15.2 | Dental Only |

| Line 13.1 | Column 4 should agree with Schedule H, Part 1, Line 2 minus Line 6, Column 3. |
| Line 13.2 | Column 4 should agree with Schedule H, Part 1, Line 2 minus Line 6, Column 5. |
| Line 14   | Column 4 should agree with Schedule H, Part 1, Line 2 minus Line 6, Column 19. |
| Line 15.1 | Column 4 should agree with Schedule H, Part 1, Line 2 minus Line 6, Column 9. |
| Line 15.2 | Column 4 should agree with Schedule H, Part 1, Line 2 minus Line 6, Column 11. |
Line 15.3 — Disability Income

Column 4 should agree with Schedule H, Part 1, Line 2 minus Line 6, Column 21.

Line 15.4 — Medicare Supplement

Column 4 should agree with Schedule H, Part 1, Line 2 minus Line 6, Column 7.

Line 15.5 — Medicaid Title XIX

Column 4 should agree with Schedule H, Part 1, Line 2 minus Line 6, Column 17.

Line 15.6 — Medicare Title XVIII

Column 4 should agree with Schedule H, Part 1, Line 2 minus Line 6, Column 15.

Line 15.7 — Long-Term Care

Column 4 should agree with Schedule H, Part 1, Line 2 minus Line 6, Column 23.

Line 15.8 — Federal Employees Health Benefits Plan Premium

Column 4 should agree with Schedule H, Part 1, Line 2 minus Line 6, Column 13.

Line 15.9 — Other Health

Column 4 should agree with Schedule H, Part 1, Line 2 minus Line 6, Column 25.
UNDERWRITING AND INVESTMENT EXHIBIT

PART 1A – RECAPITULATION OF ALL PREMIUMS

Detail Eliminated to Conserve Space

Line 15 should include additional reserves on noncancelable accident and health policies.

Refer to SSAP No. 54R—*Individual and Group Accident and Health Contracts* for accounting guidance.

Attach to the annual statement a description of the methods used in computing this reserve for each type of coverage for which a reserve is held.

**Line 13.1** – Comprehensive (Hospital and Medical) Individual Group Accident and Health

Column 1 plus Column 2 should agree with Schedule H, Part 2, Line A1, Column 2.

**Line 13.2** – Comprehensive (Hospital and Medical) Group

Column 1 plus Column 2 should agree with Schedule H, Part 2, Line A1, Column 3.

**Line 14** – Credit Accident and Health

Column 1 plus Column 2 should agree with Schedule H, Part 2, Line A1, Column 410. Column 4 should agree with Schedule H, Part 2, Line A3, Column 310. Include: Business not exceeding 120 months duration.

**Line 15.1** – Vision Only Other Accident and Health

Column 1 plus Column 2 should agree with Schedule H, Part 2, Line A1, Columns 4 through 95.

**Line 15.2** – Dental Only

Column 1 plus Column 2 should agree with Schedule H, Part 2, Line A1, Columns 6.

**Line 15.3** – Disability Income

Column 1 plus Column 2 should agree with Schedule H, Part 2, Line A1, Columns 11.

**Line 15.4** – Medicare Supplement

Column 1 plus Column 2 should agree with Schedule H, Part 2, Line A1, Columns 4.

**Line 15.5** – Medicaid Title XIX

Column 1 plus Column 2 should agree with Schedule H, Part 2, Line A1, Columns 9.

**Line 15.6** – Medicare Title XVIII

Column 1 plus Column 2 should agree with Schedule H, Part 2, Line A1, Columns 8.
Line 15.7  –  Long-Term Care

Column 1 plus Column 2 should agree with Schedule H, Part 2, Line A1, Columns 12.

Line 15.8  –  Federal Employees Health Benefits Plan Premium

Column 1 plus Column 2 should agree with Schedule H, Part 2, Line A1, Columns 7.

Line 15.9  –  Other Health

Column 1 plus Column 2 should agree with Schedule H, Part 2, Line A1, Columns 13.

Line 34  –  Aggregate Write-ins for Other Lines of Business

Enter the total of the write-ins listed in schedule Details of Write-ins Aggregated at Line 34 for Other Lines of Business.

Line 36  –  Accrued Retrospective Premiums Based on Experience

Include:

- Accrued return retrospective premiums required by policy terms or law.
- Accrued MLR Rebates per the Public Health Service Act.

**Retrospective Premium Adjustment Made Through Earned Premium:**

Enter the total gross accrued retrospective debit adjustment based on experience, included as a negative amount in Column 4 if the company accrues for additional retrospective premiums by adjusting earned premiums.

**Retrospective Premium Adjustment Made Through Written Premium:**

Enter the total gross accrued retrospective credit adjustments based on experience if the company accrues for additional retrospective premiums by adjusting written premiums.

Refer to *SSAP No. 66—Retrospectively Rated Contracts*. Per SSAP No. 66, retrospective premium adjustments shall be estimated based on the experience to date.

Details of Write-ins Aggregated at Line 34 for Other Lines of Business

List separately each line of business for which there is no pre-printed line on Underwriting and Investment Exhibit, Part 1A.
UNDERWRITING AND INVESTMENT EXHIBIT

PART 1B – PREMIUMS WRITTEN

Column 1 – Direct Business

Line 35 should agree with Schedule T, Line 59, Column 2.

Column 6 – Net Premiums Written

Should agree with Underwriting and Investment Exhibit, Part 1, Column 1, for all lines.

Line 13.1 – Comprehensive (Hospital and Medical) Individual Group Accident and Health

Column 2 plus Column 3 should agree with Schedule H, Part 4, Line A1, Column 2.

Column 4 plus Column 5 should agree with Schedule H, Part 4, Line B1, Column 2.

Column 6 should agree with Schedule H, Part 1, Line 1, Column 3.

Line 13.2 – Comprehensive (Hospital and Medical) Group

Column 2 plus Column 3 should agree with Schedule H, Part 4, Line A1, Column 3.

Column 4 plus Column 5 should agree with Schedule H, Part 4, Line B1, Column 3.

Column 6 should agree with Schedule H, Part 1, Line 1, Column 5.

Line 14 – Credit Accident and Health

Column 2 plus Column 3 should agree with Schedule H, Part 4, Line A1, Column 310.

Column 4 plus Column 5 should agree with Schedule H, Part 4, Line B1, Column 310.

Column 6 should agree with Schedule H, Part 1, Line 1, Column 519.

Include: Business not exceeding 120 months duration.

Line 15.1 – Vision Only Other Accident and Health

Column 2 plus Column 3 should agree with Schedule H, Part 4, Line A1, Columns 4 through 95.

Column 4 plus Column 5 should agree with Schedule H, Part 4, Line B1, Columns 4 through 95.

Column 6 should agree with Schedule H, Part 1, Line 1, Columns 7 through 179.

Line 15.2 – Dental Only

Column 2 plus Column 3 should agree with Schedule H, Part 4, Line A1, Columns 6.

Column 4 plus Column 5 should agree with Schedule H, Part 4, Line B1, Columns 6.

Column 6 should agree with Schedule H, Part 1, Line 1, Columns 11.

Line 15.3 – Disability Income

Column 2 plus Column 3 should agree with Schedule H, Part 4, Line A1, Columns 11.
Column 4 plus Column 5 should agree with Schedule H, Part 4, Line B1, Columns 11.

Column 6 should agree with Schedule H, Part 1, Line 1, Columns 21.

Line 15.4 – Medicare Supplement

Column 2 plus Column 3 should agree with Schedule H, Part 4, Line A1, Columns 4.

Column 4 plus Column 5 should agree with Schedule H, Part 4, Line B1, Columns 4.

Column 6 should agree with Schedule H, Part 1, Line 1, Columns 7.

Line 15.5 – Medicaid Title XIX

Column 2 plus Column 3 should agree with Schedule H, Part 4, Line A1, Columns 9.

Column 4 plus Column 5 should agree with Schedule H, Part 4, Line B1, Columns 9.

Column 6 should agree with Schedule H, Part 1, Line 1, Columns 17.

Line 15.6 – Medicare Title XVIII

Column 2 plus Column 3 should agree with Schedule H, Part 4, Line A1, Columns 8.

Column 4 plus Column 5 should agree with Schedule H, Part 4, Line B1, Columns 8.

Column 6 should agree with Schedule H, Part 1, Line 1, Columns 15.

Line 15.7 – Long-Term Care

Column 2 plus Column 3 should agree with Schedule H, Part 4, Line A1, Columns 12.

Column 4 plus Column 5 should agree with Schedule H, Part 4, Line B1, Columns 12.

Column 6 should agree with Schedule H, Part 1, Line 1, Columns 23.

Line 15.8 – Federal Employees Health Benefits Plan Premium

Column 2 plus Column 3 should agree with Schedule H, Part 4, Line A1, Columns 7.

Column 4 plus Column 5 should agree with Schedule H, Part 4, Line B1, Columns 7.

Column 6 should agree with Schedule H, Part 1, Line 1, Columns 13.

Line 15.9 – Other Health

Column 2 plus Column 3 should agree with Schedule H, Part 4, Line A1, Columns 13.

Column 4 plus Column 5 should agree with Schedule H, Part 4, Line B1, Columns 13.

Column 6 should agree with Schedule H, Part 1, Line 1, Columns 25.

Line 35 – Totals

Column 4 plus Column 5 should agree with Schedule F, Part 3, Column 6, Total multiplied by 1000.
## UNDERWRITING AND INVESTMENT EXHIBIT

### PART 2 – LOSSES PAID AND INCURRED

Refer to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses for accounting guidance.

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Losses Paid Less Salvage – Direct Business</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line 35</td>
<td>Should agree with Schedule T, Line 59, Column 5.</td>
</tr>
</tbody>
</table>

**Detail Eliminated to Conserve Space**

<table>
<thead>
<tr>
<th>Column 5</th>
<th>Net Losses Unpaid Current Year</th>
</tr>
</thead>
</table>

**Sum of Lines 13, 14 and 15 should agree with Schedule H, Part 3, Line 2.1 plus Line 2.2, Column 1**

**Detail Eliminated to Conserve Space**

<table>
<thead>
<tr>
<th>Column 8</th>
<th>Percentage of Losses Incurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line 13.1</td>
<td>Comprehensive (Hospital and Medical) Individual Group Accident and Health</td>
</tr>
<tr>
<td>Line 13.2</td>
<td>Comprehensive (Hospital and Medical) Group</td>
</tr>
</tbody>
</table>

Percentages by line of business are calculated by dividing Column 7 of Underwriting and Investment Exhibit, Part 2, by Column 4 of Underwriting and Investment Exhibit, Part 1, and then multiplying by 100.

<table>
<thead>
<tr>
<th>Line 13.1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 4</td>
<td>Should agree with Schedule H, Part 3, Line 1.1 plus Line 1.2, Column 2.</td>
</tr>
<tr>
<td>Column 7</td>
<td>Should agree with Schedule H, Part 1, Line 3, Column 3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Line 13.2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 7</td>
<td>Should agree with Schedule H, Part 1, Line 3, Column 5.</td>
</tr>
</tbody>
</table>
Line 14 – Credit Accident and Health

Column 4 should agree with Schedule H, Part 3, Line 1.1 plus Line 1.2, Column 310.
Column 5 should agree with Schedule H, Part 3, Line 2.1 plus Line 2.2, Column 310.
Column 6 should agree with Schedule H, Part 2, Line C2, Column 310.
Column 7 should agree with Schedule H, Part 1, Line 3, Column 59.

Include: Business not exceeding 120 months duration.

Line 15.1 – Vision Only Other Accident and Health

Column 4 should agree with Schedule H, Part 3, Line 1.1 plus Line 1.2, Columns 4 through 95.
Column 5 should agree with Schedule H, Part 3, Line 2.1 plus Line 2.2, Columns 4 through 95.
Column 6 should agree with Schedule H, Part 2, Line C2, Columns 4 through 95.
Column 7 should agree with Schedule H, Part 1, Line 3, Columns 2 through 179.

Line 15.2 – Dental Only

Column 4 should agree with Schedule H, Part 3, Line 1.1 plus Line 1.2, Column 6.
Column 5 should agree with Schedule H, Part 3, Line 2.1 plus Line 2.2, Column 6.
Column 6 should agree with Schedule H, Part 2, Line C2, Column 6.
Column 7 should agree with Schedule H, Part 1, Line 3, Column 11.

Line 15.3 – Disability Income

Column 4 should agree with Schedule H, Part 3, Line 1.1 plus Line 1.2, Column 11.
Column 5 should agree with Schedule H, Part 3, Line 2.1 plus Line 2.2, Column 11.
Column 6 should agree with Schedule H, Part 2, Line C2, Column 11.
Column 7 should agree with Schedule H, Part 1, Line 3, Column 21.

Line 15.4 – Medicare Supplement

Column 4 should agree with Schedule H, Part 3, Line 1.1 plus Line 1.2, Column 4.
Column 5 should agree with Schedule H, Part 3, Line 2.1 plus Line 2.2, Column 4.
Column 6 should agree with Schedule H, Part 2, Line C2, Column 4.
Column 7 should agree with Schedule H, Part 1, Line 3, Column 7.

Line 15.5 – Medicaid Title XIX

Column 4 should agree with Schedule H, Part 3, Line 1.1 plus Line 1.2, Column 9.
Column 5 should agree with Schedule H, Part 3, Line 2.1 plus Line 2.2, Column 9.
Column 6 should agree with Schedule H, Part 2, Line C2, Column 9.

Column 7 should agree with Schedule H, Part 1, Line 3, Column 17.

Line 15.6 – Medicare Title XVIII

Column 4 should agree with Schedule H, Part 3, Line 1.1 plus Line 1.2, Column 8.

Column 5 should agree with Schedule H, Part 3, Line 2.1 plus Line 2.2, Column 8.

Column 6 should agree with Schedule H, Part 2, Line C2, Column 8.

Column 7 should agree with Schedule H, Part 1, Line 3, Column 15.

Line 15.7 – Long-Term Care

Column 4 should agree with Schedule H, Part 3, Line 1.1 plus Line 1.2, Column 12.

Column 5 should agree with Schedule H, Part 3, Line 2.1 plus Line 2.2, Column 12.

Column 6 should agree with Schedule H, Part 2, Line C2, Column 12.

Column 7 should agree with Schedule H, Part 1, Line 3, Column 23.

Line 15.8 – Federal Employees Health Benefits Plan Premium

Column 4 should agree with Schedule H, Part 3, Line 1.1 plus Line 1.2, Column 7.

Column 5 should agree with Schedule H, Part 3, Line 2.1 plus Line 2.2, Column 7.

Column 6 should agree with Schedule H, Part 2, Line C2, Column 7.

Column 7 should agree with Schedule H, Part 1, Line 3, Column 13.

Line 15.9 – Other Health

Column 4 should agree with Schedule H, Part 3, Line 1.1 plus Line 1.2, Column 13.

Column 5 should agree with Schedule H, Part 3, Line 2.1 plus Line 2.2, Column 13.

Column 6 should agree with Schedule H, Part 2, Line C2, Column 13.

Column 7 should agree with Schedule H, Part 1, Line 3, Column 25.

Line 34 – Aggregate Write-ins for Other Lines of Business

Enter the total of the write-ins listed in schedule Details of Write-ins Aggregated at Line 34 for Other Lines of Business.

Details of Write-ins Aggregated at Line 34 for Other Lines of Business

List separately each line of business for which there is no pre-printed line on Underwriting and Investment Exhibit, Part 2.
UNDERWRITING AND INVESTMENT EXHIBIT

PART 2A – UNPAID LOSSES AND LOSS ADJUSTMENT EXPENSES

Refer to SSAP No. 55—Unpaid Claims, Losses and Loss Adjustment Expenses for accounting guidance.

Detail Eliminated to Conserve Space

Column 7  – Incurred But Not Reported – Reinsurance Ceded

Line 35 (total) should agree with Schedule F, Part 3, Column 11, Total multiplied by 1000.

Column 8  – Net Losses Unpaid

Line 13 should agree with Schedule H, Part 2, Line C1, Column 2.

Line 14 should agree with Schedule H, Part 2, Line C1, Column 3.

Line 15 should agree with Schedule H, Part 2, Line C1, Columns 4 through 9.

Line 35 (total) should agree with Page 3, Line 1, Column 1.

Total on Line 35 to agree with Schedule P, Part 1, Summary, Column 35, Total multiplied by 1000.

Column 9  – Net Unpaid Loss Adjustment Expenses

Report loss adjustment expenses incurred by the reinsurer.

Line 35 (total) should agree with Page 3, Line 3, Column 1.

Total on Line 35 to agree with Schedule P, Part 1, Summary, Column 36, Total multiplied by 1000.

Line 13.1  – Comprehensive (Hospital and Medical) Individual

Column 8 should agree with Schedule H, Part 2, Line C1, Column 2.

Line 13.2  – Comprehensive (Hospital and Medical) Group

Column 8 should agree with Schedule H, Part 2, Line C1, Column 3.

Line 14  – Credit Accident and Health (Group and Individual)

Column 8 should agree with Schedule H, Part 2, Line C1, Column 10.

Include: Business not exceeding 120 months duration.

Line 15.1  – Vision Only

Column 8 should agree with Schedule H, Part 2, Line C1, Columns 5.
Line 15.2 – Dental Only
  Column 8 should agree with Schedule H, Part 2, Line C1, Columns 6.

Line 15.3 – Disability Income
  Column 8 should agree with Schedule H, Part 2, Line C1, Columns 11.

Line 15.4 – Medicare Supplement
  Column 8 should agree with Schedule H, Part 2, Line C1, Columns 4.

Line 15.5 – Medicaid Title XIX
  Column 8 should agree with Schedule H, Part 2, Line C1, Columns 9.

Line 15.6 – Medicare Title XVIII
  Column 8 should agree with Schedule H, Part 2, Line C1, Columns 8.

Line 15.7 – Long-Term Care
  Column 8 should agree with Schedule H, Part 2, Line C1, Columns 12.

Line 15.8 – Federal Employees Health Benefits Plan Premium
  Column 8 should agree with Schedule H, Part 2, Line C1, Columns 7.

Line 15.9 – Other Health
  Column 8 should agree with Schedule H, Part 2, Line C1, Columns 13.

Line 34 – Aggregate Write-ins for Other Lines of Business
  Enter the total of the write-ins listed in schedule Details of Write-ins Aggregated at Line 34 for Other Lines of Business.

Line 35 – Totals
  Columns 1 plus Column 5 should agree with Schedule T, Line 59, Column 7.

Details of Write-ins Aggregated at Line 34 for Other Lines of Business
  List separately each line of business for which there is no pre-printed line on Underwriting and Investment Exhibit, Part 2A.
# ANNUAL STATEMENT BLANK – LIFE/FRATERNAL AND PROPERTY

## SCHEDULE H – ACCIDENT AND HEALTH EXHIBIT

### PART 1 – ANALYSIS OF UNDERWRITING OPERATIONS

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### DETAILS OF WRITE-INS

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### DETAILS OF WRITE-INS

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(a) Includes $ reported as "Contract membership and other fees retained by agents."
### SCHEDULE H – ACCIDENT AND HEALTH EXHIBIT

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**Note:** The table above is an example of what the content of the image might look like if it were readable. The actual content may differ due to the nature of the image as a table with potentially complex data.
### SCHEDULE H – ACCIDENT AND HEALTH EXHIBIT (Continued)

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#### PART 3 – TEST OF PRIOR YEAR’S CLAIM RESERVES AND LIABILITIES

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#### PART 4 – REINSURANCE

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**Notes:**
- Reserve for future contingent benefits
- Advance premiums
- Reinsurance
- Commissions
- Assumed claims
- Claim paid during the policy period
- Incurred claims
- Premiums written
- Total current year
- Total prior year
- Premium deficiency reserve
- Stated reasons
### SCHEDULE H – PART 5 – HEALTH CLAIMS

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Change column 4, line 19.8 for entry per information from sponsor of proposal 2020-31BWG.

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Add “Undiscounted” to columns 13 and 14 descriptions. From 2018-12BWG proposal and missed going forward.

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Change column 7 – Book Adjusted Carrying Value to allow a total. It was moved from column 9, which included a total.

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</table>

Add formulas to the illustration for Note 5A(7) to clarify calculation of balance.

A. Mortgage Loans, including Mezzanine Real Estate Loans

   (7) Allowance for Credit Losses:

   a. Balance at beginning of period
   b. Additions charged to operations
   c. Direct write-downs charged against the allowances
   d. Recoveries of amounts previously charged off
   e. Balance at end of period (a+b+c-d)
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<td>Change to Instruction</td>
<td>Add formulas to the illustration for Note 5D(2) to clarify calculation of totals.</td>
<td>D. Loan-Backed Securities</td>
<td>(2) OTTI recognized 1st Quarter</td>
<td>(a). Intent to sell</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>c. Total 1st Quarter (a+b)</td>
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<td></td>
<td>e. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis</td>
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<tr>
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<td>f. OTTI recognized 2nd Quarter</td>
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<td>g. Intent to sell</td>
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<td>h. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis</td>
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<td></td>
<td>i. Total 2nd Quarter (d+e)</td>
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<td>k. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis</td>
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<td>2022 Annual</td>
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</table>

**CHANGE TO INSTRUCTION**

Add formulas to the illustration for Note 5E(3) and 5E(5) to clarify calculation of subtotals and totals.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions

(3) Collateral Received

a. Aggregate Amount Collateral Received

1. Securities Lending
   (a) Open
   (b) 30 Days or Less
   (c) 31 to 60 Days
   (d) 61 to 90 Days
   (e) Greater Than 90 Days
   (f) Sub-Total \((a+b+c+d+e)\)
   (g) Securities Received
   (h) Total Collateral Received \((f+g)\)

2. Dollar Repurchase Agreement
   (a) Open
   (b) 30 Days or Less
   (c) 31 to 60 Days
   (d) 61 to 90 Days
   (e) Greater Than 90 Days
   (f) Sub-Total \((a+b+c+d+e)\)
   (g) Securities Received
   (h) Total Collateral Received \((f+g)\)

(5) Collateral Reinvestment

a. Aggregate Amount Collateral Reinvested

1. Securities Lending
   (a) Open
   (b) 30 Days or Less


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<tr>
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<th>Statement Type</th>
<th>Filing Type</th>
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<tbody>
<tr>
<td>(c) 31 to 60 Days</td>
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<tr>
<td>(d) 61 to 90 Days</td>
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<td></td>
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<tr>
<td>(e) 91 to 120 Days</td>
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<tr>
<td>(f) 121 to 180 Days</td>
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<td>(g) 181 to 365 Days</td>
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<td>(h) 1 to 2 Years</td>
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<td>(i) 2 to 3 Year</td>
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<td>(j) Greater Than 3 Years</td>
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<tr>
<td>(k) Sub-Total (Sum of a through j)</td>
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<tr>
<td>(l) Securities Received</td>
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<tr>
<td>(m) Total Collateral Reinvested (k+l)</td>
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</tbody>
</table>

2. Dollar Repurchase Agreement

(a) Open
(b) 30 Days or Less
(c) 31 to 60 Days
(d) 61 to 90 Days
(e) 91 to 120 Days
(f) 121 to 180 Days
(g) 181 to 365 Days
(h) 1 to 2 Years
(i) 2 to 3 Year
(j) Greater Than 3 Years
(k) Sub-Total (Sum of a through j)
(l) Securities Received
(m) Total Collateral Reinvested (k+l)

2022 Annual Notes to Financial Statements

CHANGE TO INSTRUCTION

Add formula to the illustration for Note 5L(1) to clarify calculation of total.

L. Restricted Assets

(1) Restricted Assets (Including Pledged)

<table>
<thead>
<tr>
<th>Restricted Asset Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Subject to contractual obligation for which liability is not shown</td>
</tr>
<tr>
<td>b. Collateral held under security lending agreements</td>
</tr>
<tr>
<td>Effective</td>
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<tr>
<td>2022 Annual</td>
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</tbody>
</table>

Add formulas to the illustration for Note 5M(1) and 5M(2) to clarify calculation of totals.

M. Working Capital Finance Investments

(1) Aggregate Working Capital Finance Investments (WCFI) Book/Adjusted Carrying Value by NAIC Designation:

a. WCFI Designation 1
b. WCFI Designation 2
c. WCFI Designation 3
d. WCFI Designation 4
e. WCFI Designation 5
f. WCFI Designation 6
g. Total (a+b+c+d+e+f)

(2) Aggregate Maturity Distribution on the Underlying Working Capital Finance Programs:
Effective

2022 Annual

Change to Instruction

Notes to Financial Statements

A. Derivatives under SSAP No. 86—Derivatives (8)

Add formula to the illustration for Note 8A(8) to clarify calculation of total.

1. Fiscal Year

2023
2024
2025
Thereafter
Total Future Settled Premiums (Sum of 1 through 5)

L/F, H, P, T Annual

2022 Annual

Change to Instruction

Notes to Financial Statements

B. Derivatives under SSAP No. 108—Derivative Hedging Variable Annuity Guarantees

Add formula to the illustration for Note 8B(2) to clarify calculation of total.

1. Recognition of gains/losses and deferred assets and liabilities

2. Scheduled Amortization

Amortization Year

1. 2022
2. 2023
3. 2024
4. 2025
5. 2026
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<td></td>
<td>Add formula to the illustration for Note 14A(3)c to clarify calculation of total.</td>
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<td></td>
<td></td>
<td><strong>A. Contingent Commitments</strong></td>
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<td></td>
<td></td>
<td>(3)</td>
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<tr>
<td></td>
<td></td>
<td>a. Aggregate Maximum Potential of Future Payments of All Guarantees (undiscounted) the guarantor could be required to make under guarantees. (Should equal total of Column 4 for (2) above.)</td>
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<tr>
<td></td>
<td></td>
<td>b. Current Liability Recognized in F/S:</td>
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<td></td>
<td></td>
<td>1. Noncontingent Liabilities</td>
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<td>2. Contingent Liabilities</td>
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<td></td>
<td></td>
<td>c. Ultimate Financial Statement Impact if action under the guarantee is required.</td>
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<td></td>
<td></td>
<td>1. Investments in SCA</td>
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<td>2. Joint Venture</td>
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<td>3. Dividends to Stockholders (capital contribution)</td>
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<td>4. Expense</td>
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<td>5. Other</td>
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<td>6. Total (1+2+3+4+5) (Should equal (3)a.)</td>
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<td>Add formulas to the illustration for Note 16(1) to clarify calculation of total.</td>
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<td>Add formulas to the illustration for Note 21F(2), 21F(3) and 21F(4) to clarify calculation of totals.</td>
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**F. Subprime-Mortgage-Related Risk Exposure**

1. The table below summarizes the face amount of the Company’s financial instruments with off-balance-sheet risk.
   - Swaps
   - Futures
   - Options
   - Total (a+b+c)

2. Direct exposure through investments in subprime mortgage loans.
   - Mortgages in the process of foreclosure
   - Mortgages in good standing
   - Mortgages with restructured terms
   - Total (a+b+c)

3. Direct exposure through other investments.
   - Residential mortgage-backed securities
   - Commercial mortgage-backed securities
   - Collateralized debt obligations
   - Structured securities
   - Equity investment in SCAs *
   - Other assets
   - Total (a+b+c+d+e+f)

* ABC Company’s subsidiary XYZ Company has investments in subprime mortgages. These investments comprise _____% of the companies invested assets.

4. Underwriting exposure to subprime mortgage risk through Mortgage Guaranty or Financial Guaranty insurance coverage.
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<td>Add formulas to the illustration for Note 18A and 18B to clarify calculation of totals.</td>
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<td></td>
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<td><strong>A. ASO Plans</strong></td>
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<td>a. Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses</td>
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<td></td>
<td></td>
<td>b. Total net other income or expenses (including interest paid to or received from plans)</td>
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<tr>
<td></td>
<td></td>
<td>c. Net gain or (loss) from operations (a+b)</td>
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<tr>
<td></td>
<td></td>
<td>d. Total claim payment volume</td>
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<tr>
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<td></td>
<td><strong>B. ASC Plans</strong></td>
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<tr>
<td></td>
<td></td>
<td>a. Gross reimbursement for medical cost incurred</td>
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<tr>
<td></td>
<td></td>
<td>b. Gross administrative fees accrued</td>
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<td></td>
<td></td>
<td>c. Other income or expenses (including interest paid to or received from plans)</td>
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<td></td>
<td></td>
<td>d. Gross expenses incurred (claims and administrative) (a+b+c)</td>
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<td></td>
<td></td>
<td>e. Total net gain or loss from operations</td>
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<td>Add formula to the illustration for Note 21G(2) to clarify calculation of total.</td>
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<td><strong>G. Retained Assets</strong></td>
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<td>Add formulas to the illustration for Note 32D to clarify calculation of totals.</td>
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<td><strong>D.</strong> Life &amp; Accident &amp; Health Annual Statement:</td>
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<td>(1) Exhibit 5, Annuities Section, Total (net)</td>
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<td>(2) Exhibit 5, Supplementary Contracts with Life Contingencies Section, Total (net)</td>
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<td>(3) Exhibit 7, Deposit-Type Contracts, Line 14, Column 1</td>
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<td>(4) Subtotal (1+2+3)</td>
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<td>Separate Accounts Annual Statement:</td>
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<td>(5) Exhibit 3, Line 0299999, Column 2</td>
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<td>(6) Exhibit 3, Line 0399999, Column 2</td>
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<td>(7) Policyholder dividend and coupon accumulations</td>
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<td></td>
<td></td>
<td>(8) Policyholder premiums</td>
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<td>(9) Guaranteed interest contracts</td>
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<tr>
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<td></td>
<td>(10) Other contract deposit funds</td>
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<td></td>
<td></td>
<td>(11) Subtotal (5+6+7+8+9+10)</td>
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<td>(12) Combined Total (4+11)</td>
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<td>Add formulas to the illustration for Note 33D to clarify calculation of totals.</td>
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<td><strong>D.</strong> Life &amp; Accident &amp; Health Annual Statement:</td>
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<td></td>
<td></td>
<td>(1) Exhibit 5, Life Insurance Section, Total (net)</td>
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<td>(2) Exhibit 5, Accidental Death Benefits Section, Total (net)</td>
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<td>(3) Exhibit 5, Disability – Active Lives Section, Total (net)</td>
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<td>Add formula to the illustration for Note 34A to clarify calculation of total.</td>
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<tr>
<td></td>
<td>A. Deferred and uncollected life insurance premiums and annuity considerations as of December 31, 20___, were as follows:</td>
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<tr>
<td></td>
<td><strong>Type</strong></td>
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<tr>
<td></td>
<td>(1) Industrial</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) Ordinary new business</td>
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<td></td>
<td>(3) Ordinary renewal</td>
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<td></td>
<td>(4) Credit Life</td>
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<td></td>
<td>(5) Group Life</td>
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<td></td>
<td>(6) Group Annuity</td>
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<td>(7) Totals (1+2+3+4+5+6)</td>
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<tr>
<td></td>
<td>Add formulas to the illustration for Note 35B to clarify calculation of totals.</td>
</tr>
<tr>
<td></td>
<td>(1) Premiums, considerations or deposits for year ended 12/31/___</td>
</tr>
<tr>
<td></td>
<td>Reserves at 12/31/___</td>
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<td>(2) For accounts with assets at:</td>
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<td></td>
<td>a. Fair value</td>
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<tr>
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<td>b. Amortized cost</td>
</tr>
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<td></td>
<td>c. Total Reserves* (a+b)</td>
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<td>(3) By withdrawal characteristics:</td>
</tr>
<tr>
<td></td>
<td>a. Subject to discretionary withdrawal:</td>
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<td>1. With market value adjustment</td>
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</tbody>
</table>

Add formulas to the illustration for Note 23C to clarify calculation of totals.

**C. Reinsurance Assumed and Ceded**

(1)  
- a. Affiliates  
- b. All Other  
- c. TOTAL (a+b)  
- d. Direct Unearned Premium Reserve  

Line (c) of Ceded Reinsurance Premium Reserve Column must equal Page 3, Line 9, first inside amount.

(2) The additional or return commission, predicated on loss experience or on any other form of profit sharing arrangements in this annual statement as a result of existing contractual arrangements is accrued as follows:  

**REINSURANCE**  
- a. Contingent Commission  
- b. Sliding Scale Adjustments  
- c. Other Profit Commission Arrangements  
- d. TOTAL (a+b+c)
<table>
<thead>
<tr>
<th>Effective Type</th>
<th>Notes to Financial Statements</th>
<th>CHANGE TO INSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022 Annual</td>
<td></td>
<td><strong>CHANGE TO INSTRUCTION</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add formula to the illustration for Note 14A(3)c to clarify calculation of total.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A. Contingent Commitments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Ultimate Financial Statement Impact if action under the guarantee is required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Investments in SCA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Joint Venture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Dividends to Stockholders (capital contribution)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Expense</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Total (1+2+3+4+5) (Should equal (3)a.)</td>
</tr>
<tr>
<td>2022 Annual</td>
<td>Notes to Financial Statements</td>
<td><strong>CHANGE TO INSTRUCTION</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add formulas to the illustration for Note 23F(1) to clarify calculation of totals.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F. Retroactive Reinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Reserves Transferred:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Initial Reserves</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Adjustments – Prior Year(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Adjustments – Current Year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Current Total (1+2+3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Consideration Paid or Received:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Initial Consideration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Adjustments – Prior Year(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Adjustments – Current Year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Current Total (1+2+3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Paid Losses Reimbursed or Recovered:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Prior Year(s)</td>
</tr>
<tr>
<td>Effective</td>
<td>Notes to Financial Statements</td>
<td>Filing Type</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>2022 Annual</td>
<td>12/11/21</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CHANGE TO INSTRUCTION**

Add formula to the illustration for Note 32A to clarify calculation of total.

<table>
<thead>
<tr>
<th>Schedule P Lines of Business</th>
<th>Change to Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Homeowners/Farmowners</td>
<td>Tabular Discount for Note 32A</td>
</tr>
<tr>
<td>2. Private Passenger Auto Liability/Medical</td>
<td></td>
</tr>
<tr>
<td>3. Commercial Auto-Truck Liability/Medical</td>
<td></td>
</tr>
<tr>
<td>4. Workers’ Compensation</td>
<td></td>
</tr>
<tr>
<td>5. Commercial Multiple Peril</td>
<td></td>
</tr>
<tr>
<td>6. Medical Professional Liability – occurrence</td>
<td></td>
</tr>
<tr>
<td>7. Special Liability</td>
<td></td>
</tr>
<tr>
<td>8. Other Liability – occurrence</td>
<td></td>
</tr>
<tr>
<td>9. Other Liability – claims-made</td>
<td></td>
</tr>
<tr>
<td>10. Special Property</td>
<td></td>
</tr>
<tr>
<td>11. Auto Physical Damage</td>
<td></td>
</tr>
<tr>
<td>12. Fidelity, Surety</td>
<td></td>
</tr>
<tr>
<td>13. Other (including Credit, Accident &amp; Health)</td>
<td></td>
</tr>
<tr>
<td>14. International</td>
<td></td>
</tr>
<tr>
<td>15. Reinsurance Nonproportional Assumed Property</td>
<td></td>
</tr>
<tr>
<td>Effective Date</td>
<td>Notes to Financial Statements</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>2022 Annual</td>
<td>Add formula to the illustration for Note 32B to clarify calculation of total.</td>
</tr>
</tbody>
</table>

### Change to Instruction

Add formula to the illustration for Note 32B to clarify calculation of total.

<table>
<thead>
<tr>
<th>Filing Type</th>
<th>Statement Type</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Reinsurance Nonproportional Assumed Liability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Reinsurance Nonproportional Assumed Financial Lines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Products Liability – occurrence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Products Liability – claims-made</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Warranty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Total (Sum of Lines 1 through 22)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Must exclude medical loss reserves and all loss adjustment expense reserves.

© 2021 National Association of Insurance Commissioners
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Notes to Financial Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022 Annual</td>
<td>CHANGE TO INSTRUCTION</td>
</tr>
</tbody>
</table>

Add formulas to the illustration for Note 33A to clarify calculation of totals.

A.

1. Direct –
   a. Beginning reserves:
   b. Incurred losses and loss adjustment expense:
   c. Calendar year payments for losses and loss adjustment expenses:
   d. Ending reserves \((a+b-c)\):

2. Assumed Reinsurance –
   a. Beginning reserves:
   b. Incurred losses and loss adjustment expense:
   c. Calendar year payments for losses and loss adjustment expenses:
   d. Ending reserves \((a+b-c)\):

3. Net of Ceded Reinsurance –
   a. Beginning reserves:

Columns in the table above should include medical loss reserves and all loss adjustment expense reserves, whether reported as tabular or nontabular in Schedule P.
<table>
<thead>
<tr>
<th>Effective</th>
<th>Notes to Financial Statements</th>
<th>Statement Type</th>
<th>Filing Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022 Annual</td>
<td></td>
<td>CHANGE TO INSTRUCTION</td>
<td>P</td>
</tr>
<tr>
<td>2022 Annual</td>
<td></td>
<td>CHANGE TO INSTRUCTION</td>
<td>P</td>
</tr>
</tbody>
</table>

b. Incurred losses and loss adjustment expense:

c. Calendar year payments for losses and loss adjustment expenses:

d. Ending reserves (a+b-c):

Add formulas to the illustration for Note 33D to clarify calculation of totals.

D.

(1) Direct –

a. Beginning reserves:

b. Incurred losses and loss adjustment expense:

c. Calendar year payments for losses and loss adjustment expenses:

d. Ending reserves (a+b-c):

(2) Assumed Reinsurance –

a. Beginning reserves:

b. Incurred losses and loss adjustment expense:

c. Calendar year payments for losses and loss adjustment expenses:

d. Ending reserves (a+b-c):

(3) Net of Ceded Reinsurance –

a. Beginning reserves:

b. Incurred losses and loss adjustment expense:

c. Calendar year payments for losses and loss adjustment expenses:

d. Ending reserves (a+b-c):

Add formulas to the illustration for Note 36A(1)c and 36A(3)b to clarify calculation of totals.
<table>
<thead>
<tr>
<th>Effective Statement Type</th>
<th>Filing Type</th>
<th>Notes to Financial Statements</th>
<th>2022 Annual Schedule of Insured Financial Obligations at the End of the Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Financial guarantee insurance contracts where premiums are received as installment payments over the period of the contract, rather than at inception;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Roll forward of the expected future premiums (undiscounted), including:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Expected future premiums – Beginning of Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Less - Premium payments received for existing installment contracts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Add - Expected premium payments for new installment contracts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Adjustments to the expected future premium payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Expected future premiums – End of Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1-2+3+4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Claim liability:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Significant components of the change in the claim liability for the period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Accretion of the discount</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Changes in timing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) New reserves for defaults of insured contracts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Change in deficiency reserves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) Change in incurred but not reported claims</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6) Total (1-2+3+4+5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHARGE TO INSTRUCTION</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Add formulas to the illustration for Note 36B to clarify calculation of totals.
<table>
<thead>
<tr>
<th>Filing Type</th>
<th>Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a. Principal</td>
<td></td>
</tr>
<tr>
<td>3b. Interest</td>
<td></td>
</tr>
<tr>
<td>3c. Total (3a+3b)</td>
<td></td>
</tr>
<tr>
<td>4. Gross claim liability</td>
<td></td>
</tr>
<tr>
<td>Less:</td>
<td></td>
</tr>
<tr>
<td>5a. Gross potential recoveries</td>
<td></td>
</tr>
<tr>
<td>5b. Discount, net</td>
<td></td>
</tr>
<tr>
<td>6. Net claim liability (4-5a-5b)</td>
<td></td>
</tr>
<tr>
<td>7. Unearned premium revenue</td>
<td></td>
</tr>
<tr>
<td>8. Reinsurance recoverables</td>
<td></td>
</tr>
</tbody>
</table>
General Instructions
For States to Complete Checklist

Each checklist is divided into five sections. The first section contains the major NAIC filings. The second section lists all of the NAIC supplements, whether they are to be bound into the statement or not. The third section lists items to be filed electronically with the NAIC. The fourth section is a list of all of the filings related to the audited financial statements. The fifth section lists state-specific filing requirements. **The items in the first four sections should remain in the same order as the examples.** This will enable companies to locate common information about a particular filing from each state. Finally, there is a section of notes to the instructions. The purpose of the Notes is to provide companies with state-specific information in a standard format. You may require more notes than provided; however, **the first notes should remain in the same order and format for each state.** Each state-specific note should contain state-specific instructions where any state deviates from specific NAIC instructions. The state should mail the company instructions to companies along with the checklist or post these instructions to its website. New requirements or changes to the checklists will be highlighted for your convenience.

Please Note: **Your state’s requirements for companies to file with the NAIC should be incorporated into this Checklist.**

**Column 1** Checklist

This column provides the company a method for marking completed forms or filings.

**Column 2** Line #

Refers to a standard filing number used for easy reference and which may change from year to year, but should remain the same between states (i.e., number 61 - Annual Statement Electronic Filing is the same for all jurisdictions.). States may expand the State Required Filings Section to include up to 100 filings required by any individual state.

**Column 3** Required Filings

Name of item or form to be filed. Each section is alphabetized. Please note that the items shown under “State Required Filings” may not apply to your state. The items included are those that a significant number of states require. Please add your state-specific filings in Section V.

**Form B – Holding Company Registration Statement, Form F – Enterprise Risk Report and ORSA Group Capital Calculation has have been added to the “State Required Filings” section of the checklist.**

If more than one state page is required from each company, please insert this requirement under “State Required Filings.” Likewise, if your state requires the Risk-Based Capital from your domestic companies to be filed with you in addition to companies filing this with the NAIC, please insert this requirement under “State Required Filings.”

The 1999 Annual Statement Instructions were modified to waive paper filings of certain NAIC supplements (those supplements previously included in the Electronic Filing Pilot Project) and certain investment schedule detail, if such investment schedule data is available to the states via the NAIC database. The checklists have been modified to reflect this action taken by the Blanks (EX) Task Force. XXX appears in the “Number of Copies” “Foreign” column for the appropriate schedules and exhibits. If you are deviating from the Annual Statement Instructions and wish to have these items filed in hard copy with your department, you should remove XXX from this column and insert the number of copies required. If you wish to request the documents, simply remove the XXX or N/A and insert the number of copies that you require.

**Column 4** Number of Copies

This column indicates the number of copies that a foreign or domestic company is required to file for each type of form. The 1999 Annual Statement Instructions were modified to exclude the requirement for filing paper copies of investment schedules from foreign companies if the data is captured on the NAIC database. The 1999 Annual Statement Instructions were modified to include the supplements that were part of the Electronic Filing Pilot. An XXX appears in the foreign column, if the schedule or supplement is included in either of these instructions. If you require paper copies of these schedules or supplements, you should remove XXX from this column and insert the number of copies required. An N/A appears in this column if the filing is only required with the state of domicile according to the NAIC Annual Statement Instructions. This does not preclude any state from requesting these documents from any company. If you wish to request the documents, simply remove the XXX or N/A and insert the number of copies that you require.
Column 5 Due Date

Due Date indicates the date a filing is required with the state insurance regulatory authority. If you do not require a specific filing, please replace the date with XXX. Use Note E to explain any other filing instructions regarding due dates.

Column 6 Form Source

This column contains one of three words: “NAIC,” “State,” or “Company.” If this column contains “NAIC,” the company must obtain the forms from the appropriate vendor. If this column contains “State,” the state will provide the forms with the filing instructions. If this column contains “Company,” the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC Annual Statement Instructions. Insert a “#” sign after the form source where the state has changed the requirements since last year or the item is a new NAIC blank. Do not insert a “#” sign if the NAIC blank has changed, as this would lead to many “#” signs, making its use somewhat meaningless.

Column 7 Applicable Notes

This column contains references to the Notes and Instructions that apply to each item. However, Notes A-K apply to all filings.

Item 85

Insert specific instructions related to appointment or change in Independent CPA.
Instructions and Suggested Language for the Notes

General:

1. **Suggested language** for each note should be used to the extent possible.

2. Some of the suggested language covers different ideas, for example, note E has several different issues that could apply. Where appropriate, combine language.

3. Where appropriate, list each item and special instructions (see notes H and K, for examples)

4. **Examples** for notes are shown in italics and should be replaced by your state-specific instructions.

**Note A** should provide the name(s), email address(es) and phone number(s) of a person that companies may contact with questions regarding filings. If there is more than one person, please indicate the types of calls each person takes, in addition to their name and number.

**Note B** should list the mailing address, and hand delivery address (if different) for required filings.

**Note C** should provide specific information related to the amount(s) and mailing address for filing fees.

**Note D** should list the mailing address for premium taxes (and a contact if appropriate). If your state has a different Department collect premium taxes (not the Department that collects other insurance information, fees), please indicate that Department, and provide a contact name if possible.

**Note E** should contain instructions on delivery dates, and any other special delivery instructions:

- **E-1** All filings must be physically received at one of the addresses in Note B no later than the indicated due date.
- **E-2** All filings must be postmarked no later than the indicated due date.

- All items must be mailed U.S. mail.
- If the due date falls on a weekend or holiday, then the deadline is extended to the next business day.
- or

**Note F** should describe any penalties for late filings

- Companies will be fined $100 per day for a late filing.
- Company’s license may be suspended if the annual statement is received more than 30 days late.

**Note G** should contain language on original signatures:

- Original signatures required on all filings from domestic companies. Foreign companies should follow the instructions in the NAIC Annual Statement Instructions.
- Original signatures required on all filings that require signatures.

**Note H** should contain other signature/notarization/certification instructions. These are examples and should be updated according to your state’s current requirements.

- The following officers are required to sign the annual statement:
CEOs; President; Treasurer

Special instructions:

Reinsurance Summary Statement — must be notarized

Note I ....should contain instructions on filing amended filings.

Amended items must be filed within 10 days of their amendment, along with an explanation of the amendments. If there are signature requirements for the original filing, same should be followed for any amendment.

Note J ....should contain instructions for companies to request an exemption or extension to a filing

Foreign companies must supply a written copy of any exemption or extension received by its state of domicile at least 10 days prior to the filing due date to receive such from Minnesota. Domestic companies should apply at least 30 days prior to the due date.

Note K ....should contain instructions on bar codes

Please use the bar codes supplied by Florida.

or

Please follow the instructions in the NAIC Annual Statement Instructions.

or

Bar codes for Minnesota filings should be generated according to NAIC instructions. The codes are:
Certificate of Deposit .................................................. 003
Credit Insurance Annual Report .......................................................... 004
Form 10K .................................................................................. 005
Independent Actuarial Opinion .......................................................... 006
Investment Policy Certification .......................................................... 007
Non comprehensive Accident & Health Exhibit ................................. 008
Report by Independent CPA Regarding Application of Valuation Procedures .......... 009
Report on Evaluation of Accounting Procedures and System of Internal Control .......... 010
Report of Ratio of Qualified Assets to Required Liabilities ...................... 011

Note L ....should have instructions for filing Signed Jurat page

If the state requires the filing of a Signed Jurat page for foreign companies, please indicate.

Note M ....should have instructions for NONE filings

If the state requires the filing of a “NONE” page, please indicate.

See NAIC Annual Statement Instructions for Supplemental Interrogatories. Exceptions to these instructions are noted on the form.

Note N ....Filings New, Discontinued or Materially Modified since last year.

None of the filings have been discontinued since last year

No longer required:
Listing of new Reinsurers

https://naiconline.sharepoint.com/sites/naicsupportstaffhub/member meetings/fall 2021/tf/app/blankswg/minutes/att two-c5 gi_states_instructions2021.docx
### HEALTH ENTITIES

**COMPANY NAME:** 

**NAIC Company Code:** 

**Contact:** 

**Telephone:** 

**REQUIRED FILINGS IN THE STATE OF:** 

**Filings Made During the Year:** 2022

<table>
<thead>
<tr>
<th>Checklist</th>
<th>Line #</th>
<th>REQUIRED FILINGS FOR THE ABOVE STATE</th>
<th>NUMBER OF COPIES*</th>
<th>DUE DATE</th>
<th>FORM SOURCE**</th>
<th>APPLICABLE NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. NAIC FINANCIAL STATEMENTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Annual Statement (8 1/2&quot;x14&quot;)</td>
<td>EO</td>
<td>3/1</td>
<td>NAIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Printed Investment Schedule detail (Pages E01-E29)</td>
<td>EO</td>
<td>xxx</td>
<td>3/1</td>
<td>NAIC</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Quarterly Financial Statement (8 1/2&quot; x 14&quot;)</td>
<td>EO</td>
<td></td>
<td>5/15, 8/15, 11/15</td>
<td>NAIC</td>
<td></td>
</tr>
<tr>
<td><strong>II. NAIC SUPPLEMENTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Accident &amp; Health Policy Experience Exhibit</td>
<td>EO</td>
<td>4/1</td>
<td>NAIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Actuarial Opinion</td>
<td>EO</td>
<td>3/1</td>
<td>Company</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Life Supplemental Data due March 1</td>
<td>EO</td>
<td>3/1</td>
<td>NAIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Life Supplemental Data due April 1</td>
<td>EO</td>
<td>4/1</td>
<td>NAIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Life Supp Statement non-guaranteed elements – Exh 5, Int. #3</td>
<td>EO</td>
<td>3/1</td>
<td>Company</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Life Supp Statement on par/non-par policies – Exh 5 Int. 1&amp;2</td>
<td>EO</td>
<td></td>
<td>3/1</td>
<td>Company</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Life, Health &amp; Annuity Guaranty Association Assessable Premium Exhibit, Parts I and II and Assessment Base Reconciliation Exhibit</td>
<td>EO</td>
<td>xxx</td>
<td>4/1</td>
<td>NAIC</td>
<td></td>
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<td>Life, Health &amp; Annuity Guaranty Association Assessable Premium Exhibit, Parts I and II and Assessment Base Reconciliation Exhibit Adjustment Form</td>
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<td>20</td>
<td>Management Discussion &amp; Analysis</td>
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<td>4/1</td>
<td>Company</td>
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<td>21</td>
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© 2021 National Association of Insurance Commissioners
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<td>Relief from the five-year rotation requirement for lead audit partner</td>
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V. STATE REQUIRED FILINGS

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<td>ORSA *****</td>
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</table>

*If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state. EO (electronic only filing).

**If Form Source is NAIC, the form should be obtained from the appropriate vendor.

***For those states that have adopted the NAIC Corporate Governance Annual Disclosure Model Act, an annual disclosure is required of all insurers or insurance groups by June 1. The Corporate Governance Annual Disclosure is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state if filed at the insurance group level. For more information on lead states, see the following NAIC URL: http://www.naic.org/public_lead_state_report.htm.

****For those states that have adopted the NAIC updated Holding Company Model Act, a Form F filing is required annually by holding company groups. Consistent with the Form B filing requirements, the Form F is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state. For more information on lead states, see the following NAIC URL: http://www.naic.org/public_lead_state_report.htm.

*****For those states that have adopted the NAIC Risk Management and Own Risk and Solvency Assessment Model Act, a summary report is required annually by insurers and insurance groups above a specified premium threshold. The ORSA Summary Report is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state if filed at the insurance group level. For more information on lead states, see the following NAIC URL: http://www.naic.org/public_lead_state_report.htm.
<table>
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<th>NOTES AND INSTRUCTIONS (A-K APPLY TO ALL FILINGS)</th>
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<tr>
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<td>Required Filings Contact Person:</td>
</tr>
<tr>
<td>B</td>
<td>Mailing Address:</td>
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<tr>
<td>C</td>
<td>Mailing Address for Filing Fees:</td>
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<td>D</td>
<td>Mailing Address for Premium Tax Payments:</td>
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<td>E</td>
<td>Delivery Instructions:</td>
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<tr>
<td>F</td>
<td>Late Filings:</td>
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<td>G</td>
<td>Original Signatures:</td>
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<td>Signature/Notarization/Certification:</td>
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<td>Amended Filings:</td>
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<td>Exceptions from normal filings:</td>
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<tr>
<td>K</td>
<td>Bar Codes (State or NAIC):</td>
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<td>L</td>
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<td>M</td>
<td>NONE Filings:</td>
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<tr>
<td>N</td>
<td>Filings new, discontinued or modified materially since last year:</td>
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</tbody>
</table>
General Instructions
For Companies to Use Checklist

Please Note: This state’s instructions for companies to file with the NAIC are included in this Checklist. The NAIC will not be sending their own checklist this year.

Electronic Filing is intended to be filing(s) submitted to the NAIC via the NAIC Internet Filing Site which eliminates the need for a company to submit diskettes or CD-ROM to the NAIC. Companies are not required to file hard copy filings with the NAIC.

<table>
<thead>
<tr>
<th>Column (1)</th>
<th>Checklist</th>
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<td>Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an “x” in this column when submitting information to the state.</td>
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<tr>
<td>Name of item or form to be filed.</td>
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</table>

The Annual Statement Electronic Filing includes the annual statement data and all supplements due March 1, per the Annual Statement Instructions. This includes all detail investment schedules and other supplements for which the Annual Statement Instructions exempt printed detail.

The March.PDF Filing is the .pdf file for annual statement data, detail for investment schedules and supplements due March 1.

The Risk-Based Capital Electronic Filing includes all risk-based capital data.

The Risk-Based Capital.PDF Filing is the .pdf file for risk-based capital data.

The Supplemental Electronic Filing includes all supplements due April 1, per the Annual Statement Instructions.

The Supplemental.PDF Filing is the .pdf file for all supplemental schedules and exhibits due April 1.

The Quarterly Electronic Filing includes the complete quarterly filing and the PDF files for all quarterly data.

The Quarterly.PDF Filing is the .pdf file for quarterly statement data.

The June.PDF Filing is the .pdf file for the Audited Financial Statements and Accountants Letter of Qualifications.

<table>
<thead>
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<th>Column (4)</th>
<th>Number of Copies</th>
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<tr>
<td>Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (EX) Task Force modified the 1999 Annual Statement Instructions to waive paper filings of certain NAIC supplements and certain investment schedule detail, if such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (EX) Task Force. XXX appears in the “Number of Copies” “Foreign” column for the appropriate schedules and exhibits. Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and have chosen to rely upon the NAIC database for these filings. This waiver could include supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.</td>
<td></td>
</tr>
</tbody>
</table>

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Column (5) Due Date

Indicates the date on which the company must file the form.

Column (6) Form Source

This column contains one of three words: “NAIC,” “State,” or “Company.” If this column contains “NAIC,” the company must obtain the forms from the appropriate vendor. If this column contains “State,” the state will provide the forms with the filing instructions (generally, on the state web site). If this column contains “Company,” the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC Annual Statement Instructions.

Column (7) Applicable Notes

This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.

### I. NAIC FINANCIAL STATEMENTS

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<td>Management Discussion &amp; Analysis</td>
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<td>VM 20 Reserves Supplement</td>
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### Actuarial Related Items

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<td>Actuarial Opinion on Synthetic Guaranteed Investment Contracts</td>
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<td>Actuarial Opinion on X-Factors</td>
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<td>Actuarial Opinion required by Modified Guaranteed Annuity Model Regulation</td>
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<td>Request for Life PBR Exemption (formerly Companywide Exemption)</td>
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<td>NAIC 8/15</td>
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<td>41</td>
<td>Life Summary of the PBR Actuarial Report</td>
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<td>Variable Annuities Summary of the PBR Actuarial Report</td>
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<td>43</td>
<td>PBR Actuarial Report (provide upon request)</td>
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<td>44</td>
<td>RAAS required by Estimation Manual</td>
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<td>45</td>
<td>Reasonableness &amp; Consistency of Assumptions Certification required by Actuarial Guideline XXXV</td>
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<td>Reasonableness &amp; Consistency of Assumptions Certification required by Actuarial Guideline XXXVI (Updated Average Market Value)</td>
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<td>Reasonableness &amp; Consistency of Assumptions Certification required by Actuarial Guideline XXXVI (Updated Market Value)</td>
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<td>Reasonableness of Assumptions Certification for Implied Guaranteed Rate Method required by Actuarial Guideline XXXVII</td>
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<td>RBC Certification required under C-3 Phase I</td>
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<td>Statement on non-guaranteed elements - Exhibit 5 Int. #3</td>
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<td>53</td>
<td>Statement on par/non-par policies – Exhibit 5 Int. 1&amp;2</td>
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### III. ELECTRONIC FILING REQUIREMENTS

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### IV. AUDIT/INTERNAL CONTROL RELATED REPORTS

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<td>Accountants Letter of Qualifications</td>
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<td>Audited Financial Reports Exemption Affidavit</td>
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<td>Communication of Internal Control Related Matters Noted in Audit</td>
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<td>Independent CPA (change)</td>
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<td>Management’s Report of Internal Control Over Financial Reporting</td>
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<td>Request for Exemption to File Management’s Report of Internal Control Over Financial Reporting</td>
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### V. STATE REQUIRED FILINGS

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<td>ORSA*****</td>
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### Checklist

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</table>

*a* If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state. EO (electronic only filing).

**If Form Source is NAIC, the form should be obtained from the appropriate vendor.

***For those states that have adopted the NAIC Corporate Governance Annual Disclosure Model Act, an annual disclosure is required of all insurers or insurance groups by June 1. The Corporate Governance Annual Disclosure is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state if filed at the insurance group level. For more information on lead states, see the following NAIC URL: [http://www.naic.org/public_lead_state_report.htm](http://www.naic.org/public_lead_state_report.htm).

****For those states that have adopted the NAIC updated Holding Company Model Act, a Form F filing is required annually by holding company groups. Consistent with the Form B filing requirements, the Form F is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state. For more information on lead states, see the following NAIC URL: [http://www.naic.org/public_lead_state_report.htm](http://www.naic.org/public_lead_state_report.htm).

*****For those states that have adopted the NAIC Risk Management and Own Risk and Solvency Assessment Model Act, a summary report is required annually by insurers and insurance groups above a specified premium threshold. The ORSA Summary Report is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state if filed at the insurance group level. For more information on lead states, see the following NAIC URL: [http://www.naic.org/public_lead_state_report.htm](http://www.naic.org/public_lead_state_report.htm).
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<td>C</td>
<td>Mailing Address for Filing Fees:</td>
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<td>D</td>
<td>Mailing Address for Premium Tax Payments:</td>
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<td>E</td>
<td>Delivery Instructions:</td>
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<td>F</td>
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<td>Bar Codes (State or NAIC):</td>
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<tr>
<td>N</td>
<td>Filings new, discontinued or modified materially since last year:</td>
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</table>
General Instructions
For Companies to Use Checklist

Please Note: This state’s instructions for companies to file with the NAIC are included in this Checklist. The NAIC will not be sending their own checklist this year.

Electronic filing is intended to be filing(s) submitted to the NAIC via the NAIC Internet Filing Site which eliminates the need for a company to submit diskettes or CD-ROM to the NAIC. Companies are not required to file hard copy filings with the NAIC.

Column (1) Checklist
Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an “x” in this column when submitting information to the state.

Column (2) Line #
Line # refers to a standard filing number used for easy reference. This line number may change from year to year.

Column (3) Required Filings
Name of item or form to be filed.

The Annual Statement Electronic Filing includes the annual statement data and all supplements due March 1, per the Annual Statement Instructions. This includes all detail investment schedules and other supplements for which the Annual Statement Instructions exempt printed detail.

The March.PDF Filing is the .pdf file for annual statement data, detail for investment schedules and supplements due March 1.

The Risk-Based Capital Electronic Filing includes all risk-based capital data.

The Risk-Based Capital.PDF Filing is the .pdf file for risk-based capital data.

The Separate Accounts Electronic Filing includes the separate accounts annual statement and investment schedule detail.

The Separate Accounts.PDF Filing is the .pdf file for the separate accounts annual statement and all investment schedule detail.

The Supplemental Electronic Filing includes all supplements due April 1, per the Annual Statement Instructions.

The Supplement.PDF Filing is the .pdf file for all supplemental schedules and exhibits due April 1.

The Quarterly Electronic Filing includes the quarterly statement data.

The Quarterly.PDF Filing is the .pdf for quarterly statement data.

The June.PDF Filing is the .pdf file for the Audited Financial Statements and Accountants Letter of Qualifications.

Column (4) Number of Copies
Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (EX) Task Force modified the 1999 Annual Statement Instructions to waive paper filings of certain NAIC supplements and certain investment schedule detail, if such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (EX) Task Force. XXX appears in the “Number of Copies” “Foreign” column for the appropriate schedules and exhibits. Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and to rely upon the NAIC database for these filings. This waiver could include supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.
Column (5) Due Date

Indicates the date on which the company must file the form.

Column (6) Form Source

This column contains one of three words: “NAIC,” “State,” or “Company.” If this column contains “NAIC,” the company must obtain the forms from the appropriate vendor. If this column contains “State,” the state will provide the forms with the filing instructions. If this column contains “Company,” the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC Annual Statement Instructions.

Column (7) Applicable Notes

This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.

## PROPERTY & CASUALTY INSURERS

**COMPANY NAME:**

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<th>NAIC Company Code:</th>
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**Contact:**

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### REQUIRED FILINGS IN THE STATE OF:

Filing Made During the Year 2022

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<th>(2) Line #</th>
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#### I. NAIC FINANCIAL STATEMENTS

1. Annual Statement (8 1/2” x 14”)  EO 3/1 NAIC
1.1 Printed Investment Schedule detail (Pages E01-E29)  EO xxx 3/1 NAIC
2. Quarterly Financial Statement (8 1/2” x 14”)  EO 5/15, 8/15, 11/15 NAIC
3. Protected Cell Annual Statement  0 xxx 3/1 NAIC
4. Combined Annual Statement (8 1/2” x 14”)  EO 5/1 NAIC

#### II. NAIC SUPPLEMENTS

11. Accident & Health Policy Experience Exhibit  EO 4/1 NAIC
12. Actuarial Opinion  EO 3/1 Company
13. Actuarial Opinion Summary  N/A 3/15 Company
14. Bail Bond Supplement  EO 3/1 NAIC
15. Combined Insurance Expense Exhibit  EO 5/1 NAIC
16. Credit Insurance Experience Exhibit  EO xxx 4/1 NAIC
17. Cybersecurity and Identity Theft Insurance Coverage Supplement  EO 4/1 NAIC
18. Director and Officer Insurance Coverage Supplement  EO 3/1, 5/15, 8/15, 11/15 NAIC
19. Financial Guaranty Insurance Exhibit  EO 3/1 NAIC
20. Insurance Expense Exhibit  EO xxx 4/1 NAIC
21. Life, Health & Annuity Guaranty Association Assessment Base Reconciliation Exhibit, Parts 1 and 2  EO xxx 4/1 NAIC
22. Life, Health & Annuity Guaranty Assessment Base Reconciliation Exhibit Adjustment Form  EO xxx 4/1 NAIC
23. Long-Term Care Experience Reporting Forms  EO xxx 4/1 NAIC
24. Management Discussion & Analysis  EO 4/1 Company
25a. Medicare Supplement Insurance Experience Exhibit  EO xxx 3/1 NAIC
26. Mortgage Guaranty Insurance Exhibit  EO xxx 4/1 NAIC
27. Premiums Attributed to Protected Cells Exhibit  EO 3/1 NAIC
28. Private Flood Insurance Supplement  EO 4/1 NAIC
29. Reinsurance Attestation Supplement  EO xxx 3/1 Company
30. Exceptions to Reinsurance Attestation Supplement  N/A xxx 3/1 Company
31. Reinsurance Summary Supplemental  EO xxx 3/1 NAIC
32. Risk-Based Capital Report  EO 3/1 NAIC
33. Schedule SIS  N/A N/A 3/1 NAIC
34. Supplement A to Schedule T  EO 3/1, 5/15, 8/15, 11/15 NAIC
35. Supplemental Compensation Exhibit  N/A N/A 3/1 NAIC
36. Supplemental Health Care Exhibit (Parts 1, 2 and 3)  EO 4/1 NAIC
37. Supplemental Health Care Exhibit’s Allocation Report Supplement  EO 4/1 NAIC
38. Supplemental Investment Risk Interrogatories  EO 4/1 NAIC
39. Supplemental Schedule for Reinsurance Counterparty Reporting Exception - Asbestos and Pollution Contracts  EO 3/1 NAIC
40. Trusteed Surplus Statement  EO xxx 3/1, 5/15, 8/15, 11/15 NAIC

Property/Casualty

© 2021 National Association of Insurance Commissioners
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*If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state. EO (electronic only filing).

**If Form Source is NAIC, the form should be obtained from the appropriate vendor.

***For those states that have adopted the NAIC Corporate Governance Annual Disclosure Model Act, an annual disclosure is required of all insurers or insurance groups by June 1. The Corporate Governance Annual Disclosure is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state if filed at the insurance group level. For more information on lead states, see the following NAIC URL: http://www.naic.org/public_lead_state_report.htm.
***For those states that have adopted the NAIC updated Holding Company Model Act, a Form F filing is required annually by holding company groups. Consistent with the Form B filing requirements, the Form F is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state. For more information on lead states, see the following NAIC URL: http://www.naic.org/public_lead_state_report.htm

******For those states that have adopted the NAIC Risk Management and Own Risk and Solvency Assessment Model Act, a summary report is required annually by insurers and insurance groups above a specified premium threshold. The ORSA Summary Report is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state if filed at the insurance group level. For more information on lead states, see the following NAIC URL: http://www.naic.org/public_lead_state_report.htm
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### General Instructions

**For Companies to Use Checklist**

**Please Note:** This state’s instructions for companies to file with the NAIC are included in this Checklist. The NAIC will not be sending their own checklist this year.

Electronic filing is intended to be filing(s) submitted to the NAIC via the NAIC Internet Filing Site which eliminates the need for a company to submit diskettes or CD-ROM to the NAIC. Companies are not required to file hard copy filings with the NAIC.

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<tr>
<th>Column (1)</th>
<th>Checklist</th>
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<td>Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an “x” in this column when submitting information to the state.</td>
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The **Annual Statement Electronic Filing** includes the annual statement data and all supplements due March 1, per the Annual Statement Instructions. This includes all detail investment schedules and other supplements for which the Annual Statement Instructions exempt printed detail.

The **March .PDF Filing** is the .pdf file for annual statement data, detail for investment schedules and supplements due March 1.

The **Risk-Based Capital Electronic Filing** includes all risk-based capital data.

The **Risk-Based Capital.PDF Filing** is the .pdf file for risk-based capital data.

The **Supplemental Electronic Filing** includes all supplements due April 1, per the Annual Statement Instructions.

The **Supplemental.PDF Filing** is the .pdf file for all supplemental schedules and exhibits due April 1.

The **Quarterly Statement Electronic Filing** includes the complete quarterly statement data.

The **Quarterly Statement.PDF Filing** is the .pdf file for quarterly statement data.

The **Combined Annual Statement Electronic Filing** includes the required pages of the combined annual statement and the combined Insurance Expense Exhibit.

The **Combined Annual Statement.PDF Filing** is the .pdf file for the Combined annual statement data and the combined Insurance Expense Exhibit.

The **June .PDF Filing** is the .pdf file for the Audited Financial Statements and Accountants Letter of Qualifications.

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<td>Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (EX) Task Force modified the 1999 Annual Statement Instructions to waive paper filings of certain NAIC supplements and certain investment schedule detail if such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (EX) Task Force. XXX appears in the “Number of Copies” “Foreign” column for the appropriate schedules and exhibits. <strong>Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and to rely upon the NAIC database for these filings. This waiver could include</strong></td>
<td></td>
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© 2021 National Association of Insurance Commissioners
supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.

**Column (5) Due Date**

Indicates the date on which the company must file the form.

**Column (6) Form Source**

This column contains one of three words: “NAIC,” “State,” or “Company.” If this column contains “NAIC,” the company must obtain the forms from the appropriate vendor. If this column contains “State,” the state will provide the forms with the filing instructions. If this column contains “Company,” the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC Annual Statement Instructions.

**Column (7) Applicable Notes**

This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.

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*If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state. EO (electronic only filing).

**If Form Source is NAIC, the form should be obtained from the appropriate vendor.

***For those states that have adopted the NAIC Corporate Governance Annual Disclosure Model Act, an annual disclosure is required of all insurers or insurance groups by June 1. The Corporate Governance Annual Disclosure is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state if filed at the insurance group level. For more information on lead states, see the following NAIC URL: [http://www.naic.org/public_lead_state_report.htm](http://www.naic.org/public_lead_state_report.htm).

****For those states that have adopted the NAIC updated Holding Company Model Act, a Form F Filing is required annually by holding company groups. Consistent with the Form B filing requirements, the Form F is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state. For more information on lead states, see the following NAIC URL: [http://www.naic.org/public_lead_state_report.htm](http://www.naic.org/public_lead_state_report.htm).

*****For those states that have adopted the NAIC Risk Management and Own Risk and Solvency Assessment Model Act, a summary report is required annually by insurers and insurance groups above a specified premium threshold. The ORSA Summary Report is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state if filed at the insurance group level. For more information on lead states, see the following NAIC URL: [http://www.naic.org/public_lead_state_report.htm](http://www.naic.org/public_lead_state_report.htm).
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**General Instructions**

**For Companies to Use Checklist**

**Please Note:** This state’s instructions for companies to file with the NAIC are included in this Checklist. The NAIC will not be sending their own checklist this year.

Electronic filing is intended to be filing(s) submitted to the NAIC via the NAIC Internet Filing Site which eliminates the need for a company to submit diskettes or CD-ROM to the NAIC. Companies are not required to file hard copy filings with the NAIC.

**Column (1) Checklist**

Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an “x” in this column when submitting information to the state.

**Column (2) Line #**

Line # refers to a standard filing number used for easy reference. This line number may change from year to year.

**Column (3) Required Filings**

Name of item or form to be filed.

The *Annual Statement Electronic Filing* includes the annual statement data and all supplements due March 1, per the *Annual Statement Instructions*. This includes all detail investment schedules and other supplements for which the *Annual Statement Instructions* exempt printed detail.

The *March.PDF Filing* is the .pdf file for the annual statement, detail for investment schedules and all supplements due March 1.

The *Supplemental Electronic Filing* includes all supplements due April 1, per the *Annual Statement Instructions*.

The *Supplemental.PDF Filing* is the .pdf file for all supplements due April 1.

The *Quarterly Electronic Filing* includes the quarterly statement data.

The *Quarterly.PDF Filing* is the .pdf for quarterly statement data.

The *June.PDF Filing* is the .pdf file for the Audited Financial Statements and Accountants Letter of Qualifications.

**Column (4) Number of Copies**

Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (EX) Task Force modified the 1999 *Annual Statement Instructions* to waive paper filings of certain NAIC supplements and certain investment schedule detail, if such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (EX) Task Force. XXX appears in the “Number of Copies” “Foreign” column for the appropriate schedules and exhibits. *Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and to rely upon the NAIC database for these filings. This waiver could include supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.*

**Column (5) Due Date**

Indicates the date on which the company must file the form.
**Column (6)  Form Source**

This column contains one of three words: “NAIC,” “State,” or “Company.” If this column contains “NAIC,” the company must obtain the forms from the appropriate vendor. If this column contains “State,” the state will provide the forms with the filing instructions (generally, on its web site). If this column contains “Company,” the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC Annual Statement Instructions.

**Column (7)  Applicable Notes**

This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.

CAPITAL ADEQUACY (E) TASK FORCE

Capital Adequacy (E) Task Force Nov. 17, 2021, Minutes.................................................................10-841
Capital Adequacy (E) Task Force Sept. 30, 2021, Minutes (Attachment One).................................10-843
2022 Proposed Charges (Attachment One-A) ..................................................................................10-844
Health Risk-Based Capital (E) Working Group Nov. 4, 2021, Minutes (Attachment Two) ..........10-846
Life Risk-Based Capital (E) Working Group Nov. 9, 2021, Minutes (Attachment Three) ...........10-848
Presentation of the American Academy of Actuaries (Academy) C-2 Mortality Work Group
  Recommendation (Attachment Three-A) ......................................................................................10-849
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Catastrophe Risk (E) Subgroup Sept. 28, 2021, Minutes (Attachment Four-A) ..............................10-881
Property and Casualty Risk-Based Capital (E) Working Group Oct. 25, 2021, Minutes (Attachment Five).................10-882
Risk-Based Capital (RBC) Action Level Analysis (Attachment Five-A) .......................................10-884
Proposal 2021-16 CR (2021 Catastrophe Event List) (Attachment Six) ..............................................10-886
Working Agenda (Attachment Seven) ...............................................................................................10-892
The Capital Adequacy (E) Task Force met Nov. 17, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Tom Botsko (OH); Cassie Brown, Vice Chair, represented by Rachel Hemphill (TX); Lori K. Wing-Heier represented by David Phifer (AK); Jim L. Ridling represented by Charles Hale (AL); Ricardo Lara represented by Thomas Reedy (CA); Andrew N. Mais represented by Wanchin Chou (CT); David Altmaier represented by Carolyn Morgan and Ray Spudeck (FL); Doug Ommen represented by Mike Yanacheak (IA); Dana Popish Severinghaus represented by Kevin Fry (IL); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Russell Coy (KY); Chlora Lindley-Myers represented by John Rehagen and William Leung (MO); Mike Causey represented by Jackie Obusek (NC); Eric Dunning represented Michael Muldoon (NE); Glen Mulready represented by Eli Snowbarger (OK); Raymond G. Farmer represented by Michael Shull (SC); Mike Kreidler represented by Steve Drutz (WA); and Mark Afable represented by Amy Malm (WI).

1. Adopted its Sept. 30 Minutes

The Task Force conducted an e-vote that ended Sept. 30 to adopt its 2022 proposed charges. No significant changes were made to the charges.

Mr. Drutz made a motion, seconded by Mr. Chou to adopt the Task Force’s Sept. 30 minutes (Attachment One). The motion passed unanimously.

2. Adopted the Reports and Minutes of its Working Groups

a. Health Risk-Based Capital (E) Working Group

Mr. Drutz said the Health Risk-Based Capital (E) Working Group met Nov. 4 (Attachment Two) and took the following action: 1) exposed benchmark guidelines for Investment Income Adjustment for the Underwriting Risk Factors for a 30-day public comment period; and 2) discussed incorporating pandemic risk into the Health Risk-Based Capital (RBC) Formula.

b. Life Risk-Based Capital (E) Working Group

Mr. Botsko said the Life Risk-Based Capital (E) Working Group met Nov. 9 (Attachment Three) and took the following action: 1) exposed guidance on the bond factor changes for a 30-day public comment period; and 2) exposed the American Academy of Actuaries’ (Academy’s) C2 Mortality Risk Work Group recommendation on mortality factor updates for a 60-day public comment period.

c. Catastrophe Risk (E) Subgroup

Mr. Chou said the Catastrophe Risk (E) Subgroup met Oct. 27 (Attachment Four) and Sept. 28. During the Oct. 27 meeting, the Subgroup took the following action: 1) adopted its Sept. 28 minutes; 2) heard a presentation from Karen Clark & Company (KCC) regarding the KCC U.S. wildfire model, which included the current wildfire trends and an overview of the KCC U.S. wildfire model; 3) discussed the possibility of allowing additional third-party models or adjustments to the vendor models; and 4) heard updates from the Catastrophe Model Technical Review Ad Hoc Group.

d. Property and Casualty Risk-Based Capital (E) Working Group

Mr. Botsko said the Property and Casualty Risk-Based Capital (E) Working Group met Oct. 25 (Attachment Five) and took the following action: 1) adopted its July 22 minutes; 2) heard a report from the Catastrophe Risk (E) Subgroup; 3) exposed a draft recommendation to the Restructuring Mechanism (E) Subgroup for a 30-day public comment period ending Nov. 24. The draft recommendation was developed by the Working Group, which included the findings and recommendation of the runoff companies; 4) exposed proposal 2021-14-P (R3 Factor Adjustment) for a 30-day public comment period ending Nov. 24; and 5) heard an update on the status of the research on recommended adjustments to the formulas for premium and reserve risk to reflect the impact of interest rates from the Academy.
Mr. Chou made a motion, seconded by Mr. Reedy, to adopt the minutes of its working groups and subgroup. The motion passed unanimously.


Mr. Chou said the Catastrophe Risk (E) Subgroup and the Property and Casualty Risk-Based Capital (E) Working Group jointly conducted an e-vote that concluded Nov. 12 to adopt the 2021 (January through October) Catastrophe Event List. Both groups are planning to conduct another e-vote in January 2022 to adopt any November and December catastrophe events.

Mr. Chou made a motion, seconded by Mr. Reedy, to adopt proposal 2021-16 CR (2021 Catastrophe Event List) (Attachment Six). The motion passed unanimously.

4. **Adopted its Working Agenda**

Mr. Drutz said Item 19 was added to the Health RBC Working Agenda section to evaluate the underwriting risk factors for an adjustment of investment income based on a six-month U.S. Department of the Treasury (Treasury Department) bond on an annual basis. The second change was to Item 29 for bond evaluation, which was to change the priority status to a 3 and the expected completion date to year-end 2023 or later.

Mr. Drutz made a motion, seconded by Mr. Muldoon, to adopt its working agenda (Attachment Seven). The motion passed unanimously.

5. **Discussed a Memorandum to the Financial Condition (E) Committee**

Mr. Botsko said the Task Force has received numerous referrals over the past several years regarding investments that could potentially start being evaluated by the Securities Valuation Office (SVO) and reported with an NAIC designation in the investment schedules of the annual statement. The purpose of this new working group (RBC Investment Risk and Evaluation (E) Working Group) will be to evaluate the impact this could have, whether those changes are significant enough to change the current structure of the RBC formula, and whether the added granularity is beneficial to determine the appropriate capital standard. Mr. Botsko noted that an informal group was recently formed to discuss investment schedule reporting in the annual statement, and unlike the Investment Risk-Based Capital (E) Working Group that was recently disbanded, its focus was strictly with bond reporting and the RBC investment formula, and factors have been in place for 20 years, so a formal group is warranted to document its analysis for updates or justification of no changes to the factors and formula.

6. **Heard a Presentation from RMS Regarding its North America Wildfire HD Model**

Michael Young (Risk Management Solutions—RMS) provided a brief overview on its North America Wildfire High-Definition (HD) Model regarding: 1) the rationale for the development of its model; 2) key features and differentiators of the model; 3) factors influencing wildfire losses; and 4) the application of wildfire mitigation to insured property exposure. Mr. Chou encouraged all the interested parties to review this presentation and provide comments on the upcoming conference call.

Mr. Chou also stated that a Subgroup member met with the three wildfire modelers—i.e., AIR, KCC, and RMS—earlier to discuss the result of the impact analysis earlier. He said he believes that gaining a better understanding of the modeling results will enable the development of a better wildfire structure in the RBC formula. He said he expects that the initial RBC structure for wildfire will be ready for discussion in December. Thoughts and ideas on the structure are welcome at the upcoming meeting to complete this project effectively.

Having no further business, the Capital Adequacy (E) Task Force adjourned.

11_CapitalAdequacyTFmin.docx
The Capital Adequacy (E) Task Force conducted an e-vote that concluded Sept. 30, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Tom Botsko (OH); Cassie Brown, Vice Chair, represented by Mike Boerner (TX); Jim L. Ridling represented by Sheila Travis (AL); Ricardo Lara represented by Thomas Reedy (CA); Andrew N. Mais represented Kathy Belfi (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmaier represented by Carolyn Morgan (FL); Dana Popish Severinghaus represented by Kevin Fry (IL); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Russell Coy (KY); Chlora Lindley-Myers represented by John Rehagen (MO); Eric Dunning represented by Lindsay Crawford (NE); Mike Kreidler represented by Steve Drutz (WA); and Mark Afable represented by Amy Malm (WI).

1. **Adopted its 2022 Proposed Charges**

The Task Force conducted an e-vote to consider adoption of its 2022 proposed charges.

Mr. Mais made a motion, seconded by Mr. Rehagen, to adopt the Task Force’s 2022 proposed charges (Attachment One-A). The motion passed unanimously.

Having no further business, the Capital Adequacy (E) Task Force adjourned.
Draft: 8/17/21  
Adopted by the Executive (EX) Committee and Plenary, Dec. xx, 2021  
Adopted by the Financial Condition (E) Committee, Dec. xx, 2021  
Adopted by the Capital Adequacy (E) Task Force, TBD

2022 Proposed Charges

CAPITAL ADEQUACY (E) TASK FORCE

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

Ongoing Support of NAIC Programs, Products or Services

1. The Capital Adequacy (E) Task Force will:
   A. Evaluate emerging “risk” issues for referral to the risk-based capital (RBC) working groups/subgroups for certain issues involving more than one RBC formula. Monitor emerging and existing risks relative to their consistent or divergent treatment in the three RBC formulas.
   B. Review and evaluate company submissions for the schedule and corresponding adjustment to total adjusted capital (TAC).
   C. Evaluate relevant historical data and apply defined statistical safety levels over appropriate time horizons in developing recommendations for revisions to the current asset risk structure and factors in each of the RBC formulas.

2. The Health Risk-Based Capital (E) Working Group, Life Risk-Based Capital (E) Working Group and Property and Casualty Risk-Based Capital (E) Working Group will:
   A. Evaluate refinements to the existing NAIC risk-based capital (RBC) formulas implemented in prior year. Forward the final version of the structure of the current year life and fraternal, property/casualty (P/C) and health RBC formulas to the Financial Condition (E) Committee by June.
   B. Consider improvements and revisions to the various RBC blanks to: 1) conform the RBC blanks to changes made in other areas of the NAIC to promote uniformity; and 2) oversee the development of additional reporting formats within the existing RBC blanks as needs are identified. Any proposal that affects the RBC structure must be adopted no later than April 30 in the year of the change and adopted changes will be forwarded to the Financial Condition (E) Committee by the next scheduled meeting or conference call. Any adoptions made to the annual financial statement blanks or statutory accounting principles that affect an RBC change adopted by April 30 and results in an amended change may be considered by July 30 for those exceptions where the Capital Adequacy (E) Task Force votes to pursue by super-majority (two-thirds) consent of members present, no later than June 30 for the current reporting year.
   C. Monitor changes in accounting and reporting requirements resulting from the adoption and continuing maintenance of the revised Accounting Practices and Procedures Manual (AP&P Manual) to ensure that model laws, publications, formulas, analysis tools, etc., supported by the Task Force continue to meet regulatory objectives.
   D. Review the effectiveness of the NAIC’s RBC policies and procedures as they affect the accuracy, audit ability, timeliness of reporting access to RBC results and comparability between the RBC formulas. Report on data quality problems in the prior year RBC filings at the summer and fall national meetings.

3. The Variable Annuities Capital and Reserve (E/A) Subgroup, a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force, will:
   A. Monitor the impact of the changes to the variable annuities reserve framework and risk-based capital (RBC) calculation and determine if additional revisions need to be made.
   B. Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.

4. The Longevity Risk (E/A) Subgroup, a joint subgroup of the Life Risk-Based Capital (E) Working Group and the Life Actuarial (A) Task Force, will:
   A. Provide recommendations for the appropriate treatment of longevity risk transfers by the new longevity factors.
5. The **Catastrophe Risk (E) Subgroup** of the Property and Casualty Risk-Based Capital (E) Working Group will:
   A. Recalculate the premium risk factors on an ex-catastrophe basis, if needed.
   B. Continue to update the U.S. and non-U.S catastrophe event list.
   C. Continue to evaluate the need for exemption criteria for insurers with minimal risk.
   D. Evaluate the risk-based capital (RBC) results inclusive of a catastrophe risk charge.
   E. Refine instructions for the catastrophe risk charge.
   F. Continue to evaluate any necessary refinements to the catastrophe risk formula.
   G. Evaluate other catastrophe risks for possible inclusion in the charge.

NAIC Support Staff: Jane Barr
The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Nov. 4, 2021. The following Working Group members participated: Steve Drutz, Chair (WA); Jennifer Li (AL); Wanchin Chou (CT); Carolyn Morgan and Kyle Collins (FL); Michael Muldoon (NE); Tom Dudek (NY); Kimberly Rankin (PA); and Aaron Hodges (TX).

1. **Exposed Proposal 2021-18-H**

   Mr. Drutz said the Working Group adopted adjusted underwriting factors to include investment income for year-end 2021; during these discussions, the Working Group agreed to develop benchmarking guidelines to review the adjustment based on the current market environment. These discussions ranged from a five-year holding period to coincide with the five-year time horizon used in the development of the bond factors to a shorter holding period, such as the six-month treasury due to companies not recognizing investment income in their rate filings with the states. A 0.5% investment yield was incorporated into the factors for year-end 2021. Mr. Drutz said the proposed language states that the benchmarking parameters would be based on a six-month Treasury bond as of Jan. 1 of each year.

   Hearing no objections, the Working Group agreed to expose proposal 2021-18-H (Benchmarking Guidelines for Investment Income Adjustment in the Underwriting Risk Factors) for a 30-day public comment period ending Dec. 3.

2. **Adopted its 2021 Revised Working Agenda**

   Mr. Drutz said the working agenda was revised to include an agenda item for reviewing the investment income adjustment on Jan. 1 of each year. The six-month Treasury bond was used as the basis since this is what was used in the 2021 adjustment. Mr. Drutz said further modifications or changes can be incorporated based on the final benchmarking guidelines adopted.

   Mr. Drutz said an additional item that the Working Group may consider is related to the bond factors for the 20 designations; for year-end 2021, the health bond factors were adopted based on the American Academy of Actuaries (Academy) report and recommendations, while the life bond factors were adopted based on the Moody’s Analytics report. He said the asset risk component is typically not a material component of the health risk-based capital (RBC) formula; therefore, he recommended revising Item 29 on the working agenda to a Priority 3, and he expects a completion date of year-end 2023 or later. He said this will allow the Working Group to further evaluate the differences between the two methodologies and gather at least one year of data to analyze the new factors and overall impact of the bonds on the health formula. Mr. Chou asked what the plan would be if the expected completion date is 2023 and when the Working Group would begin discussing this. Mr. Drutz said the Working Group would need to get through at least the middle of 2022 to get the data and then coordinate these discussions with the Property and Casualty Risk-Based Capital (E) Working Group. Mr. Chou agreed with this approach to move forward.

   Mr. Chou made a motion, seconded by Mr. Dudek, to adopt the working agenda with the friendly amendment to revise Item 29 to a Priority 3 and an expected completion date of year-end 2023 or later (see NAIC Proceedings – Fall 2021, Capital Adequacy (E) Task Force, Attachment Seven). The motion passed unanimously.

3. **Received an Update from the Academy on H2 – Underwriting Risk Component Review**

   Steve Guzski (Academy) said the Health Solvency Subcommittee of the Academy is operating on multiple workstreams and meeting continually over the last few months to review the H2 – Underwriting Risk component. He said the Subcommittee is on track to deliver its initial report to the Working Group by year-end. Crystal Brown (NAIC) asked if the Working Group plans to propose changes to the factors or structure. Mr. Guzski said he does not have that information at this time, but with the multiple workstreams, there is one group assessing the formula and another group assessing the new risk factor development. He said the Subcommittee plans to convene to determine if there are any proposed changes that would be included in the initial report.
4. Relected an Update on the Excessive Growth Charge Ad Hoc Group and the Health Test Ad Hoc Group

Mr. Drutz said the Excessive Growth Charge Ad Hoc Group continued to meet and work on its analysis. He said the focus of the analysis has been to identify the factors that may be correlated and affected by excessive growth. The ad hoc group will continue its review and plans to meet later this month.

Mr. Drutz said the Health Test Ad Hoc Group met Nov. 3 and discussed the summary of the 2020 results and analysis. The ad hoc group discussed the continued inclusion of the reserve ratio in the test and whether that ratio should be adjusted. Mr. Drutz said a draft proposal has been developed and would remove the writing in five states or less and 75% of the writing in the domiciliary state requirements. The ad hoc group also discussed asset adequacy testing and the expectation of continuing to provide this in the actuarial opinion if a company were to move from the life blank to the health blank. The ad hoc group plans to meet again in early December.

5. Discussed Incorporating a Pandemic Risk Component into the Health RBC Formula

Mr. Drutz said the Working Group previously added a working agenda to consider the impact of pandemic risk and COVID-19 on the health RBC formula. The Working Group agreed to place a hold on reviewing this item until the world had moved further through the pandemic, as the full effects of the pandemic were not yet realized. Mr. Drutz asked the Working Group if it believes this item should remain on hold or if the Working Group should begin discussing it. The Working Group agreed to continue to table this discussion until next year.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.
The Life Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Nov. 9, 2021. The following Working Group members participated: Philip Barlow, Chair (DC); Jennifer Li (AL); Ben Bock (CA); Wanchin Chou (CT); Sean Collins (FL); Carrie Mears (IA); Vincent Tsang (IL); Ben Slutsker (MN); William Leung (MO); Derek Wallman (NE); Seong-min Eom (NJ); Bill Carmello (NY); Andrew Schallhorn (OK); Mike Boerner and Rachel Hemphill (TX); and Tomasz Serbinowski (UT).

1. Adopted its Summer National Meeting Minutes

Mr. Chou made a motion, seconded by Mr. Schallhorn, to adopt the Working Group’s July 21 (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment Four) minutes. The motion passed unanimously.

2. Exposed the Guidance Document on Bond Factor Changes

Mr. Barlow said this was directed to NAIC staff to draft in order to assist financial examiners and other state insurance regulators as they review the results of 2021 risk-based capital (RBC) calculations for life insurers in light of the 2021 bond factor changes. The Working Group exposed the guidance document for a 30-day public comment period ending Dec. 9.


Chris Trost (American Academy of Actuaries—Academy), chair of the Academy’s C2 Mortality Work Group, said the last time the Work Group was able to provide a report was last year due to the focus on bonds, real estate, and longevity this year. He said the Work Group has continued its work and, where previous updates have been focused on methodology, the Work Group is now at a point to present its recommendations (Attachment Three-A). He noted that included with the recommendations is a full report (Attachment Three-B) that highlights the major changes in the proposed methodology along with detailed documentation on the methodology and assumptions. He said the Work Group is looking for additional feedback, questions, and any other information the Working Group would like to have provided.

Ryan Fleming (Academy) presented the recommendations. Discussing the overall framework and the mortality risk categories, he noted that while the previous recommendation included catastrophe risk, the Work Group has included two new components, one for a terrorism-type event as well as providing for some chance of a currently unknown event. Mr. Carmello asked about the work done for the original factors and suggested it was not stochastic. Mr. Fleming said it was a more limited number of potential scenarios related to various adverse events and did not involve running thousands of scenarios and getting a full distribution of results. Mr. Carmello said it appears these were more deterministic scenarios. Mr. Fleming highlighted what had changed in the recommendation from the original work and what had not as presented on slide six and noted that the expanded factor categories for both individual and group life are needed to reflect differences in mortality risk. He continued this aspect with the information in slides nine and 10, highlighting the relative contribution of the risk categories to the overall capital factors and noting that those factors should recognize that there are varying levels of flexibility to adjust premiums or mortality charges between the products.

The Working Group agreed to expose the Academy’s recommendations and report for a public comment period ending Jan. 10, 2022. Mr. Barlow suggested scheduling a meeting to continue discussion of this recommendation during the exposure period and asked Mr. Trost to work with NAIC staff on drafting the actual blank and instructions necessary for a formal proposal.

4. Discussed Other Matters

Mr. Barlow reminded the Working Group that there is work being done by the American Council of Life Insurers (ACLI) on making the necessary modifications to the asset valuation reserve (AVR) factors related to the bond factor changes. He also noted that Dave Fleming (NAIC) has continued work on the statistics review and that the goal is to have this presented to those Working Group members who volunteered in December.

Having no further business, the Life Risk-Based Capital (E) Working Group adjourned.
Academy C-2 Mortality Work Group Recommendation

Chris Trost, MAAA, FSA
Chairperson C-2 Mortality Work Group

Ryan Fleming, MAAA, FSA
Vice Chair C-2 Mortality Work Group

American Academy of Actuaries

National Association of Insurance Commissioners (NAIC) Life Risk-Based Capital (E) Working Group—November 9, 2021

Agenda

- Review Life RBC C-2 mortality overall approach and current risk-based capital (RBC) factors
- Present recommendation on updated C-2 factors
  - Structural changes to factor categories
  - Updated factors under the recommended structure
- Appendix:
  - Methodology, assumption, and risk distribution comparisons
  - Validation, peer review, limitations

Life RBC C-2 Mortality Overall Approach (1 of 2)

- Mortality risk is defined as adverse variance in life insurance deaths (i.e., insureds dying sooner than expected) over the remaining lifetime of a block of business while appropriately reflecting the pricing flexibility to adjust current mortality rates for emerging experience.
- C-2 requirement covers mortality risk up to the 95th percentile covering adverse experience in excess of the amount covered in statutory reserves.
- C-2 requirement includes mortality risks related to:
  - Volatility Risk—natural statistical deviations in experienced mortality
  - Level Risk—error in experience mortality assumption
  - Trend Risk—adverse mortality trend
  - Catastrophe Risks
    - Large temporary mortality increase from a severe event such as a pandemic or terrorism
    - Sustained mortality increase from an unknown risk

Life RBC C-2 Mortality Overall Approach (2 of 2)

- Evaluate mortality risks using stochastic simulation of projected statutory losses.
- Discount after-tax cash flows (at 2.765% after-tax discount rate [3.5% pre-tax]).
- Express capital requirement using a factor-based approach applied to Net Amount at Risk (NAR) and convert to pre-tax.
The C-2 component of RBC represents 17-18% of total life industry risk-based capital.

### Pre-Tax C-2 Factor Recommendation versus Current RBC

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<th>Small Inforce Size NAR</th>
<th>Key Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Scenarios</td>
<td>↓ 45%</td>
<td>↑ 25%</td>
<td>Removal of discrete HIV scenarios</td>
</tr>
<tr>
<td>Level</td>
<td>↓ 25%</td>
<td>↑ 5%</td>
<td>Lower experience mortality rates, reducing risk with large inforce blocks</td>
</tr>
<tr>
<td>Trend</td>
<td>↑ 20%</td>
<td>↑ 10%</td>
<td>Greater range of mortality trends and differences by age/sex cohort</td>
</tr>
<tr>
<td>Catastrophe</td>
<td>↑ 10%</td>
<td>↑ 5%</td>
<td>Higher mortality rates associated with larger exposure periods</td>
</tr>
<tr>
<td>Capital</td>
<td>↑ 10%</td>
<td>↑ 5%</td>
<td>Addion of additional mortality rates (1980)</td>
</tr>
<tr>
<td>Sensitivity</td>
<td>↑ 0%</td>
<td>↓ 5%</td>
<td>Similar results as the original model</td>
</tr>
<tr>
<td>Length of Risk</td>
<td>↑ varies</td>
<td>↑ varies</td>
<td>Factors include seasonality of the length of mortality reserve period</td>
</tr>
</tbody>
</table>

### Lower Experience Mortality Rates

- The new model uses a distribution of rating classes using 2017 CSO tables
- 2023 Commissioners Standard Ordinary (CSO) mortality rates are significantly lower (50%-90%) than “88% of the 1975-80 Basic Table” used previously due to decades of mortality improvement in the U.S.
- An example at a typical age highlights the significant decrease

<table>
<thead>
<tr>
<th>Comparison of Experience Mortality Rates</th>
<th>2017 CSO</th>
<th>1975-80 Basic Table</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% to 70%</td>
<td>3.98</td>
<td>2.68</td>
<td>0.38</td>
</tr>
</tbody>
</table>

- Similar % decreases also occur at different gender, ages and underwriting classes
- Experience mortality manifests through the level risk component
C-2 Factor Attribution by Mortality Risk
Individual Life - 5-Year Projection Period Example

- Risks for large inforce blocks are spread proportionately between volatility/level, trend, and catastrophe.
- Smaller inforce blocks are subject to higher volatility and level risks, which result in higher factors versus larger blocks.

C-2 Factor Attribution by Mortality Risk
Group Life - 5-Year Projection Period Example

- Risks for large inforce blocks are spread proportionately between volatility/level, trend, and catastrophe.
- Smaller inforce blocks are subject to higher volatility and level risks, which result in higher factors versus larger blocks.

Expanded Categories to Three Products for Individual Life and Two Categories for Remaining Rate Terms for Group Life

Original 1990s Work
- 1993 factors used a 5-year risk exposure period for all individual life business and a 3-year risk exposure period for group life because it assumed that management actions would occur to reset current mortality rates to reflect emerging experience.

Current Work
- For individual life, management action to reset current mortality rates may be limited or non-existent for products that offer longer term mortality rate guarantees (e.g., Universal Life with Secondary Guarantees [ULSG], Level Term).
- For group life, there are varying lengths of premium rate terms in the marketplace.
- Factors aligned with the remaining risk exposure period of current mortality rates on an inforce block is appropriate. This risk differentiation can be accomplished by varying factors by product for individual life and by remaining premium term for group life.
- The recommendation is to expand factors into additional categories to reflect the current mortality rate risk exposure period over the remaining lifetime of an inforce block of business.

For individual life insurance, the recommendation is to differentiate into three product categories with definitions consistent with the annual statement – analysis of operations by line of business – individual life insurance and VM-20.

For group life insurance, the recommendation is to differentiate into two categories by remaining length of the rate term based on company records by group contract.
Two New Catastrophe Components

A terrorism component was developed based on industry experience from the September 11, 2001 terrorist attacks.

- Component assumes a 2.5% annual probability of an event.
- This component was intended to cover unknown risks that could materialize in the insured population.
- The component assumes a 2.5% annual probability of an event.

- In follow-up to a question at the 9/11/20 meeting, sensitivity testing was performed to adjust the component’s size.
- If the event occurs, it is sustained for the remainder of the projection period up to a maximum period of 10 years.
- The recommendation is to include these two new catastrophe components.

Recommended Updated C-2 Factors

<table>
<thead>
<tr>
<th>Pre-Tax Life RBC C-2 Factors</th>
<th>Per $1000 of NAR</th>
<th>Individual &amp; Industrial Life</th>
<th>Group &amp; Credit Life</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Universal Life with Secondary Guarantees</td>
<td>Term Life</td>
<td>All Other Life</td>
</tr>
<tr>
<td>First $50M (Small)</td>
<td>1.90</td>
<td>2.70</td>
<td>1.90</td>
</tr>
<tr>
<td>Next $4.5B (Medium)</td>
<td>1.65</td>
<td>2.30</td>
<td>1.70</td>
</tr>
<tr>
<td>US$5B Target</td>
<td>1.30</td>
<td>0.75</td>
<td>0.50</td>
</tr>
</tbody>
</table>

Notes:

- The other category is remaining premium rate terms 3 years and under, which is represented by a 3-year exposure period.
- Size bands were reviewed, and the recommendation is to combine the current middle two categories ($500M-$5B and $5B-$25B) into one category ($500M-$25B).
- The recommendation is to continue categorizing industrial life with individual life and credit life with group life.
- The recommendation is to continue with the 50% premium rate term.
- The recommendation is to include these two new catastrophe components.

Recommendation on Updated C-2 Factors

<table>
<thead>
<tr>
<th>Pre-Tax Life RBC C-2 Factors</th>
<th>Per $1000 of NAR</th>
<th>Individual &amp; Industrial Life</th>
<th>Group &amp; Credit Life</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>1.30</td>
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<td>0.50</td>
</tr>
</tbody>
</table>

Notes:

- The other category is remaining premium rate terms 3 years and under, which is represented by a 3-year exposure period.
- Size bands were reviewed, and the recommendation is to combine the current middle two categories ($500M-$5B and $5B-$25B) into one category ($500M-$25B).
- The recommendation is to continue categorizing industrial life with individual life and credit life with group life.
- The recommendation is to continue with the 50% credit given for group premium stabilization reserves.

* As of 2019 annual statement reporting.
Recommendation vs Current RBC Group & Credit Life Impacts

<table>
<thead>
<tr>
<th>For $1000 of NAR</th>
<th>Group &amp; Credit Life</th>
<th>Change as Current RBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>$&lt; 500M</td>
<td>1.76</td>
<td>1.30</td>
</tr>
<tr>
<td>$500M – 4.5B</td>
<td>1.16</td>
<td>0.70</td>
</tr>
<tr>
<td>$4.5B – 20B</td>
<td>0.87</td>
<td>0.45</td>
</tr>
<tr>
<td>$&gt; 20B</td>
<td>0.76</td>
<td>0.45</td>
</tr>
</tbody>
</table>

- Overall group industry impact would be a significant decrease in C-2 capital
- Factors decrease for all but one category: small size for longer rate terms which stays about the same
- Group life factors decreased due to the decades-long decline in experience mortality rates, and the exposure periods remain shorter term as compared to individual life
- C-2 is reduced by up to 50% of premium stabilization reserves

C-2 Factors as an Overall Mortality Increase and Observations Versus Other Capital Regimes

- Table translates factors to an overall mortality percentage increase for a 5-year risk exposure period
- Percentage increases are similar for other risk exposure periods with cumulative magnitudes being greater for longer periods
- For example, a 10% increase for 10 years is more severe than a 10% increase for 5 years
- Factors were reviewed against other capital regimes, including Canada, International Capital Standards (ICS), Solvency II and rating agency
- Mortality risk drivers are consistent
- Confirmed magnitudes are reasonable for the 95th percentile

Overall Mortality Increase

<table>
<thead>
<tr>
<th>Inforce Block Size</th>
<th>Individual &amp; Industrial Life – 5-year</th>
<th>Group &amp; Credit Life – 5-year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>+22%</td>
<td>+31%</td>
</tr>
<tr>
<td>Medium</td>
<td>+10%</td>
<td>+14%</td>
</tr>
<tr>
<td>Large</td>
<td>+8%</td>
<td>+10%</td>
</tr>
</tbody>
</table>

- The model was extensively sensitivity tested, and the following attributes increase mortality risk for companies concentrated in these areas
  - The C-2 Mortality Work Group doesn’t recommend differentiating RBC factors by these attributes; however, they may be useful to regulators when reviewing potentially weakly capitalized companies
  - Older Attained Ages: capital needs per unit of net amount at risk increase for attained ages 65 and older due to increasing mortality rates
  - Substandard/Classified Underwriting Classes: capital needs are higher due to higher mortality rates on unhealthier/riskier lives

Summary of Recommendations

1. The Academy C-2 Life Mortality Work Group recommends the factors shown on Slide 14 which reflect
2. Expanding factors into additional categories to reflect the current mortality rate risk exposure period over the remaining lifetime of an inforce block of business
   - For individual life insurance, the recommendation is to differentiate into three product categories with definitions considered will be an annual statement analysis of operations by the 5 largest – individual life insurance and life reinsurance life insurer.
   - For group life insurance, the recommendations can be differentiated into two categories by the remaining length of the in-force block of business.
3. Including the two new catastrophe components for 1) terrorism (expressed as a 5% annual probability of an extra 0.05 deaths per 1,000) and 2) the risk of a sustained mortality increase from an unknown event (expressed as a 2.5% annual probability of a 5% sustained mortality increase)
4. Combining the current middle two size categories into one category
5. Continue categorizing industrial life with individual life and credit life with group life
6. Continue with the 50% credit given for group life premium stabilization reserves
7. The work group opines that additional review of the adopted correlation factor with longevity C-2 is not necessary as the Life C-2 modeling was completed consistently with longevity

Sensitivity Testing: Other Attributes that Increase Mortality Risk

- The model was extensively sensitivity tested, and the following attributes increase mortality risk for companies concentrated in these areas
  - The C-2 Mortality Work Group doesn’t recommend differentiating RBC factors by these attributes; however, they may be useful to regulators when reviewing potentially weakly capitalized companies
  - Older Attained Ages: capital needs per unit of net amount at risk increase for attained ages 65 and older due to increasing mortality rates
  - Substandard/Classified Underwriting Classes: capital needs are higher due to higher mortality rates on unhealthier/riskier lives
Proposed Timeline

- A proposed timeline for a year-end 2022 implementation
- By end of Q4 2021: expose recommended final factors
- By end of Q1 2022: structural changes are adopted
- By end of Q2 2022: updated factors are adopted
- Year-end 2022: factors are implemented for year-end 2022 annual statements

Questions?

Additional Questions, contact:

Khloe Greenwood, Life Policy Analyst
greenwood@actuary.org

Chris Trost, Chairperson C-2 Mortality Work Group

Ryan Fleming, Vice Chair C-2 Mortality Work Group

Appendix: Method and Assumption Comparison

<table>
<thead>
<tr>
<th>Item</th>
<th>Original Work</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Method</td>
<td>Monte Carlo Model – Present Value (PV) of Death Benefits</td>
<td>Monte Carlo Model – PV of Death Benefits</td>
</tr>
<tr>
<td></td>
<td>• PV of Statutory Losses</td>
<td>• PV of Statutory Losses</td>
</tr>
<tr>
<td></td>
<td>• Loss defined as death benefits minus reserves released</td>
<td>• Loss defined as death benefits minus reserves released</td>
</tr>
<tr>
<td></td>
<td>• 5% margin/load assumed in reserve mortality</td>
<td>• 5% margin/load assumed in reserve mortality</td>
</tr>
<tr>
<td>Length of Exposure Period</td>
<td>5 years</td>
<td>5, 10, and 20 years for Individual Life</td>
</tr>
<tr>
<td></td>
<td>• Assumed exposure past 5 years could be offset through management actions</td>
<td>• Assumed exposure past 5 years could be offset through management actions</td>
</tr>
<tr>
<td></td>
<td>3 and 5 years for Group Life</td>
<td>3 and 5 years for Group Life</td>
</tr>
<tr>
<td>Discount Rate</td>
<td>6% after -tax</td>
<td>2.765% after -tax (3.5% pre-tax)</td>
</tr>
<tr>
<td>Experience Mortality</td>
<td>88% of 1975-1980 Male Basic Table</td>
<td>2017 Unloaded Commissioners’ Standard Ordinary Table (CSO) for Individual Life</td>
</tr>
<tr>
<td></td>
<td>• 15Y Select &amp; Ultimate Structure</td>
<td>• 25Y Select &amp; Ultimate structure</td>
</tr>
<tr>
<td></td>
<td>• Gender distinct – Male/Female</td>
<td>• Gender distinct – Male/Female</td>
</tr>
<tr>
<td></td>
<td>• 5 underwriting classes (3 non-smoker/2 smoker)</td>
<td>• 5 underwriting classes (3 non-smoker/2 smoker)</td>
</tr>
<tr>
<td>Mortality Improvement</td>
<td>Binomial, Poisson</td>
<td>2017 Improvement Scale for VM-20</td>
</tr>
<tr>
<td></td>
<td>• Varies by gender and age</td>
<td>• Varies by gender and age</td>
</tr>
</tbody>
</table>

Appendix: Risk Distribution Approach Comparison

<table>
<thead>
<tr>
<th>Item</th>
<th>Original Work</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volatility</td>
<td>Binomial (Policies, q)</td>
<td>Binomial (Policies, q)</td>
</tr>
<tr>
<td></td>
<td>• Competitive Pressures scenarios – risk of overoptimistic pricing assumptions</td>
<td>• Competitive Pressures scenarios – risk of overoptimistic pricing assumptions</td>
</tr>
<tr>
<td></td>
<td>• Early 90’s estimates of the impact of AIDS on insured mortality (could fit in level, trend, or catastrophe)</td>
<td>• Early 90’s estimates of the impact of AIDS on insured mortality (could fit in level, trend, or catastrophe)</td>
</tr>
<tr>
<td></td>
<td>LR ~ N(0, σLev); σLev = σLev1 + σLev2, 6:1</td>
<td>LR ~ N(0, σLev); σLev = σLev1 + σLev2, 6:1</td>
</tr>
<tr>
<td></td>
<td>• Two independent components:</td>
<td>• Two independent components:</td>
</tr>
<tr>
<td></td>
<td>• Credibility/statistical sampling volatility</td>
<td>• Credibility/statistical sampling volatility</td>
</tr>
<tr>
<td></td>
<td>• True mortality volatility</td>
<td>• True mortality volatility</td>
</tr>
<tr>
<td></td>
<td>Continuous normal distribution</td>
<td>Continuous normal distribution</td>
</tr>
<tr>
<td>Trend</td>
<td>Discrete Distribution</td>
<td>Discrete Distribution</td>
</tr>
<tr>
<td></td>
<td>• 6 gender/age group improvement variables</td>
<td>• 6 gender/age group improvement variables</td>
</tr>
<tr>
<td></td>
<td>• Correlated normally distributed random variables</td>
<td>• Correlated normally distributed random variables</td>
</tr>
<tr>
<td></td>
<td>• Pandemic – calibrated from multiple sources</td>
<td>• Pandemic – calibrated from multiple sources</td>
</tr>
<tr>
<td></td>
<td>• Terrorism – 5% probability of additional 0.05 / 1K</td>
<td>• Terrorism – 5% probability of additional 0.05 / 1K</td>
</tr>
<tr>
<td></td>
<td>• Unknown Risk – 2.5% probability of a sustained 5% increase</td>
<td>• Unknown Risk – 2.5% probability of a sustained 5% increase</td>
</tr>
</tbody>
</table>
Appendix: Model Validation, Peer Review, Limitations

**Validation:** Model assumptions were developed by the work group through reviewing current mortality research and studies applicable to the U.S. life insurance industry. The assumptions were discussed, revised, and agreed upon through the work group’s bi-weekly calls. Model results and sensitivities were also reviewed extensively by the work group. The work group also provided several updates to the NAIC Life Risk-Based Capital Working Group throughout the project and feedback was obtained from regulators.

**Peer Review:** The model was independently peer reviewed by a member of the work group. The peer review confirmed that the calculations performed by the model were reasonable for the intended purpose and were being applied as intended.

**Limitations:** The model is intended to stochastically project through Monte Carlo simulation the run-off of in-force life insurance blocks typical of U.S. life insurers in order to develop capital factors for use in the NAIC RBC formula for C-2 life insurance mortality risk. Other uses outside of this intended purpose may not be appropriate. Product features in the model were developed at a very basic level and consider differences in base statutory reserves, lapses, post-level term mortality experience, face amounts and attained ages. The model is not designed to replicate detailed product and in-force block characteristics unique to individual companies. In particular, ULSG products were not directly modeled. The work group concluded based on the modeling that the capital factors are insensitive to product differences for a given risk exposure period. The recommendation to differentiate based on product is an indirect way to get at the length of mortality rate guarantee, utilizes the current reporting structure of the annual statements, and is aligned with principles based reserving differentiation.

Appendix: Prior Work Group Presentations to Life RBC

- September 2020
- December 2019
- June 2019
- April 2019
- August 2018
- August 2017
November 9, 2021

Mr. Philip Barlow
Chair, Life Risk-Based Capital (E) Working Group
National Association of Insurance Commissioners (NAIC)

Dear Philip,

On behalf of the C-2 Mortality Work Group of the American Academy of Actuaries\(^1\), we are providing a recommendation on updates to the Life Risk-Based Capital (RBC) C-2 Mortality Factors. The objective of the work group was to review and update the model developed in the early 1990’s, which was used in setting the currently applicable Life RBC C-2 factors.

The recommendation may be found in the attached report and accompanying slide presentation. The recommended factors are based on the following key changes.

1. Expanding factors into additional categories to reflect the assumed current mortality rate risk exposure period over the remaining lifetime of an inforce block of business.
2. Adding two catastrophe components for a) terrorism (expressed as a 5% annual probability of an extra 0.05 deaths per 1,000), and b) the risk of a sustained mortality increase from an unknown event (expressed as a 2.5% annual probability of a 5% sustained mortality increase). These two new components are in addition to the pandemic component previously included.
3. Combining the current middle two size categories into one category.

The remainder of the structure is recommended to stay the same. We look forward to presenting the work group’s recommendation at the November 9, 2021 Life Risk-Based Capital (E) Working Group meeting.

Sincerely,

Chris Trost, MAAA, FSA
Chairperson, C-2 Mortality Work Group
American Academy of Actuaries

Ryan Fleming, MAAA, FSA
Vice Chair, C-2 Mortality Work Group
American Academy of Actuaries

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\(^1\) The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
Life RBC – C-2 Mortality Risk
Model Documentation Report of the American Academy of Actuaries C-2
Mortality Work Group
to the National Association of Insurance Commissioners (NAIC)
Life Risk-Based Capital (E) Working Group

November 9, 2021

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Executive Summary

Introduction

The purpose of this report is to document the model developed and used by the Academy C-2 Life Mortality Work Group in support of its work to consider and propose updates to the C-2 capital factors for life insurance mortality within the NAIC Risk-Based Capital formula. The objective of the work group was to review and update the model developed in the early 1990’s, which was used in setting the Life RBC C-2 factors which have been in place since 1993.

Mortality risk is defined as adverse variance in life insurance deaths (i.e., insureds dying sooner than expected) over the remaining lifetime of a block of business while appropriately reflecting the pricing flexibility to adjust current mortality rates for emerging experience. Life insurance mortality risk was evaluated by stochastic simulation through the model documented in this memo. The mortality risks evaluated were volatility, level, trend, and catastrophe. The model is intended to simulate the run-off of inforce life insurance blocks typical of U.S. life insurers.

The capital need, expressed as a dollar amount, is determined as the greatest present value of accumulated deficiencies at the 95th percentile of the stochastic distribution of scenarios over the remaining lifetime of a block of business while appropriately reflecting the pricing flexibility to adjust current mortality rates. Statutory losses are defined as the after-tax quantification of gross death benefits minus reserves released minus mortality margin present in reserves. The after-tax statutory losses are discounted to the present by using 20-year averages for U.S. swap rates. By selecting the largest present value accumulated loss across all projection years, the solved for capital ensures survival at all projection periods. Earlier period losses are not allowed to be offset by later period gains to reduce capital. The 95th percentile is the commonly accepted statistical safety level used for Life RBC C-2 mortality risk to identify weakly capitalized companies. The after-tax capital needs are translated to a factor expressed as a percentage of the initial net amount at risk (NAR), and are shown as an amount per $1,000 of NAR. The pre-tax factor is determined by taking the after-tax factor divided by (1 minus the tax rate).

The documentation includes descriptions of model inputs and assumptions, capital quantification method, results and sensitivities, validation and peer review and limitations.

Key Assumption Changes from Original Work

The following assumptions changes from the original work are highlighted as having the most significant impact on the modeled results.

1. Experience mortality rates are significantly lower than when the original work was completed, reflecting decades of U.S. insured population mortality improvement. This leads to lower capital need through the level risk component for large inforce blocks with credible mortality experience.

2. In place of the severe human immunodeficiency virus (HIV) scenarios assumed in the original work, a new catastrophe risk component was developed for an unknown sustained increase in mortality. The net impact of these two changes was a reduction in the capital need as the higher probability, higher severity HIV assumptions were replaced with the unknown risk component that has lower probability and severity.
3. The pandemic distribution was updated, and a terrorism component was added, leading to a modest increase in the capital need.

4. Trend risk was expanded to reflect a greater range of mortality trends and differences by age/gender cohorts. This update resulted in higher capital factors.

5. The capital quantification method was updated to a greatest present value of accumulated deficiencies (GPVAD) method with statutory losses defined as death benefits minus reserves released. This resulted in a modest increase compared to the prior method.

6. The risk exposure period to current mortality rates was expanded to reflect product and premium terms available in the marketplace. For individual life, the risk exposure periods were expanded from 5 years to 5 years, 10 years, and 20 years. For group life, the risk exposure periods were expanded from 3 years to 3 years and 5 years. The longer a company is exposed to current mortality rates without being able to adjust pricing, the greater the capital need.

The directional impact relative to the current RBC factors for large and small inforce block sizes is highlighted in Exhibit 1 below. For a 5-year risk exposure period, the overall impact of the model updates results in a significant decrease in most factors. However, the risk exposure period is a critical variable, and this component factors into the structural changes being recommended by this work group.

<table>
<thead>
<tr>
<th>Risk Component</th>
<th>Large Inforce Size &gt;$25B NAR</th>
<th>Small Inforce Size ≤$500M NAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Scenarios</td>
<td>↓ 45%</td>
<td>↓ 25%</td>
</tr>
<tr>
<td>Level</td>
<td>↓ 25%</td>
<td>↑ 5%</td>
</tr>
<tr>
<td>Trend</td>
<td>↑ 20%</td>
<td>↑ 10%</td>
</tr>
<tr>
<td>Catastrophe</td>
<td>↑ 10%</td>
<td>↑ 5%</td>
</tr>
<tr>
<td>Capital Quantification Method</td>
<td>↑ 10%</td>
<td>↑ 5%</td>
</tr>
<tr>
<td>Volatility</td>
<td>↑ 0%</td>
<td>↓ 5%</td>
</tr>
<tr>
<td>Length of Risk Exposure Period</td>
<td>↑ varies</td>
<td>↑ varies</td>
</tr>
</tbody>
</table>

**Overall Results and Recommended C-2 Factors**

The recommended pre-tax factors per $1,000 of retained NAR are shown in Table 1 below. Business assumed by reinsurers is treated as direct for reinsurer financial statements. The factors are differentiated by individual & industrial life and group & credit life, consistent with the current framework. The modeling focused on individual and group life, and the work group evaluated the continued appropriateness of applying the factors to industrial life and credit life business. It is recommended that industrial life and credit life continue to be mapped to individual and group life, respectively, as the product attributes are similar. The factors are rounded to the nearest 0.05 to recognize the randomness inherent in the model (see Impact of Random Number Seed for additional information). Three size bands are recommended to represent inforce blocks of small, medium, and large sizes. This reflects combining the two middle
categories of the current framework as the risk characteristics are similar. The size bands were reviewed and continue to be relevant and appropriate, and a material portion of life insurers are represented within each category.

Within individual & industrial life, the factors are differentiated into three product categories: Universal life with secondary guarantees (ULSG), term life, and all other life. The product definitions are consistent with the annual statement – analysis of operations by line of business – individual life insurance and Valuation Manual (VM)-20. The differences by product category are the sole result of applying different risk exposure periods to an aggregate life inforce block. As described in Sensitivity 4 Individual Life Products under Model Sensitivities, the model produces consistent results by product for a given risk exposure period, as expressing the factor as a percentage of net amount at risk neutralizes product differences.

ULSG factors are the highest due to the longest current mortality rate exposure and are based on a 20-year risk exposure period for a mature inforce block. Term life factors are based on a typical 10-year risk exposure period for a mature inforce block. The industry is concentrated in 10-, 20- and 30-year level term. All other life factors are based on a 5-year risk exposure period and assume inforce pricing may be adjusted following adverse mortality experience due to the presence of non-guaranteed elements. Examples are universal life (UL) products without secondary guarantees and participating whole life products.

Within group & credit life, the factors are differentiated into two categories based on the remaining length of the premium term based on company records by group contract. The two categories are remaining rate terms over 3 years and remaining rate terms 3 years and under. The remaining rate terms over 3 years category is represented by a 5-year risk exposure period, and the remaining rate terms 3 years and under is represented by a 3-year risk exposure period. The risk exposure periods recognize a time lag between when experience emerges and when pricing is adjusted.

Table 2 and Table 3 compare the recommended factors versus the current RBC factors in place as of 12/31/2020.

<table>
<thead>
<tr>
<th>Per $1,000 of Inforce NAR</th>
<th>Pre-Tax RBC C-2 Factors</th>
<th>Individual &amp; Industrial Life</th>
<th>Group &amp; Credit Life</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Universal Life with Secondary Guaranteed (ULSG)</td>
<td>Term Life</td>
<td>All Other</td>
</tr>
<tr>
<td>First $500M</td>
<td>3.50</td>
<td>2.70</td>
<td>1.90</td>
</tr>
<tr>
<td>Next $24.5B</td>
<td>1.10</td>
<td>0.75</td>
<td>0.50</td>
</tr>
</tbody>
</table>

* as of 2019 annual statement reporting

The overall individual life industry impact would be a modest decrease with industry exposure by NAR concentrated in term life business amongst large insurers. Factors increase for ULSG due to the long-term
exposure period to current mortality rates. As indicated in Exhibit 1, factors decrease for products with near-term inforce pricing flexibility (i.e., all other category). Small ULSG and term carriers would experience an increase on retained business. However, reinsurance is often used to transfer/mitigate the mortality risk for small carriers.

The overall group industry impact would be a significant decrease in C-2 capital. The factors decrease for all but one category: small size for longer rate terms which stays about the same. Group life factors decreased due to the decades-long decline in experience mortality rates, and the risk exposure periods remain shorter term as compared to individual life.

Credit for Group Life Premium Stabilization Reserves

The current RBC formula includes a 50% credit for group life premium stabilization reserves to offset the group life C-2 requirement. This component was reviewed by the work group. Based on a theoretical framework and professional experience, the 50% factor was deemed to be an appropriate offset to the capital requirement.

Correlation with Longevity C-2

The updated Life C-2 mortality modeling was completed consistent with the development of the adopted Longevity C-2 factors and correlation factor. Therefore, the work group opines that additional review of the adopted correlation factor is not necessary because of the updates to the Life C-2 mortality factors being recommended by this work group.

Introduction

The purpose of this report is to document the model developed and used by the Academy C-2 Life Mortality Work Group in support of its work to consider and propose updates to the C-2 capital factors for life insurance mortality within the NAIC Life Risk-Based Capital formula. The objective of the work group was to review and update the model developed in the early 1990’s, which was used in setting the Life RBC C-2 factors which have been in place since 1993.

Mortality risk is defined as adverse variance in life insurance deaths (i.e., insureds dying sooner than expected) over the remaining lifetime of a block of business while appropriately reflecting the pricing flexibility to adjust current mortality rates for emerging experience. Life insurance mortality risk was evaluated by stochastic simulation through the model documented in this memo. The mortality risks evaluated were volatility, level, trend, and catastrophe. The model is intended to simulate the run-off of inforce life insurance blocks typical of U.S. life insurers.
The capital need, expressed as a dollar amount, is determined as the GPVAD at the 95th percentile of the stochastic distribution of scenarios over the remaining lifetime of a block of business while appropriately reflecting the pricing flexibility to adjust current mortality rates. Statutory losses are defined as the after-tax quantification of gross death benefits minus reserves released minus mortality margin present in reserves. The after-tax statutory losses are discounted to the present by using 20-year averages for U.S. swap rates. By selecting the largest present value accumulated loss across all projection years, the solved for capital ensures survival at all projection periods. Earlier period losses are not allowed to be offset by later period gains to reduce capital. The 95th percentile is the commonly accepted statistical safety level used for Life RBC C-2 mortality risk to identify weakly capitalized companies. The after-tax capital needs are translated to a factor expressed as a percentage of the initial NAR, and are shown as amount per $1,000 of NAR. The pre-tax factor is determined by taking the after-tax factor divided by (1 minus the tax rate).

The documentation includes descriptions of model inputs and assumptions, capital quantification method, results and sensitivities, validation and peer review and limitations.

**Inputs and Assumptions**

This section describes the inputs and assumptions used by the model. Detail on specific assumptions is available upon request.

**Model Assumptions**

The model assumptions section are high-level parameters for running the model and include the following inputs.

- **Random Number Seed:** This is the random number seed for starting the sequence of numbers for the random number generator. This was randomly set to 25 for the modeling. This assumption is necessary in order to be able to exactly re-produce model results. Changing the random number seed will result in a different sequence of random numbers and changes to model results (See sensitivities).

- **Scenarios:** This is a number of scenarios the model runs. 10,000 scenarios were assumed to obtain a smooth and full distribution of results.

- **Projection Years:** This is a number of years the model will run for each scenario. The model is set up to run from 1-30 years. The projection period represents the risk exposure period for an inforce block where current mortality rates are at risk for adverse experience. 3-year and 5-year projection periods were selected for group life insurance to cover the typical remaining periods for rate terms for group products and the ability to re-price for mortality changes after this period. This was a change from the 3-year period assumed in the prior work. Individual life insurance was selected to run for projection periods of 5 years, 10 years, and 20 years. The 5-year period is intended to represent inforce blocks where pricing may be adjusted following adverse mortality experience due to the presence of non-guaranteed elements, which are not yet being charged at maximum levels. Longer projection periods are intended to represent inforce blocks that have little to no flexibility to respond to mortality changes over the remaining lifetime. ULSG factors are based on a 20-year risk exposure period for a mature inforce block. Term life factors are based on a typical 10-year risk exposure period for a mature inforce block. The industry is concentrated in 10-, 20- and 30-year level term.
• **Policies:** This is the assumed number of policies in a life insurer’s inforce block. Three size bands were modeled: 1,000,000 policies for large inforce blocks, 100,000 policies for medium inforce blocks, and 10,000 policies for small inforce blocks. Policy size weightings are applied by face amount subject to the retention limits.

• **Discount Rate (Pre-Tax):** Projected amounts are discounted to the present using this assumption converted to an after-tax rate. A 3.5% discount rate was selected based on the 2001-2020 average of 10-year U.S. swap rates. The selection of the discount rates is aligned with the same methodology used to determine the discount rate for the RBC C-1 bond factors. The methodology uses a 20-year average and is intended to represent a risk-free rate.

• **Retention Limit:** This represents the maximum retained face amount per policy for a company’s inforce block. Amounts above this limit are assumed to be reinsured (or not issued above the limit). Three retention limits were modeled based on company size: $1,000,000 for large inforce blocks, $250,000 for medium inforce blocks, and $50,000 for small inforce blocks. These assumptions are used to calibrate the total inforce block size for the three size categories. Results are insensitive to variations in retained face amount for a given number of policies (see Sensitivity 8 Face Amount under Model Sensitivities).

• **Tax Rate:** This represents the tax rate applied to pre-tax statutory losses to determine after-tax losses. The rate of 21% is based on the current U.S. corporate tax rate. It is also used to convert the discount rate to an after-tax rate.

**Initial Inforce Assumptions**

These set of assumptions are used to specify parameters for inforce weightings that is used to develop a block of inforce policies. Given the weights input in this section, the “Initial Inforce Loaded in Model” section is weighted to specify the inforce cohorts and policy counts run through the model processing. Based on the characteristics outlined, the inforce population may have up to 8,748 unique cohorts. The weightings assumed for the modeling analysis were developed using data from the two experience reports in the table below. The model has the ability to run individual and group life together, but the analysis was done modeling these separately to determine unique factors for each category.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Life</td>
<td>Society of Actuaries 2016 Group Life Experience Committee Report</td>
</tr>
</tbody>
</table>

• **Gender:** The overall percentages of males and females for individual and group life.

• **Underwriting Code:** The underwriting codes and rating class weightings for the inforce population. The underwriting code for a given cohort is used to map to a mortality based on that underwriting class. There are 5 underwriting codes/classes for individual life aligned with the categories for the 2017 Commissioners Standard Ordinary (CSO) mortality table: non-smoker best class (super preferred), non-smoker mid class (preferred), non-smoker residual (standard), smoker best class (preferred), and smoker residual (standard). Group life policies are not assumed to be underwritten and are mapped to mortality developed from the SOA 2016 group life experience study.
Product Code: The product weightings for the inforce population. There are four individual life products simulated: 10-year level term, 20-year level term, permanent whole life, and accumulation universal life. Group life is simulated as a term product. The following assumptions vary by product type.

- Attained Age and Policy Duration
- Face Amount
- Lapse Rates
- Post-level Term Mortality
- Reserve Factors

Attained Age and Duration: These are weightings by product that vary by attained age and duration.

Face Amount: These are weightings by product for various face amount sizes.

Mortality Risk Drivers

The model projects four categories of mortality risk through stochastic simulation: volatility, level, trend, and catastrophe. See the Experience Mortality Rates section for a description of the base mortality rates (referenced by q in the following formulas).

1. Volatility Risk: The risk of natural statistical deviations in mortality experience. These natural statistical deviations from expected deaths are represented in the model through a binomial distribution. Volatility risk decreases with increased exposure, and thus is lower for larger blocks than smaller blocks.

   \[ \text{Prob}[Deaths = n] = \binom{\text{Policies}}{n} \times q^n \times (1 - q)^{\text{Policies} - n} \]

2. Level Risk: The risk of incorrect experience mortality assumptions. This risk is also known as pricing risk. The level risk parameters were developed from two components. This component is consistent with the level risk component used by the Academy C2 Longevity Risk Task Force to develop RBC C-2 factors for longevity products.

   a. Statistical Sampling Volatility (Credibility): Assumes mortality rates are set with experience studies. Credibility of estimates is dependent on study size (number of policies and years in the study).

   \[ \text{Cred}(\sigma) = \sqrt{\frac{q(1-q)}{\text{Number of Policies \times Study Years}}} / q \]

   - Study Years: 5 years was selected to represent a company’s typical experience study period.
   - q per 1K: represents the experience mortality rate in the first projection year expressed per 1,000 lives. This value is calculated from initial inforce cells from the...
experience mortality tables (2017 CSO tables for individual life, 2016 group life experience table for group life).

- q: experience mortality rate in the first projection year, derived from “q per 1K”.

b. Natural Mortality Volatility: Assumes that there is natural volatility around the mortality mean.

- NatVol(σ) = 2.2%/$\sqrt{\text{Study Years}}$

- The 2.2% implied annual volatility was derived from an insured age-weighted regression on U.S. Social Security data from 1950 to 2014.

- Study Years: the natural mortality volatility scales down with the number of years in a company’s study period. 5 years was selected to represent a company’s typical experience study period.

c. Overall Level Mortality Volatility: The statistical sampling and natural volatility components are combined assuming independence.

- $\sigma_L = \sqrt{\text{Cred}(\sigma)^2 + \text{NatVol}(\sigma)^2}$

d. Level Mortality Mean: The average pricing error is assumed to be 0.00%.

- $\mu_L = 0.00\%$

3. Trend Risk: The risk that future mortality improvement is different than assumed. Historically, both mortality improvement (MI) and MI volatility have differed by historical period, gender, and age, among others. While average MI over long periods tends to stabilize, period to period MI can be quite different. An improvement distribution that captures these characteristics was developed while balancing the desire for simplicity. Deviation in mortality improvement is modeled across male/female and young/ middle/old ages as correlated normally distributed random variables. An MI deviation is generated for each cohort in each year of each scenario. This allows for large differences year-to-year consistent with historical data.

<table>
<thead>
<tr>
<th>MI Deviation</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young (&lt;45)</td>
<td>$D_{YM}$</td>
<td>$D_{YF}$</td>
</tr>
<tr>
<td>Middle(45-79)</td>
<td>$D_{MM}$</td>
<td>$D_{MF}$</td>
</tr>
<tr>
<td>Old(80+)</td>
<td>$D_{OM}$</td>
<td>$D_{OF}$</td>
</tr>
</tbody>
</table>

a. Years Since Study: 3 years was selected to represent a typical time period since a company’s last mortality experience study was completed. Mortality improvement is stochastically projected 3 years from the experience study table date to the model start date.

$[D_{YM}, D_{MM}, ..., D_{OF}] \sim N(\mu, \Sigma)$

Where:
- $\mu =$ zero vector = [0, 0, ..., 0]
- $\Sigma =$ covariance matrix calibrated with social security data 1950+
b. Covariance Matrix: Historical mortality improvement and covariance between gender and age was calibrated from insured age-weighted U.S. Social Security data from 1950 to 2014, consistent with the data source for level risk. The covariance matrix is shown in the following table, and the resulting correlations are shown as well.

<table>
<thead>
<tr>
<th>Covariance</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Young</td>
<td>Middle</td>
</tr>
<tr>
<td>Males</td>
<td>0.00085</td>
<td>0.00018</td>
</tr>
<tr>
<td></td>
<td>0.00018</td>
<td>0.00023</td>
</tr>
<tr>
<td>Old</td>
<td>0.00016</td>
<td>0.00027</td>
</tr>
<tr>
<td>Females</td>
<td>0.00050</td>
<td>0.00016</td>
</tr>
<tr>
<td></td>
<td>0.00015</td>
<td>0.00017</td>
</tr>
<tr>
<td>Old</td>
<td>0.00012</td>
<td>0.00024</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Correlation</th>
<th>Male</th>
<th>Male</th>
<th>Male</th>
<th>Female</th>
<th>Female</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Young</td>
<td>Middle</td>
<td>Old</td>
<td>Young</td>
<td>Middle</td>
<td>Old</td>
</tr>
<tr>
<td>Male</td>
<td>1.00000</td>
<td>0.41796</td>
<td>0.24114</td>
<td>0.73152</td>
<td>0.37883</td>
<td>0.16771</td>
</tr>
<tr>
<td>Male</td>
<td>0.41796</td>
<td>1.00000</td>
<td>0.79815</td>
<td>0.45102</td>
<td>0.79461</td>
<td>0.68000</td>
</tr>
<tr>
<td>Male</td>
<td>0.24114</td>
<td>0.79815</td>
<td>1.00000</td>
<td>0.34168</td>
<td>0.79350</td>
<td>0.90577</td>
</tr>
<tr>
<td>Female</td>
<td>0.73152</td>
<td>0.45102</td>
<td>0.34168</td>
<td>1.00000</td>
<td>0.59030</td>
<td>0.34196</td>
</tr>
<tr>
<td>Female</td>
<td>0.37883</td>
<td>0.79461</td>
<td>0.79350</td>
<td>0.59030</td>
<td>1.00000</td>
<td>0.81325</td>
</tr>
<tr>
<td>Female</td>
<td>0.16771</td>
<td>0.68000</td>
<td>0.90577</td>
<td>0.34196</td>
<td>0.81325</td>
<td>1.00000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chol Decomp Matrix</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Young</td>
<td>Middle</td>
</tr>
<tr>
<td>Males</td>
<td>0.02921</td>
<td>0.00000</td>
</tr>
<tr>
<td></td>
<td>0.00632</td>
<td>0.01375</td>
</tr>
<tr>
<td></td>
<td>0.00537</td>
<td>0.01708</td>
</tr>
<tr>
<td>Females</td>
<td>0.01715</td>
<td>0.00375</td>
</tr>
<tr>
<td></td>
<td>0.00528</td>
<td>0.00976</td>
</tr>
<tr>
<td></td>
<td>0.00396</td>
<td>0.01583</td>
</tr>
</tbody>
</table>

4. **Catastrophe Risk**: The risk of a short-term spike in mortality or a longer-term increase in mortality from a currently unknown health event. This risk includes 3 components: a pandemic risk distribution, a terrorism risk distribution, and an unknown sustained risk distribution.

a. **Pandemic Risk**: The risk of a one-year increase in mortality from a new pandemic, such as a new flu strain. The distribution is discrete and was calibrated from historical observations and multiple sources: current RBC, Swiss Re’s model, Solvency II, U.S. Centers for Disease Control and Prevention (CDC)/Department of Health and Human Services Pandemic Severity Assessment Framework (PSAF). Rates are expressed as deaths per 1,000 lives and are applied as an add-on.
across all ages if triggered. Multiple pandemics may occur in a given scenario.

b. **Terrorism Risk:** The risk of a one-year increase in mortality from a terrorism event. The discrete distribution was calibrated based on U.S. life insurer experience from the Sept 11, 2011 terrorism events. The rate is expressed as deaths per 1,000 lives and is applied as an add-on across all ages if triggered. Multiple terrorism events may occur in a given scenario.

<table>
<thead>
<tr>
<th>Annl. Prob</th>
<th>Dths/1K</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.00%</td>
<td>0.05</td>
</tr>
<tr>
<td>95.00%</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Max Duration</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annl. Prob</td>
<td>Scalar</td>
</tr>
<tr>
<td>2.50%</td>
<td>5.0%</td>
</tr>
<tr>
<td>97.50%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

c. **Unknown Sustained Risk:** The risk of a sustained increase in mortality from an unknown health event. The discrete distribution was calibrated from two historical health events impacting the U.S. population: HIV and opioid abuse. The mortality increase is defined as a percentage increase applied across all ages if triggered. If the event is triggered in the scenario it continues for the lesser of the maximum duration assumption and remainder of the projection period. A 10-year period was selected for the maximum duration based on the historical events and to provide for an event lasting up to a decade. The maximum duration assumption is relevant only when modeling projection periods longer than this assumption. Given the sustained nature of the event, it can only occur once per scenario.

**Reserve Mortality Margin**

- **Load (Margin):** A 5% load was used for the load built into reserve mortality rates. This is intended to represent the margin companies have to absorb moderately adverse mortality experience through the conservatism built into statutory reserve calculations. This assumption was used in the current RBC factors and was deemed to remain consistent with moderately adverse experience. Capital is thus determined for 95th percentile experience above moderately adverse outcomes as represented by the 5% load.

**Experience Mortality Improvement**

- Experience mortality improvement is set equal to the 2017 SOA mortality improvement scale for use with Actuarial Guideline (AG) 38 and VM-20. The rates vary by age and gender and are converted to lognormal rates for input in the model.

**Lapse Rates**

- Lapse rates are set for each product type and vary by issue age, policy duration and underwriting class. For the recommended individual life capital factors, the simulated lapses are a weighted average of the four product types. For a given risk exposure period, results are insensitive to the product type (including lapses) as shown in Sensitivity 4 under the Model Sensitivities section.

  o **10-Year Term:** Lapse rates were developed using a combination of the SOA/LIMRA U.S. Individual Life Insurance Persistency Study for 2005-2007 and the SOA/RGA Report on the Lapse and Mortality Experience of Post-Level Premium Period Term Plans (2014). The 10-

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2 Reinsurance Group of America
Year Term product is assumed to be a level term product for 10 years. Lapse rates spike beginning in year 10 at the end of the level term period.

- **20-Year Term**: Lapse rates were developed using a combination of the SOA/LIMRA U.S. Individual Life Insurance Persistency Study for 2005-2007 and the SOA/RGA Report on the Lapse and Mortality Experience of Post-Level Premium Period Term Plans (2014). The 20-Year Term product is assumed to be a level term product for 20 years. Lapse rates spike beginning in year 20 at the end of the level term period.

- **Permanent Whole Life**: Lapse rates were developed using the SOA/LIMRA U.S. Individual Life Insurance Persistency Study for 2005-2007. The Permanent Whole Life product is assumed to be a whole life product. Lapse rates are higher in early policy years and grade down with policy duration.

- **Accumulation Universal Life**: Lapse rates were developed using the SOA/LIMRA U.S. Individual Life Insurance Persistency Study for 2005-2007. The UL product is assumed to be a cash value accumulation universal life product. Lapse rates are higher in early policy years and grade down with policy duration.

- **Group**: Lapse rates were set equal to 10 Year Term rates for the first 5 policy durations. Durations 6 and later were assumed to remain constant. Sensitivity testing demonstrated that group life results are relatively insensitive to lapse rates.

**Post Level Term Mortality**

- Mortality experience for 10-year and 20-year term products following the level premium period is set through these assumptions through actual to expected ratios. Mortality rates spike following the level premium period because healthy insureds find new coverage, while unhealthy insureds are more likely to keep the coverage due to insurability concerns. The post-level term mortality actual to expected rates were developed using the SOA/RGA Report on the Lapse and Mortality Experience of Post-Level Premium Period Term Plans (2014).

**Experience Mortality Rates**

- **Individual Life**: Experience mortality rates were set using the 2017 CSO Unloaded Age Nearest Birthday (ANB) tables and vary by gender, smoking status, and underwriting class. Each table is structured as select and ultimate by issue ages 18-95 and select period policy durations 1-25. The 10 individual life tables have the following naming convention:
  - **Gender**: Male (M) or Female (F)
  - **Smoking Status**: Non-smoker (NS) or Smoker (SM)
  - **Underwriting Class**: Super Preferred (1), Preferred (2 for NS, 1 for SM), Residual (3 for NS, 2 for SM)

- **Group Life**: Experience mortality rates were developed using the SOA 2016 Group Life Experience Committee Report study. The table is structured by gender (male and female) and attained age.
Reserve Factors

- **Permanent Life:** Reserve factors for permanent life (whole life and cash value accumulation universal life) plans were developed using the 2017 CSO tables with a 3.5% interest rate and vary by gender and smoking status. Each table is structured as by issue ages 20-75 in 5-year increments and policy durations 1-101. The 4 individual life tables have the following naming convention:
  - Gender: Male (M) or Female (F)
  - Smoking Status: Non-smoker (NS) or Smoker (SM)

- **Term Life:** Reserve factors for term life (level term 10 and level term 20) plans were developed using the 2017 CSO tables with a 4.5% interest rate and vary by gender, smoking status, and underwriting class. Each table is structured as by issue ages 20-75 in 5-year increments and policy durations 1-10 for level term 10 and 1-20 for level term 20. The 20 individual life tables have the following naming convention:
  - Product: Level Term 10 (LT10) or Level Term 20 (LT20)
  - Gender: Male (M) or Female (F)
  - Smoking Status: Non-smoker (NS) or Smoker (SM)
  - Underwriting Class: Super Preferred (1), Preferred (2 for NS, 1 for SM), Residual (3 for NS, 2 for SM)

- **Group Life:** Reserves for group life were set simply as a yearly renewable term (YRT) reserve equal to ½ of the mortality rate for a given cohort based on gender and attained age. A separate table of factors was not needed.

**Capital Factor Quantification Method**

The capital need, expressed as a dollar amount, is determined as the GPVAD at the 95th percentile of the stochastic distribution of scenarios over the remaining lifetime of a block of business while appropriately reflecting the pricing flexibility to adjust current mortality rates. Statutory losses are defined as the after-tax quantification of gross death benefits minus reserves released minus mortality margin present in reserves. The after-tax statutory losses are discounted to the present by using 20-year averages for U.S. swap rates. By selecting the largest present value accumulated loss across all projection years, the solved for capital ensures survival at all projection periods. Earlier period losses are not allowed to be offset by later period gains to reduce capital. The 95th percentile is the regulator accepted statistical safety level used for Life RBC C-2 mortality risk to identify weakly capitalized companies. The after-tax capital needs are translated to a factor expressed as a percentage of the initial NAR and are shown as amount per $1,000 of NAR. The pre-tax factor is determined by taking the after-tax factor divided by (1 minus the tax rate).
Model Results

Overall Results and Recommended C-2 Factors

The recommended pre-tax factors per $1,000 of retained NAR are shown in Table 1 below. Business assumed by reinsurers is treated as direct for reinsurer financial statements. The factors are differentiated by individual & industrial life and group & credit life, consistent with the current framework. The modeling focused on individual and group life, and the work group evaluated the continued appropriateness of applying the factors to industrial life and credit life business. It is recommended that industrial life and credit life continue to be mapped to individual and group life, respectively, as the product attributes are similar. The factors are rounded to the nearest 0.05 to recognize the randomness inherent in the model (see Impact of Random Number Seed for additional information). Three size bands are recommended to represent inforce blocks of small, medium, and large sizes. This reflects combining the two middle categories in the current framework. The size bands continue to be relevant and appropriate as a material portion of life insurers are represented within each category.

Within individual & industrial life, the factors are differentiated into three product categories: ULSG, term life, and all other life. The product definitions are consistent with the annual statement – analysis of operations by line of business – individual life insurance and VM-20. The differences by product category are the sole result of applying different risk exposure periods to an aggregate life inforce block. As described in Sensitivity 4 Individual Life Products under Model Sensitivities, the model produces consistent results by product for a given risk exposure period, as expressing the factor as a percentage of net amount at risk neutralizes product differences.

ULSG factors are the highest due to the longest current mortality rate guarantees and are based on a 20-year risk exposure period for a mature inforce block. Term life factors are based on a typical 10-year risk exposure period for a mature inforce block. The industry is concentrated in 10-, 20- and 30-year level term. All other life factors are based on a 5-year risk exposure period and assume inforce pricing may be adjusted following adverse mortality experience due to the presence of non-guaranteed elements. Examples are universal life products without secondary guarantees and participating whole life products.

Within group & credit life, the factors are differentiated into two categories based on the remaining length of the premium term based on company records by group contract. The two categories are remaining rate terms over 3 years and remaining rate terms 3 years and under. The remaining rate terms over 3 years category is represented by a 5-year risk exposure period, and the remaining rate terms 3 years and under is represented by a 3-year risk exposure period. The risk exposure periods recognize a time lag between when experience emerges and when pricing is adjusted.

<table>
<thead>
<tr>
<th>Pre-Tax RBC C-2 Factors</th>
<th>Universal Life with Secondary Guarantee [ULSG]</th>
<th>Term Life</th>
<th>All Other Life</th>
<th>% of Individual Life Insurers*</th>
<th>Remaining Rate Terms Over 3 Years</th>
<th>Remaining Rate Terms 3 Years and Under</th>
<th>% of Group Life Insurers*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per $1,000 of Inforce NAR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First $500M</td>
<td>1.90</td>
<td>2.70</td>
<td>1.90</td>
<td>43%</td>
<td>1.80</td>
<td>1.30</td>
<td>54%</td>
</tr>
<tr>
<td>Next $24.5B</td>
<td>1.65</td>
<td>1.10</td>
<td>0.75</td>
<td>36%</td>
<td>0.70</td>
<td>0.45</td>
<td>33%</td>
</tr>
<tr>
<td>&gt; $25B</td>
<td>1.10</td>
<td>0.75</td>
<td>0.50</td>
<td>21%</td>
<td>0.45</td>
<td>0.30</td>
<td>12%</td>
</tr>
</tbody>
</table>

* as of 2019 annual statement reporting
Table 2 and Table 3 compare the recommended factors versus the current RBC factors in place as of 12/31/2020.

<table>
<thead>
<tr>
<th>Table 2 - Individual &amp; Industrial Life Comparison Versus Current RBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per $1,000 of Inforce NAR</td>
</tr>
<tr>
<td>Current RBC</td>
</tr>
<tr>
<td>First $500M</td>
</tr>
<tr>
<td>Next $4.5B</td>
</tr>
<tr>
<td>Next $20B</td>
</tr>
<tr>
<td>&gt; $25B</td>
</tr>
</tbody>
</table>

The overall individual life industry impact would be a modest decrease with industry exposure by NAR concentrated in term life business amongst large insurers. Factors increase for ULSG due to the long-term risk exposure period to current mortality rates. As indicated in Exhibit 1, factors decrease for products with near-term inforce pricing flexibility (i.e., all other category). Small ULSG and term carriers would experience an increase on retained business. However, reinsurance is typically used to transfer/mitigate the mortality risk.

<table>
<thead>
<tr>
<th>Table 3 - Group &amp; Credit Life Comparison Versus Current RBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per $1,000 of Inforce NAR</td>
</tr>
<tr>
<td>Current RBC</td>
</tr>
<tr>
<td>First $500M</td>
</tr>
<tr>
<td>Next $4.5B</td>
</tr>
<tr>
<td>Next $20B</td>
</tr>
<tr>
<td>&gt; $25B</td>
</tr>
</tbody>
</table>

The overall group industry impact would be a significant decrease in C-2 capital. The factors decrease for all but one category: small size for longer rate terms which stays about the same. Group life factors decreased due to the decades-long decline in experience mortality rates, and the risk exposure periods remain shorter term as compared to individual life.

Credit for Group Life Premium Stabilization Reserves

The current RBC formula includes a 50% credit for group life premium stabilization reserves to offset the group life C-2 requirement. This component was reviewed by the work group. Based on a theoretical framework and professional experience, the 50% factor was deemed to be an appropriate offset to the capital requirement.

Correlation with Longevity C-2

The updated Life C-2 mortality modeling was completed consistent with the development of the adopted Longevity C-2 factors and correlation factor. Therefore, the work group opines that additional review of the adopted correlation factor is not necessary because of the updates to the Life C-2 mortality factors being recommended by this work group.
Attribution Analysis

The model mortality risk components were analyzed to determine the relative contribution to the overall recommended factors. Charts 1 and 2 below show the results of the attribution analysis for individual and group life. Individual and group life have similar breakdowns by inforce block size with small differences due to the inforce mix, experience mortality rates and other assumptions. For small inforce blocks, the primary mortality risk drivers are volatility and level risks. For large inforce blocks, catastrophe and trend risks become the primary drivers. For medium inforce blocks, the risks are relatively balanced between categories.

95th Percentile Mortality Increase

The 95th percentile capital factors were translated into overall mortality increases (% increase vs experience mortality) for the projection period. Table 4 highlights the results. As expected, the higher the capital factor, the larger the mortality increase. Differences between individual and group life are due to lapse assumptions. Group life has a higher overall lapse rate, which translates into a larger mortality increase needed to reproduce a given capital factor.

| Table 4 - Capital Factors Expressed as an Overall % Mortality Increase |
|---------------------------------|----------------|----------------|----------------|
| Inforce Block Size              | Large | Medium | Small |
| Individual Life                 |       |        |       |
| Group Life                      |       |        |       |
| 8%                              | 10%   | 22%    |
| 10%                             | 14%   | 31%    |

Model Sensitivities

Various sensitivity tests were performed to understand the results of the model under alternative assumptions. Most of the sensitivities were based on the individual life large inforce block size for a 5-year exposure period. However, the sensitivities are similar for group life (if applicable), for the small and medium inforce block sizes, and for different risk exposure periods.

1. Random Number Seed
The model results vary slightly depending on the initial random number seed selected as shown in the table below. As a result of these fluctuations even when running 10,000 scenarios, the recommendation was to round the factors to the nearest 0.05.

<table>
<thead>
<tr>
<th>Sensitivity 1 - Impact of Random Number Seed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Tax RBC C-2 Factors Per $1,000 of Inforce NAR</td>
</tr>
<tr>
<td>Individual Life - Large Size</td>
</tr>
<tr>
<td>RN Seed 5</td>
</tr>
<tr>
<td>RN Seed 15</td>
</tr>
<tr>
<td>RN Seed 35</td>
</tr>
<tr>
<td>RN Seed 45</td>
</tr>
<tr>
<td>RN Seed 55</td>
</tr>
<tr>
<td>RN Seed 65</td>
</tr>
<tr>
<td>RN Seed 75</td>
</tr>
<tr>
<td>RN Seed 85</td>
</tr>
<tr>
<td>RN Seed 95</td>
</tr>
</tbody>
</table>

2. Mortality Load (Margin)

Sensitivities under alternative mortality loads of 2.5% and 0% are shown in the table below. Lowering the mortality load increases the factor as this assumption is used to represent the amount of mortality margin embedded in statutory reserves. The 5% assumption maps to a 1 standard deviation moderately adverse standard at approximately the 85th percentile. For smaller inforce blocks the 5% mortality load covers less than 1 standard deviation of mortality experience due to the volatility and level risks present with low mortality credibility.

<table>
<thead>
<tr>
<th>Sensitivity 2 - Reserve Mortality Load Assumption</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Tax RBC C-2 Factors Per $1,000 of Inforce NAR</td>
</tr>
<tr>
<td>Factor</td>
</tr>
<tr>
<td>5% Reserve Mortality Load</td>
</tr>
<tr>
<td>2.5% Reserve Mortality Load</td>
</tr>
<tr>
<td>0% Reserve Mortality Load</td>
</tr>
</tbody>
</table>

3. Attained Age

Model results are stable for most of the initial attained age categories. The exception is for older attained ages where the factors increase due to higher mortality rates. Exposure to attained ages 65 and older is relatively small in the assumed inforce mixes based on industry data. However, if a company is concentrated in older age inforce business, then it is subject to higher mortality risk. The recommended factors are not differentiated by attained age due to the low percentage of inforce policies at older attained ages and the data not being readily available in the annual statements.

<table>
<thead>
<tr>
<th>Sensitivity 3 - Results by Initial Attained Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Tax RBC C-2 Factors Per $1,000 of Inforce NAR</td>
</tr>
<tr>
<td>Factor</td>
</tr>
<tr>
<td>Inforce Mix</td>
</tr>
<tr>
<td>Age 25</td>
</tr>
<tr>
<td>Age 35</td>
</tr>
<tr>
<td>Age 45</td>
</tr>
<tr>
<td>Age 55</td>
</tr>
<tr>
<td>Age 65</td>
</tr>
<tr>
<td>Age 75</td>
</tr>
</tbody>
</table>
4. Individual Life Products

Model results by individual life product type are relatively stable as shown in the table below. Expressing the capital factors as a percentage of net amount at risk neutralizes product differences. For example, term life products have higher relative net amounts at risk than permanent life products for mature blocks, but the mortality risk is proportionate to the net amount at risk. Therefore, term products will tend to have higher dollar amounts of capital per policy or per unit of face amount due to being subject to higher net amounts at risk.

Given the small product differences, the recommended factors were developed by differentiating the projection period on an entire mix of inforce business containing all products. The risk exposure period as represented by the projection period is the critical variable in recognizing product differences.

As discussed in the Limitations section, product features are modeled at a very basic level and consider differences in base statutory reserves, lapses, post level term mortality experience, face amounts and attained ages.

<table>
<thead>
<tr>
<th>Sensitivity 4 - Results by Product Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Tax RBC C-2 Factors</td>
</tr>
<tr>
<td>Per $1,000 of inforce NAR</td>
</tr>
<tr>
<td>Inforce Mix</td>
</tr>
<tr>
<td>Level Term 10</td>
</tr>
<tr>
<td>Level Term 20</td>
</tr>
<tr>
<td>Whole Life</td>
</tr>
<tr>
<td>Universal Life</td>
</tr>
</tbody>
</table>

5. Longer Projection Periods

The length of the projection period is a key assumption and is intended to represent the risk exposure period to current mortality rates over the remaining lifetime of a block of business. The impact of longer projection periods is shown in the table and chart below. Mortality risk increases with projection period as it exposes a company increasingly to trend risk and longer-term mortality shocks.

<table>
<thead>
<tr>
<th>Sensitivity 5 - Results by Projection Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Tax RBC C-2 Factors</td>
</tr>
<tr>
<td>Per $1,000 of inforce NAR</td>
</tr>
<tr>
<td>5-Year Projection</td>
</tr>
<tr>
<td>10-Year Projection</td>
</tr>
<tr>
<td>15-Year Projection</td>
</tr>
<tr>
<td>20-Year Projection</td>
</tr>
<tr>
<td>30-Year Projection</td>
</tr>
</tbody>
</table>
6. Gender

Model results by gender are small as shown in the table below.

<table>
<thead>
<tr>
<th>Sensitivity 6 - Results by Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Tax RBC C-2 Factors</td>
</tr>
<tr>
<td>Per $1,000 of Inforce NAR</td>
</tr>
<tr>
<td>Inforce Mix</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
</tbody>
</table>

7. Underwriting Class

Model results were measured for the best underwriting class (lowest experience mortality) and worst underwriting class (highest experience mortality), which highlights that factor increase slightly with higher experience mortality. However, it’s important to note that the mortality risk assumptions would be different if they were calibrated by underwriting class (versus the approach used to develop assumptions appropriate for the entire industry / inforce mix). Arguably, companies concentrated in exposure to less healthy / lower underwriting classes would be subject to higher mortality risk due to the higher experience mortality rates. The recommended factors are not differentiated by underwriting class due to the low percentage of inforce policies at residual underwriting classes and the data not being readily available in the annual statements.

<table>
<thead>
<tr>
<th>Sensitivity 7 - Results by Underwriting Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Tax RBC C-2 Factors</td>
</tr>
<tr>
<td>Per $1,000 of Inforce NAR</td>
</tr>
<tr>
<td>Inforce Mix</td>
</tr>
<tr>
<td>Non-Smoker Best Class</td>
</tr>
<tr>
<td>Smoker Residual Class</td>
</tr>
</tbody>
</table>
8. Face Amount

The model was run with the smallest and largest face amounts which confirmed the impact of the face amount assumptions is small.

<table>
<thead>
<tr>
<th>Sensitivity 8 - Results by Face Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Tax RBC C-2 Factors</strong></td>
</tr>
<tr>
<td>Per $1,000 of Inforce NAR</td>
</tr>
<tr>
<td>Inforce Mix</td>
</tr>
<tr>
<td>Smallest Face ($17.5K)</td>
</tr>
<tr>
<td>Largest Face ($77.5M)</td>
</tr>
</tbody>
</table>

9. Discount Rate

The impact of an alternative (higher) discount rate was assessed, and the impact is small. The longer the projection period, the greater the impact.

<table>
<thead>
<tr>
<th>Sensitivity 9 - Impact of Discount Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Tax RBC C-2 Factors</strong></td>
</tr>
<tr>
<td>Per $1,000 of Inforce NAR</td>
</tr>
<tr>
<td>3.5% Discount Rate - 5-Year</td>
</tr>
<tr>
<td>5% Discount Rate - 5-Year</td>
</tr>
<tr>
<td>3.5% Discount Rate - 10-Year</td>
</tr>
<tr>
<td>5% Discount Rate - 10-Year</td>
</tr>
<tr>
<td>3.5% Discount Rate - 20-Year</td>
</tr>
<tr>
<td>5% Discount Rate - 20-Year</td>
</tr>
</tbody>
</table>

10. Tax Rate

The pre-tax factors are impacted very slightly by the tax rate through discounting (after-tax cash flows are discounted at an after-tax discount rate). The impact becomes slightly greater with longer projection periods. There is obviously a direct impact to the after-tax factors and RBC amounts based on the applicable corporate tax rate.

<table>
<thead>
<tr>
<th>Sensitivity 10 - Impact of Tax Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Tax RBC C-2 Factors</strong></td>
</tr>
<tr>
<td>Per $1,000 of Inforce NAR</td>
</tr>
<tr>
<td>21% Tax Rate</td>
</tr>
<tr>
<td>35% Tax Rate</td>
</tr>
</tbody>
</table>

11. Larger Number of Inforce Policies

A sensitivity test was performed with an even larger number of inforce policies to assess the impact. The volatility risk component is directly impacted by the inforce policies assumption. At 5 million inforce policies, the factor ends up a little lower. However, the volatility risk component can’t go lower than 0. Therefore, increasing the number of inforce policies beyond 1 million or even 5 million won’t materially decrease the large size factors.
12. Larger Retention Limit

A larger retention limit increases the large size pre-tax factor slightly due to increased fluctuation from the large face amounts inforce. This assumption is used primarily to control for inforce block size. Smaller inforce blocks are characterized by smaller retention limits as companies tend to reinsure mortality risk in excess of the capability to retain the risk on the balance sheet. If a company were to be concentrated in very large face amounts and a small amount of inforce policies, then it would be subject to higher mortality risk due to volatility.

<table>
<thead>
<tr>
<th>Pre-Tax RBC C-2 Factors</th>
<th>Individual Life - Large Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per $1,000 of Inforce NAR</td>
<td>Factor Difference</td>
</tr>
<tr>
<td>1 Million Policies</td>
<td>0.50</td>
</tr>
<tr>
<td>5 Million Policies</td>
<td>0.43</td>
</tr>
</tbody>
</table>

13. Group Life Lapse Rates

A sensitivity test was performed with lower group life lapses to confirm that results are insensitive to this assumption. A 4% average annual lapse rate was assumed for sensitivity versus base lapse rates around 8% per year. The results confirmed that changes to this assumption do not materially change the results.

<table>
<thead>
<tr>
<th>Pre-Tax RBC C-2 Factors</th>
<th>Group Life - Large Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per $1,000 of Inforce NAR</td>
<td>Factor Difference</td>
</tr>
<tr>
<td>Base Lapse Rates</td>
<td>0.456</td>
</tr>
<tr>
<td>4% Lapse Rates</td>
<td>0.474</td>
</tr>
</tbody>
</table>

14. Unknown Catastrophe Risk Probability

During the development of the unknown sustained catastrophe component, there was much debate surrounding the probability of the event occurring. There were arguments for both a 2.5% and 5% annual probability with the 2.5% ultimately being the work group’s recommendation. As shown in the table below, increasing the annual probability from 2.5% to 5.0% has only a modest impact on the factor. The reason for this result resides in the cumulative probabilities over the projection period. Since the factor is determined at the 95th percentile, both assumptions result in the unknown risk event being triggered (i.e. cumulative probabilities greater than 5%). The annual probability assumption therefore impacts the length of the event as once the event is triggered it is sustained for the rest of the projection period. A higher probability assumption increases the likelihood of a longer event occurring.

<table>
<thead>
<tr>
<th>Pre-Tax RBC C-2 Factors</th>
<th>Individual - Large Size</th>
<th>Cumulative Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per $1,000 of Inforce NAR</td>
<td>Factor Difference</td>
<td></td>
</tr>
<tr>
<td>2.5% Annual Probability</td>
<td>0.50</td>
<td>-</td>
</tr>
<tr>
<td>5% Annual Probability</td>
<td>0.53</td>
<td>0.03</td>
</tr>
</tbody>
</table>
15. Individual Life Lapses

As with group life, results are relatively insensitive to lapse rates. While a separate sensitivity test is not shown here, differences in lapses are reflected in the product differences (see sensitivity test 4).

Comparison Versus Other Capital Regimes

The work group reviewed characteristics of non-U.S. based capital regimes to evaluate the mortality risks covered and capital requirements versus the results of this project. Other capital regimes have different intended purposes, so differences were expected. The reviews of other capital regimes confirmed that the U.S. Life RBC model includes the same mortality risk types and at an overall magnitude in the proximity of other regimes. One overall difference versus other regimes is that internal company-based modeling is used (or there is the company option to use).

- **Canada Life Insurance Capital Adequacy Test:** The Canadian framework assesses the same mortality risk components as the U.S. Life RBC model: volatility, level, trend, and catastrophe risks. The framework differs in that the capital requirement is unique to each individual company and is determined through company determined modeling.

- **International Association of Insurance Supervisors (IAIS) Insurance Capital Standard (ICS):** The IAIS framework uses a stress-based framework with shocks to the level of mortality (+10%), the trend in mortality, and the volatility in mortality. There is a separate catastrophe risk component equating to an additional 1 death per thousand. This framework is also completed through modeling by each individual entity. Management responses to mortality events are reflected in the modeling. The ICS separately has a basic capital requirement equating to a factor of 0.56 per thousand of NAR.

- **Solvency II:** This framework applies mortality stresses assessed at the 99.5th confidence interval. The standard formula applies a 15% mortality rate increase and is intended to cover volatility, trend, and level risks. The catastrophe risk is modeled as an additional 1.5 deaths per thousand. Companies have the option to use an approved internal model in place of the standard formula.

- **Standard & Poor’s (S&P) Ratings Model:** S&P uses a factor-based approach in assessing U.S. life insurer ratings. For mortality risk, the ratings model recognizes inforce block size differences, and the factors scale down with increasing inforce block size. For the BBB category, the capital factors range from 0.57 per thousand of NAR for the largest inforce blocks (> $100B NAR) to 2.29 per thousand of NAR for the smallest inforce blocks (< $1B NAR). Arguably, having capital below BBB levels is indicative of being weakly capitalized as a company would be rated below investment grade.

Validation and Peer Review

Model assumptions were developed by the work group through reviewing current mortality research and studies applicable to the U.S. life insurance industry. The assumptions were discussed, reviewed, and agreed upon through the work group’s bi-weekly calls. Model results and sensitivities were also reviewed extensively by the work group. The work group also provided several updates to the NAIC Life Risk-Based Capital Working Group throughout the project and feedback was obtained from regulators.
The model was independently peer reviewed by a member of the work group. The peer review confirmed that the calculations performed by the model were reasonable for the intended purpose and were being applied as intended. The detailed results of the peer review are documented separately by the work group.

Additional detailed documentation on model assumptions, output structure and modeling methodology was created by the work group and may be made available upon request.

**Limitations**

The model is intended to stochastically project through stochastic simulation the run-off of inforce life insurance blocks typical of U.S. life insurers in order to develop capital factors for use in the NAIC RBC formula for C-2 life insurance mortality risk. Other uses outside of this intended purpose may not be appropriate.

Product features in the model were developed at a very basic level and consider differences in base statutory reserves, lapses, post level term mortality experience, face amounts and attained ages. The model is not designed to replicate detailed product and inforce block characteristics unique to individual companies. In particular, ULSG products were not directly modeled. The work group concluded based on the modeling that the capital factors are insensitive to product differences for a given risk exposure period. The recommendation to differentiate based on product is an indirect way to get at the length of mortality rate guarantee, utilizes the current reporting structure of the annual statements, and is aligned with principles based reserving differentiation.
The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Oct. 27, 2021. The following Subgroup members participated: Wanchin Chou, Chair, and Qing He (CT); Jane Nelson (FL); Laura Clements, Lynne Wehmuller, and Giovanni Muzzarelli (CA); Judy Mottar (IL); Gordon Hay (NE); Anna Krylova (NM); Halina Smosna and Gloria Huberman (NY); Tom Botsko and Dale Bruggeman (OH); Andrew Schallhorn (OK); and Miriam Fisk, Monica Avila, and Rebecca Armon (TX).

1. **Adopted its Sept. 28 Minutes**

   The Subgroup met Sept. 28. During this meeting, the Subgroup took the following action: 1) discussed its 2021 working agenda; 2) heard a presentation from Karen Clark & Company (KCC) regarding the KCC U.S. wildfire model, which included the current wildfire trends and an overview of the KCC U.S. wildfire model; and 3) discussed the possibility of allowing additional third-party models or adjustments to the vendor models.

   Mr. Schallhorn made a motion, seconded by Mr. Botsko, to adopt the Subgroup’s Sept. 28 minutes (Attachment Four-A). The motion passed unanimously.

2. **Discussed the Possibility of Allowing Third-Party Models to Calculate the Catastrophe Model Losses**

   Mr. Chou said during the Subgroup’s previous meeting on Sept. 28, the Subgroup agreed that the KCC models for earthquakes and hurricanes meet the similar standards as the other approved commercial models had. He said a proposal was set up to include KCC earthquake and hurricane models as one of the approved third-party commercial vendor models to calculate the catastrophe risk charge.


   Mr. Chou said the purpose of the proposal is to include the KCC earthquake and hurricane models as one of the approved third-party commercial vendor models to calculate the catastrophe risk charge. He stated that the Florida Commission on Hurricane Loss Projection Methodology (FCHLPM) reviewed and verified the KCC hurricane model on June 4, 2021. The Subgroup believes that the KCC models seem to qualify under the same standards as the other modeling firms have for earthquakes and hurricanes. Mr. Chou asked the interested parties to review the proposal and provide comments during the exposure period.

   The Subgroup agreed to expose proposal 2021-15-CR (Adding KCC Models) for a 30-day public comment period ending Nov. 26.

4. **Heard an Update from its Catastrophe Model Technical Review Ad Hoc Group**

   Mr. Chou said the ad hoc group met Oct. 18 to discuss additional questions with Risk Management Solutions (RMS) on its wildfire model. She said the ad hoc group gained a better understanding on: 1) the landfire database; 2) historical data; 3) model parameters; 4) demand surge; and 5) period loss tables (PLTs) versus event loss tables (ELTs). Mr. Chou stated that there were 21 technical questions discussed with RMS, and he indicated that the ad hoc group will meet next month to review and discuss the impact analysis on different third-party commercial wildfire models.

   Having no further business, the Catastrophe Risk (E) Subgroup adjourned.
Catastrophe Risk (E) Subgroup  
Virtual Meeting  
September 28, 2021

The Catastrophe Risk (E) Subgroup of the Property and Casualty Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met Sept. 28, 2021. The following Subgroup members participated: Wanchin Chou, Chair, Susan Andrews, and Qing He (CT); Robert Ridenour, Vice Chair, David Altmaier, and Jane Nelson (FL); Li Lim, Laura Clements, Giovanni Muzzarelli, Mitra Sanandajifar, and Lynne Wehmueller (CA); Judy Mottar (IL); Gordon Hay (NE); Anna Krylova (NM); Halina Smosna (NY); Tom Botsko and Dale Bruggeman (OH); Andrew Schallhorn (OK); Will Davis (SC); and Miriam Fisk, Andy Liao, Rebecca Armon, and Monica Avila (TX).

1. Discussed its 2021 Working Agenda

Mr. Chou said one of the items in the 2021 working agenda that will require being accomplished by the 2022 Spring National Meeting is the implementation of the wildfire peril in the Rcat component for informational purposes only. He said he expects the Catastrophe Model Technical Review Ad Hoc Group will finish the entire review process by end of October. Mr. Chou also stated that different modeling firms are in the stage of preforming the impact analysis. Then, the Subgroup will start developing the formula structure of the wildfire peril base on the analysis results and findings. Mr. Chou said he anticipates the initial structure will be shared with all the interested parties at the Fall National Meeting.

2. Heard an Update from its Catastrophe Model Technical Review Ad Hoc Group

Ms. Wehmueller said the ad hoc group met twice to review some additional technical questions with Karen Clark & Company (KCC) on its wildfire model since the Summer National Meeting. She said the ad hoc group gained a better understanding on different aspects of its model during this question-and-answer (Q&A) section. She also said the ad hoc group will meet next month with Risk Management Solutions (RMS) to review/discuss some technical questions of its model. She said she anticipates the ad hoc group will have a better idea on how to implement the risk-based capital (RBC) charge for wildfire peril after the impact analysis is completed by the modeling firms.

3. Heard a Presentation from KCC Regarding the KCC U.S. Wildfire Reference Model

Glen Daraskevich (KCC) said this presentation includes the following main topics: 1) current wildfire trends; and 2) an overview of the KCC U.S. wildfire reference model. He stated that wildfires are a major driver of the U.S. insured losses, particularly in California. He indicated that the KCC U.S. Wildfire Model employs a physical modeling approach, which includes hazard, vulnerability, and financial modules. He stated that the hazard module predicts where the future events are most likely to occur. The vulnerability module estimates the level of damage that would occur to any type of structures. He also said the model has undergone meticulous validation of simulated events versus historical footprints, and it details evaluations of insurer claims data at an event and location resolution.

4. Discussed the Possibility of Allowing Additional Third-Party Models or Adjustments to the Vendor Models

Mr. Chou said another item listed in the working agenda that requires the Subgroup to address soon is to evaluate the possibility of allowing additional third-party models or adjustments to the vendor models to calculate the catastrophe model losses. He said the KCC earthquake and hurricane models have been reviewed and verified by the Florida Commission. He said he believes adding its models as one of the approved commercial models is worth considering. Mr. Botsko said he agrees. Scott Williamson (Reinsurance Association of America—RAA) said the RAA supports the KCC being added to the approval list. The seems to qualify under the same standards as the other modeling firms have. Mr. Chou said a proposal for adding the KCC models as one of the approval models for earthquake and hurricane perils will be drafted for discussion in the upcoming meeting.

Mr. Chou said the Subgroup will continue discussing all the outstanding issues in the meeting next month.

Having no further business, the Catastrophe Risk (E) Subgroup adjourned.

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The following Working Group members participated: Tom Botsko, Chair, and Dale Bruggeman (OH); Wanchin Chou, Susan Andrews, and Qing He (CT); Nicole Altieri Crockett (FL); Judy Mottar (IL); Leatrice Geckler (NM); Halina Smosna (NY); Will Davis (SC); Rebecca Armon, Miriam Fisk, and Monica Avila (TX).

1. Adopted its Summer National Meeting Minutes

Mr. Botsko said the Working Group met July 22 in lieu of the Summer National Meeting and took the following action: 1) adopted its June 9 and April 27 minutes, which included the following action: a) adopted proposal 2021-05-P (Underwriting Risk Line 1 Factors); b) adopted proposal 2021-08-P (P/C Bond Factors and Instructions); c) adopted proposal 2021-03-P (Credit Risk Instruction Modification); d) forwarded the response to the Restructuring Mechanisms (E) Subgroup; and e) heard a presentation on property/casualty (P/C) risk-based capital (RBC) underwriting risk factors from the American Academy of Actuaries (Academy); 2) adopted the report of the Catastrophe Risk (E) Subgroup, which included the following action: a) adopted its June 1 and April 26 minutes; b) adopted its 2021 working agenda items; c) received an update from its Catastrophe Model Technical Review Ad Hoc Group and; 3) adopted the 2021 P/C RBC Newsletter; 4) discussed 2020 P/C RBC statistics; 5) discussed its 2021 working agenda items; and 6) heard a presentation on a P/C RBC underwriting risk project from the Academy.

Mr. Chou made a motion, seconded by Ms. Mottar, to adopt the Working Group’s July 22 minutes (see NAIC Proceedings – Summer 2021, Capital Adequacy (E) Task Force, Attachment Five). The motion passed unanimously.

2. Adopted the Report of the Catastrophe Risk (E) Subgroup

Mr. Chou said the Subgroup met Sept. 28 and took the following action: 1) discussed its 2021 working agenda; 2) heard a presentation from Karen Clark & Company (KCC) regarding the KCC U.S. wildfire reference model; and 3) discussed the possibility of allowing additional third-party models or adjustments to the Vendor Models. He also stated that the Subgroup is finishing up the technical review with Risk Management Solutions (RMS) on the wildfire model and working on impact analysis with three wildfire modelers—AIR, KCC, and RMS. He said the Subgroup expects that the wildfire risk structure will be ready for discussion in December. He also indicated that the KCC hurricane models have been reviewed and verified by the Florida Commission. Most of the Subgroup members agreed that KCC seems to qualify under the same standards as the other modeling firms have for hurricane and earthquake.

Mr. Chou also provided an overview of the Subgroup’s Oct. 27 meeting in lieu of the Fall National Meeting, which included the following action: 1) adopted its Sept. 28 minutes; 2) discussed the possibility of allowing third-party models calculate the catastrophe model losses; 3) considered exposure of proposal 2021-15-CR (Adding KCC Model); 4) heard an update from the Catastrophe Model Technical Review Ad Hoc Group; 5) heard a presentation from RMS regarding its Wildfire High Definition (HD) Model; and 5) discussed the impact analysis on different third-party commercial wildfire models.

Mr. Chou made a motion, seconded by Ms. Smosna, to adopt the report of the Catastrophe Risk (E) Subgroup (see NAIC Proceedings – Fall 2021, Capital Adequacy (E) Task Force, Attachment Four). The motion passed unanimously.

3. Exposed a Draft Recommendation to the Restructuring Mechanism (E) Subgroup

Mr. Botsko said the Runoff Ad Hoc Group met Oct. 13 to continue discussing the best course of treatment of runoff companies. He stated that the drafted recommendation indicated that a run-off company should include the following characteristics: 1) no renewing of policies for at least 12 months; 2) no new direct or assumed business; and 3) no additional runoff blocks of business. Mr. Botsko also said the ad hoc group agrees with the international treatment of runoff companies, which is handled through the Analysis and Exam Teams. In addition, the ad hoc group recommended that the Working Group adjust the instruction to better reflect the unique runoff characteristics, such as removing: 1) the trend test from the RBC calculation; 2) the charge for premium growth; and 3) Rcat from the RBC formula. Lastly, Mr. Botsko stated that this recommendation letter will be shared.
with the Health Risk-Based Capital (E) Working Group and the Life Risk-Based Capital (E) Working Group for further consideration.

The Working Group agreed to expose the recommendation to the Restructuring Mechanism (E) Subgroup for a 30-day public comment period ending Nov. 24.

4. **Exposed Proposal 2021-14-P (R3 Factor Adjustment)**

Mr. Botsko said when the reinsurance recoverable credit risk charge was implemented in 2018, a load of operational risk was embedded in the R3 charge. Currently, the operational risk is separately addressed in the RBC as a stand-alone capital add-on; it results with duplication of the operational risk charge on the reinsurance recoverable component. He stated that this proposal intends to eliminate the double-counting effect of the operational risk charge on the component. He said NAIC staff performed an analysis to determine the impact on the RBC action levels by reducing the 2% reinsurance recoverable RBC charge for all reinsurance designation equivalents (Attachment Five-A). The result indicated that the impact is insignificant, as only three companies with Total Adjusted Capital (TAC) between zero to 75 million will change the RBC results from action level to no action.

The Working Group agreed to expose proposal 2021-14-P (R3 Factor Adjustment) for a 30-day public comment period ending Nov. 24.

5. **Heard Updates on a P/C RBC Underwriting Risk Project from the Academy**

David Traugott (Academy) provided a status on the recommended adjustments to the formulas for premium and reserve risk to reflect the impact of interest rates. He stated that this project is still a work in progress status; the results may change based on further review by the Academy Property and Casualty Risk-Based Capital Committee. He also stated that this presentation relates to premium risk only; an analysis of reserve risk is underway. During the presentation, he provided a brief overview of: 1) background of the Investment Income Adjustments (IIAs); 2) interest rate history 3) payment patterns; 4) risk charge versus interest rate; and 5) analysis of present value calibration. He also stated that the next steps in the Committee work plan include: 1) further examining the line-by-line risk charges to assess the extent to which the general approach described in the presentation is applicable by line; 2) applying the present value analysis to the RBC data for the short-tail lines; and 3) applying the same type of analysis to reserve risk.

Mr. Botsko said he appreciates all the Academy does for the Working Group. He said the Working Group will provide the needed support to ensure the projects are completed in time.

Having no further business, the Property and Casualty Risk-Based Capital (E) Working Group adjourned.

W:\National Meetings\2021\Fall\TF\CapAdequacy\PCRBC\Att01_10_25propertyrbcwg.doc
## 2020 P&C RBC - Comparison of Action Levels

**Current RBC Action Levels vs Alternative RBC Action Level**

*Alternative RBC: 2% Reduction on Reinsurance Recoverable RBC Charge for All Reinsurance Designation Equivalents (Excluding Companies with Negative TAC)*

### (Companies with TAC Between $0 and $5 Million)

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### (Companies with TAC Between $75 Million and $250 Million)

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### (Companies with TAC Between $250 Million and $1 Billion)

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### (Companies with TAC Greater Than $1 Billion)

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## 2020 RBC Action Level under Current RBC Formula

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### Distributions of Percentage Change in 2020 RBC Ratios by Company Size under Alternative RBC Formula

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<tr>
<th>RBC Ratio Change</th>
<th>TAC Range</th>
<th>$0 to $5</th>
<th>$5 to $25</th>
<th>$25 to $75</th>
<th>$75 to $250</th>
<th>$250 to $1,000</th>
<th>Over $1,000</th>
<th>Total</th>
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<td>-5% to 5%</td>
<td>227</td>
<td>662</td>
<td>494</td>
<td>381</td>
<td>140</td>
<td>2,153</td>
<td>3,404</td>
<td>7,238</td>
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<td>5% to 15%</td>
<td>12</td>
<td>56</td>
<td>31</td>
<td>12</td>
<td>9</td>
<td>140</td>
<td>2,153</td>
<td>2,475</td>
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<td>15% to 25%</td>
<td>9</td>
<td>21</td>
<td>15</td>
<td>11</td>
<td>2</td>
<td>58</td>
<td>2,153</td>
<td>283</td>
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<tr>
<td>25% to 50%</td>
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<td>21</td>
<td>15</td>
<td>11</td>
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<td>58</td>
<td>2,153</td>
<td>283</td>
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<tr>
<td>Greater than 50%</td>
<td>5</td>
<td>21</td>
<td>15</td>
<td>11</td>
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<td>58</td>
<td>2,153</td>
<td>283</td>
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<tr>
<td><strong>Subtotal</strong></td>
<td>258</td>
<td>780</td>
<td>586</td>
<td>494</td>
<td>149</td>
<td>2,475</td>
<td>10,370</td>
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### Comparison of 2020 RBC Charge under Alternative RBC Formula

<table>
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<tr>
<th>TAC Range ($ Million)</th>
<th>$0 to $5</th>
<th>$5 to $25</th>
<th>$25 to $75</th>
<th>$75 to $250</th>
<th>$250 to $1,000</th>
<th>Over $1,000</th>
<th>Total</th>
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<tr>
<td>R3 - Current</td>
<td>71,884,508</td>
<td>267,078,272</td>
<td>829,927,624</td>
<td>1,471,721,675</td>
<td>1,935,441,255</td>
<td>5,794,628,606</td>
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<tr>
<td>R3 - Alternative</td>
<td>56,439,676</td>
<td>183,797,021</td>
<td>536,125,852</td>
<td>916,477,625</td>
<td>1,278,922,632</td>
<td>4,052,194,696</td>
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<td>Percentage Change</td>
<td>-21.5%</td>
<td>-31.2%</td>
<td>-35.4%</td>
<td>-37.7%</td>
<td>-33.9%</td>
<td>-30.1%</td>
<td>-32.3%</td>
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<tr>
<td>R4 - Current</td>
<td>394,872,924</td>
<td>798,332,703</td>
<td>2,428,351,877</td>
<td>7,678,683,209</td>
<td>19,336,240,504</td>
<td>99,340,612,630</td>
<td>129,977,155,847</td>
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<td>R4 - Alternative</td>
<td>385,941,326</td>
<td>773,790,796</td>
<td>2,382,242,619</td>
<td>7,513,699,697</td>
<td>19,005,250,705</td>
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<tr>
<td>Percentage Change</td>
<td>-2.3%</td>
<td>-3.1%</td>
<td>-1.9%</td>
<td>-2.1%</td>
<td>-1.7%</td>
<td>-1.7%</td>
<td>-1.8%</td>
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<tr>
<td>RBC After Covariance (incl. Oper Risk) - Current</td>
<td>562,635,100</td>
<td>1,314,873,807</td>
<td>5,166,388,207</td>
<td>18,478,094,605</td>
<td>38,933,609,666</td>
<td>314,405,511,521</td>
<td>373,680,033,100</td>
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<tr>
<td>RBC After Covariance (incl. Oper Risk) - Alternative</td>
<td>547,595,325</td>
<td>1,852,681,548</td>
<td>5,154,973,004</td>
<td>18,108,875,222</td>
<td>36,390,336,203</td>
<td>312,791,382,248</td>
<td>370,675,815,080</td>
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<td>Percentage Change</td>
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<tr>
<td>Type of Event</td>
<td>Name</td>
<td>Date</td>
<td>Location</td>
<td>Overall losses when occurred</td>
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<tr>
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<td>Isaac</td>
<td>2012</td>
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<td>Earthquake</td>
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<td>2014</td>
<td>California</td>
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<td>Patricia</td>
<td>2015</td>
<td>$25+ million</td>
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<td>2015</td>
<td>$25+ million</td>
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<td>Matthew</td>
<td>2016</td>
<td>Florida, North Carolina, South Carolina, Georgia and Virginia $2,698,400,000</td>
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<tr>
<td>Hurricane</td>
<td>Harvey</td>
<td>2016</td>
<td>Florida, North Carolina, South Carolina, Georgia and Virginia $2,456,400,000</td>
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<td>Jose</td>
<td>2017</td>
<td>Eastern Coast of the United States</td>
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<td>Irma</td>
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<td>Eastern United States</td>
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<td>Hurricane</td>
<td>Maria</td>
<td>2017</td>
<td>Southeastern United States, Mid-Atlantic States</td>
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<tr>
<td>Hurricane</td>
<td>Nate</td>
<td>2017</td>
<td>Louisiana, Mississippi, Alabama, Tennessee and Eastern United States</td>
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<td>Tropical Storm</td>
<td>Alberto</td>
<td>2018</td>
<td>Southeast, Midwest</td>
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<td>2018</td>
<td>Hawaii</td>
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<td>Southeast, Gulf coast of the United States, Arkansas and Missouri</td>
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<td>2018</td>
<td>Southeastern and East Coasts of United States</td>
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© 2021 National Association of Insurance Commissioners
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<th>Event Type</th>
<th>Begin</th>
<th>End</th>
<th>Event</th>
<th>Country Affected Area (Detail)</th>
<th>Munich Re NatCATService Insured losses (in original values, US$m)</th>
<th>Criteria: insured losses equal/greater US $25m. Tries to reflect non-US losses only</th>
<th>Swiss Re Sigma: Insured Loss Est. US$m (mid point shown if range given) Mostly reflect total US and non-US losses combined</th>
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<td>Europe</td>
<td>N/A</td>
<td>&gt; 25 million</td>
</tr>
<tr>
<td>2017</td>
<td>Earthquake</td>
<td>01/28/17</td>
<td>N/A</td>
<td>Earthquake</td>
<td>China, Taiwan</td>
<td>Asia</td>
<td>N/A</td>
<td>&gt; 25 million</td>
</tr>
<tr>
<td>2017</td>
<td>Earthquake</td>
<td>02/10/17</td>
<td>N/A</td>
<td>Earthquake</td>
<td>Philippines</td>
<td>Asia</td>
<td>N/A</td>
<td>&gt; 25 million</td>
</tr>
<tr>
<td>2017</td>
<td>Earthquake</td>
<td>03/28/17</td>
<td>N/A</td>
<td>Earthquake</td>
<td>China</td>
<td>Asia</td>
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<td>&gt; 25 million</td>
</tr>
<tr>
<td>2017</td>
<td>Cyclone</td>
<td>04/05/17</td>
<td>N/A</td>
<td>CY Debbie</td>
<td>Australia, Queensland, New South Wales, New Zealand</td>
<td>Asia</td>
<td>N/A</td>
<td>&gt; 25 million</td>
</tr>
<tr>
<td>2017</td>
<td>Earthquake</td>
<td>05/11/17</td>
<td>N/A</td>
<td>Earthquake</td>
<td>China</td>
<td>Asia</td>
<td>N/A</td>
<td>&gt; 25 million</td>
</tr>
<tr>
<td>2017</td>
<td>Typhoon</td>
<td>03/28/17</td>
<td>04/05/17</td>
<td>CY Debbie</td>
<td>Australia, Queensland, New South Wales, New Zealand</td>
<td>Asia</td>
<td>N/A</td>
<td>&gt; 25 million</td>
</tr>
<tr>
<td>2017</td>
<td>Typhoon</td>
<td>07/29/17</td>
<td>07/31/17</td>
<td>TY Nesat &amp; TS Haiyan</td>
<td>China, Taiwan, Philippines</td>
<td>Asia</td>
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<td>&gt; 25 million</td>
</tr>
<tr>
<td>2017</td>
<td>Typhoon</td>
<td>09/12/17</td>
<td>09/14/17</td>
<td>TY Haiyan</td>
<td>China, Taiwan, Philippines</td>
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<td>N/A</td>
<td>&gt; 25 million</td>
</tr>
<tr>
<td>2017</td>
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<td>09/19/17</td>
<td>09/21/17</td>
<td>TY Halong</td>
<td>Vietnam</td>
<td>Asia</td>
<td>N/A</td>
<td>&gt; 25 million</td>
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<td>2017</td>
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<td>09/22/17</td>
<td>09/23/17</td>
<td>TY Haiyan</td>
<td>China, Taiwan, Philippines</td>
<td>Asia</td>
<td>N/A</td>
<td>&gt; 25 million</td>
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<td>09/23/17</td>
<td>09/26/17</td>
<td>TY Haiyan</td>
<td>China, Taiwan, Philippines</td>
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<td>&gt; 25 million</td>
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<td>Hurricane</td>
<td>09/27/17</td>
<td>09/28/17</td>
<td>TY Haiyan</td>
<td>China, Taiwan, Philippines</td>
<td>Asia</td>
<td>N/A</td>
<td>&gt; 25 million</td>
</tr>
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<td>Hurricane</td>
<td>09/28/17</td>
<td>09/29/17</td>
<td>TY Haiyan</td>
<td>China, Taiwan, Philippines</td>
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<td>&gt; 25 million</td>
</tr>
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<td>09/30/17</td>
<td>09/30/17</td>
<td>TY Haiyan</td>
<td>China, Taiwan, Philippines</td>
<td>Asia</td>
<td>N/A</td>
<td>&gt; 25 million</td>
</tr>
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<td>2017</td>
<td>Hurricane</td>
<td>10/03/17</td>
<td>10/04/17</td>
<td>Hurricane Maria</td>
<td>Caribbean Islands, UK, France and Spain</td>
<td>Asia</td>
<td>N/A</td>
<td>&gt; 25 million</td>
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<td>2017</td>
<td>Hurricane</td>
<td>10/06/17</td>
<td>10/06/17</td>
<td>Hurricane Irma</td>
<td>Caribbean Islands and Cape Verde</td>
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<td>N/A</td>
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<td>2017</td>
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<td>10/08/17</td>
<td>10/09/17</td>
<td>Hurricane Jose</td>
<td>Caribbean Islands and Eastern Canada</td>
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</tr>
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<td>2017</td>
<td>Hurricane</td>
<td>10/10/17</td>
<td>10/11/17</td>
<td>Hurricane Maria</td>
<td>Caribbean Islands, UK, France and Spain</td>
<td>Asia</td>
<td>N/A</td>
<td>&gt; 25 million</td>
</tr>
<tr>
<td>2017</td>
<td>Hurricane</td>
<td>10/11/17</td>
<td>10/11/17</td>
<td>Hurricane Maria</td>
<td>Caribbean Islands, UK, France and Spain</td>
<td>Asia</td>
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<td>&gt; 25 million</td>
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<td>2017</td>
<td>Hurricane</td>
<td>10/18/17</td>
<td>10/19/17</td>
<td>Hurricane Nate</td>
<td>Mexico City, Mexico, Central America</td>
<td>Mexico</td>
<td>N/A</td>
<td>&gt; 25 million</td>
</tr>
<tr>
<td>2018</td>
<td>Hurricane</td>
<td>08/29/17</td>
<td>09/05/17</td>
<td>Hurricane Nate</td>
<td>Mexico City, Mexico, Central America</td>
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<td>09/01/17</td>
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<td>Earthquake</td>
<td>Mexico</td>
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<td>10/04/17</td>
<td>10/04/17</td>
<td>Earthquake</td>
<td>Mexico</td>
<td>Mexico</td>
<td>N/A</td>
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</tr>
<tr>
<td>Year</td>
<td>Type</td>
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<td>2018</td>
<td>Cyclone</td>
<td>02/09/18</td>
<td>Tonga, Fiji, Samoa, New Zealand</td>
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<td>2018</td>
<td>Earthquake</td>
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<td>Papua New Guinea</td>
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<td>2018</td>
<td>Cyclone</td>
<td>02/17/18</td>
<td>CY Marcus</td>
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<tr>
<td>2018</td>
<td>Tropical Storm</td>
<td>05/23/18</td>
<td>Yemen, Oman, Saudi Arabia</td>
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<td>2018</td>
<td>Tropical Storm</td>
<td>06/02/18</td>
<td>Vietnam, China, Taiwan, Philippines, Ryukyu Islands</td>
<td>Guangdong Province, Jiangxi, Fujian, Zhejiang Provinces, and Hainan Island</td>
<td>&gt; 25 million</td>
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<tr>
<td>2018</td>
<td>Earthquake</td>
<td>06/18/18</td>
<td>Japan</td>
<td>&gt; 25 million</td>
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<td>2018</td>
<td>Super Typhoon</td>
<td>07/10/18</td>
<td>China, Taiwan, Guam and Japan</td>
<td>Fujian province, Yangtze River Basin, Japan's Ryukyu Islands</td>
<td>&gt; 25 million</td>
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<td>Tropical Storm</td>
<td>07/17/18</td>
<td>Vietnam, China, Laos</td>
<td>Japan, Russian Far East</td>
<td>&gt; 25 million</td>
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<tr>
<td>2018</td>
<td>Tropical Storm</td>
<td>07/22/18</td>
<td>TS Ampil</td>
<td>Jiangsu, Zhejiang, Shandong, and Hebei</td>
<td>&gt; 25 million</td>
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<tr>
<td>2018</td>
<td>Typhoon</td>
<td>08/02/18</td>
<td>TY Jongdari</td>
<td>Japan, China</td>
<td>&gt; 25 million</td>
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<td>2018</td>
<td>Earthquake</td>
<td>08/05/18</td>
<td>Indonesia</td>
<td>&gt; 25 million</td>
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<td>Tropical Storm</td>
<td>08/09/18</td>
<td>TS Yagi</td>
<td>Zhejiang, Anhui, Jiangsu and Shandong Provinces</td>
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<td>08/13/18</td>
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<td>&gt; 25 million</td>
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<td>Typhoon</td>
<td>08/16/18</td>
<td>TY Rumba</td>
<td>Shanghai, Jiangsu, Zhejiang, Anhui, Shandong and Hainan</td>
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<td>Typhoon</td>
<td>08/23/18</td>
<td>TY Soulik</td>
<td>Haenam County, South Jeolla Province</td>
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<td>Typhoon</td>
<td>08/04/18</td>
<td>RY Jebi</td>
<td>Japan, Manzana Islands, Taiwan, Japan, Russian Far East and Arctic</td>
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<tr>
<td>Year</td>
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<td>Date1</td>
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<tr>
<td>2018</td>
<td>Earthquake</td>
<td>09/06/18</td>
<td>09/18/18</td>
<td>N. Mariana Islands, Philippines, China and Hong Kong</td>
<td>&gt; 25 million</td>
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<td>Hurricane Leslie</td>
<td>09/23/18</td>
<td>09/25/18</td>
<td>Azores, Bermuda, Europe</td>
<td>&gt; 25 million</td>
<td></td>
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<td>2018</td>
<td>Hurricane Michael</td>
<td>10/07/18</td>
<td>10/15/18</td>
<td>Central American, Yucatan Peninsula, Caribbean islands, Cuba, Atlantic, Carri</td>
<td>&gt; 25 million</td>
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<tr>
<td>2019</td>
<td>Cyclone Fani</td>
<td>05/03/19</td>
<td>05/05/19</td>
<td>India, Bangladesh</td>
<td>&gt; 5 billion</td>
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<td>2019</td>
<td>Earthquake</td>
<td>06/17/19</td>
<td>06/19/19</td>
<td>China</td>
<td>&gt; 25 million</td>
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<td>Tropical Storm Washa</td>
<td>09/08/19</td>
<td>09/10/19</td>
<td>China, Vietnam</td>
<td>&gt; 25 million</td>
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<td>Typhoon</td>
<td>09/09/19</td>
<td>09/11/19</td>
<td>Typhoon Lekima</td>
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<td>09/12/19</td>
<td>09/14/19</td>
<td>Typhoon Krosa</td>
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<td>09/15/19</td>
<td>09/17/19</td>
<td>Hurricane Dorian</td>
<td>Caribbean, Bahamas, Canada</td>
<td>&gt; 1 billion</td>
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<td>Typhoon</td>
<td>09/18/19</td>
<td>09/20/19</td>
<td>Typhoon Faxai</td>
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<td>&gt; 25 billion</td>
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<td>09/18/19</td>
<td>09/20/19</td>
<td>Hurricane Hybrid</td>
<td>Bermuda</td>
<td>&gt; 2.5 billion</td>
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<td>09/17/19</td>
<td>09/20/19</td>
<td>Hurricane Lorenzo</td>
<td>Portugal</td>
<td>&gt; 25 billion</td>
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<td>Earthquake</td>
<td>11/09/19</td>
<td>11/11/19</td>
<td>Earthquake</td>
<td>Japan</td>
<td>&gt; 25+ billion</td>
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<tr>
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<td>10/31/19</td>
<td>11/04/19</td>
<td>Hurricane Iota</td>
<td>Caribbean, Central America, Cyclone Islands</td>
<td>&gt; 7 billion</td>
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<td>11/04/19</td>
<td>Hurricane Laila</td>
<td>Cuba</td>
<td>&gt; 25+ million</td>
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<td>11/11/19</td>
<td>Hurricane Ophelia</td>
<td>Portugal</td>
<td>&gt; 25+ million</td>
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<td>11/08/19</td>
<td>11/11/19</td>
<td>Earthquake</td>
<td>Philippines</td>
<td>&gt; 25+ million</td>
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<td>01/22/20</td>
<td>01/25/20</td>
<td>Earthquake</td>
<td>Croatia</td>
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<td>2020</td>
<td>Cyclone</td>
<td>04/01/20</td>
<td>04/14/20</td>
<td>Cyclone Harold</td>
<td>Solomon Islands, Canuatu, Fiyi Tonga</td>
<td>&gt; 25+ million</td>
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<tr>
<td>2020</td>
<td>Typhoon</td>
<td>04/11/20</td>
<td>04/14/20</td>
<td>Typhoon Harold</td>
<td>Solomon Islands, Canuatu, Fiyi Tonga</td>
<td>&gt; 25+ million</td>
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<tr>
<td>2020</td>
<td>Tropical Storm</td>
<td>05/31/20</td>
<td>06/03/20</td>
<td>Tropical Storm Amanda</td>
<td>El Salvador, Guatemala, Honduras</td>
<td>&gt; 25+ million</td>
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<td>Tropical Storm</td>
<td>06/01/20</td>
<td>06/05/20</td>
<td>Tropical Storm Cristobal</td>
<td>Mexico, Guatemala, El Salvador</td>
<td>&gt; 25+ million</td>
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<td>Hurricane</td>
<td>07/05/20</td>
<td>07/08/20</td>
<td>Hurricane Hanna</td>
<td>Mexico</td>
<td>&gt; 3 billion</td>
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<td>Typhoon</td>
<td>08/22/20</td>
<td>08/25/20</td>
<td>Typhoon Laura</td>
<td>Canuatu, Fiyi Tonga</td>
<td>&gt; 4 billion</td>
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<td>Typhoon</td>
<td>09/01/20</td>
<td>09/03/20</td>
<td>Typhoon Amphan</td>
<td>India, Bangladesh, Sri Lanka</td>
<td>&gt; 1.5 billion</td>
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<tr>
<td>2020</td>
<td>Typhoon</td>
<td>09/02/20</td>
<td>09/03/20</td>
<td>Typhoon Harold</td>
<td>Solomon Islands, Canuatu, Fiyi Tonga</td>
<td>&gt; 25+ million</td>
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<tr>
<td>2020</td>
<td>Hurricane</td>
<td>09/13/20</td>
<td>09/16/20</td>
<td>Hurricane Delta</td>
<td>Jamaica, Nicaragua, Cayman Islands, Yucatan Peninsula</td>
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<td>09/16/20</td>
<td>Hurricane Zeta</td>
<td>Cayman Islands, Jamaica, Central America, Yucatan Peninsula, Ireland, United Kingdom</td>
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<tr>
<td>2020</td>
<td>Cyclone</td>
<td>09/14/20</td>
<td>09/16/20</td>
<td>Cyclone Harold</td>
<td>Solomon Islands, Canuatu, Fiyi Tonga</td>
<td>&gt; 25+ million</td>
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<tr>
<td>2020</td>
<td>Hurricane</td>
<td>10/31/20</td>
<td>11/14/20</td>
<td>Hurricane Eta</td>
<td>Colombia, Jamaica, Central America, Cayman Islands, Cuba, The Bahamas</td>
<td>&gt; 7.9 billion</td>
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<tr>
<td>Year</td>
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<td>End Date</td>
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<tr>
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<td>Hurricane</td>
<td>11/14/20</td>
<td>11/19/20</td>
<td>ABC Islands, Colombia, Jamaica, Central America</td>
<td>&gt; 1.4 billion</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2020</td>
<td>Typhoon</td>
<td>11/08/20</td>
<td>11/15/20</td>
<td>Philippines, Vietnam, Laos, Thailand</td>
<td>&gt; 400+ million</td>
<td></td>
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<tr>
<td>2021</td>
<td>Earthquake</td>
<td>01/14/21</td>
<td>01/14/21</td>
<td>West Sumatra, Indonesia</td>
<td>&gt; 58.1 million</td>
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<tr>
<td>2021</td>
<td>Earthquake</td>
<td>02/13/21</td>
<td>02/13/21</td>
<td>Fukushima Prefecture, Offshore, Japan</td>
<td>1.3 billion</td>
<td></td>
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<tr>
<td>2021</td>
<td>Tropical Cyclone</td>
<td>05/17/21</td>
<td>05/24/21</td>
<td>Tropical Cyclone, Taif, India</td>
<td>&gt; 25+ million</td>
<td></td>
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<tr>
<td>2021</td>
<td>Tropical Storm</td>
<td>06/19/21</td>
<td>06/23/21</td>
<td>Tropical Storm, Claudette, Osaka, Veracruz, Atlantic Canada</td>
<td>&gt; 25+ million</td>
<td></td>
<td></td>
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<tr>
<td>2021</td>
<td>Earthquake</td>
<td>06/21/21</td>
<td>06/21/21</td>
<td>China, Yunnan, Dal</td>
<td>&gt; 25+ million</td>
<td></td>
<td></td>
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<tr>
<td>2021</td>
<td>Earthquake</td>
<td>06/21/21</td>
<td>06/21/21</td>
<td>China, Southern Qinghai</td>
<td>&gt; 25+ million</td>
<td></td>
<td></td>
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<tr>
<td>2021</td>
<td>Hurricane</td>
<td>07/01/21</td>
<td>07/14/21</td>
<td>Lesser Antilles, Greater Antilles, Venezuela, Colombia, Atlantic Canada, Greenland, Iceland</td>
<td>50 million</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>Typhoon</td>
<td>07/10/21</td>
<td>07/31/21</td>
<td>In-fa (Fabian), Philippines, Ryukyu Islands, Taiwan, China, North Korea</td>
<td>&gt; 25+ million</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>Tropical Storm</td>
<td>08/11/21</td>
<td>08/20/21</td>
<td>Fred, Lesser Antilles, Greater Antilles, Southern Quebec, The Maritimes</td>
<td>25 million</td>
<td></td>
<td></td>
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<tr>
<td>2021</td>
<td>Hurricane</td>
<td>08/13/21</td>
<td>08/21/21</td>
<td>Lesser Antilles, Greater Antilles, Yucatan Peninsula, Central Mexico</td>
<td>513 million</td>
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<tr>
<td>2021</td>
<td>Earthquake</td>
<td>08/14/21</td>
<td>08/14/21</td>
<td>Haiti, Venezuela, Colombia, Jamaica, Cayman Islands, Cuba, Atlantic Canada</td>
<td>1 billion</td>
<td></td>
<td></td>
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<tr>
<td>2021</td>
<td>Hurricane</td>
<td>08/26/21</td>
<td>08/26/21</td>
<td>Ida, Venezuela, Colombia, Jamaica, Cayman Islands, Cuba, Atlantic Canada</td>
<td>&gt; 250 million</td>
<td></td>
<td></td>
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<tr>
<td>2021</td>
<td>Earthquake</td>
<td>08/07/21</td>
<td>08/07/21</td>
<td>Guanacaste, Mexico</td>
<td>200 million</td>
<td></td>
<td></td>
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<tr>
<td>2021</td>
<td>Earthquake</td>
<td>08/16/21</td>
<td>08/16/21</td>
<td>China</td>
<td>&gt; 25+ million</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>Hurricane</td>
<td>08/12/21</td>
<td>08/18/21</td>
<td>Nicholas, Yucatan Peninsula, Tamaulipas</td>
<td>1.1 billion</td>
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<td></td>
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</tbody>
</table>
## Working Agenda Items for Calendar Year 2021

### Ongoing Items – Life RBC

<table>
<thead>
<tr>
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<th>Owner</th>
<th>2021 Priority</th>
<th>Expected Completion Date</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Life RBC WG</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Make technical corrections to Life RBC instructions, blank and/or methods to provide for consistent treatment among asset types and among the various components of the RBC calculations for a single asset type.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021 or later</td>
<td>1. Monitor the impact of the changes to the variable annuities reserve framework and risk-based capital (RBC) calculation and determine if additional revisions need to be made. 2. Develop and recommend appropriate changes including those to improve accuracy and clarity of variable annuity (VA) capital and reserve requirements.</td>
<td>CATF</td>
<td>Being addressed by the Variable Annuities Capital and Reserve (E/A) Subgroup</td>
</tr>
<tr>
<td>3</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021 or later</td>
<td>Provide recommendations for the appropriate treatment of longevity risk transfers by the new longevity factors.</td>
<td>New Jersey</td>
<td>Being addressed by the Longevity (E/A) Subgroup</td>
</tr>
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</table>

### Carry-Over Items Currently being Addressed – Life RBC

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>4</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021 or later</td>
<td>Update the current C-3 Phase I or C-3 Phase II methodology to include indexed annuities with consideration of contingent deferred annuities as well.</td>
<td>AAA</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021 or later</td>
<td>Work with the Life Actuarial (A) Task Force and Conning to develop the economic scenario generator for implementation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021</td>
<td>Develop guidance for regulators as it relates to the potential impact of the bond factor changes on 2021 RBC results and the trend test.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Life RBC WG</td>
<td>1</td>
<td>2021 or later</td>
<td>Review companies at action levels, including previous years, to determine what drivers of the events are and consider whether changes to the RBC statistics are warranted.</td>
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### New Items – Life

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<th>2021 Priority</th>
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</thead>
<tbody>
<tr>
<td>8</td>
<td>Cat Risk SG</td>
<td>1</td>
<td></td>
<td>Continue development of RBC formula revisions to include a risk charge based on catastrophe model output: a) Evaluate other catastrophe risks for possible inclusion in the charge - determine whether to recommend developing charges for any additional perils, and which perils or perils those should be.</td>
<td>Referral from the Climate and Resiliency Task Force</td>
<td>4/26/21 - The SG expose the referral for a 30-day exposure period. 6/2/21 - The SG forwarded the response to the Climate and Resiliency Task Force.</td>
</tr>
<tr>
<td>9</td>
<td>P&amp;C RBC WG</td>
<td>1</td>
<td>Year-end 2020 or later</td>
<td>Evaluate a) the current growth risk methodology whether it is adequately reflects both operational risk and underwriting risk; b) the premium and reserve based growth risk factors either as a stand-alone task or in conjunction with the ongoing underwriting risk factor review with consideration of the operational risk component of excessive growth; c) whether the application of the growth factors to NET proxies adequately accounts for growth risk that is ceded to reinsurers that do not trigger growth risk in their own right.</td>
<td>Refer from Operational Risk Subgroup</td>
<td>1/25/2018</td>
</tr>
</tbody>
</table>

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**Priority 1 – High priority**  
**Priority 2 – Medium priority**  
**Priority 3 – Low priority**
<table>
<thead>
<tr>
<th>2021 #</th>
<th>Owner</th>
<th>2021 Priority</th>
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<th>Date Added to Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>P&amp;C</td>
<td>1</td>
<td>2020 Summer Meeting or later</td>
<td>Continue development of RBC formula revisions based on the Covered Agreement: consider whether the factor for uncollateralized, unrated reinsurers, runoff and captive companies should be adjusted</td>
<td>1/25/19 - The WG exposed Proposal 2018-19-P (Vulnerable or unrated risk charge) for a 30-day exposure period. 2/3/20 - The WG adopted Proposal 2018-19-P. However, the WG intended to evaluate the data annually until reaching any agreement upon change to the factor and structure. 3/15/21 - The WG exposed Proposal 2021-03-P (Credit Risk Instruction Modification) for a 30-day exposure period. 4/27/21 - The WG adopted proposal 2021-03-P. 6/30/21 - The CADTF adopted this proposal.</td>
<td>8/4/2018</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>P&amp;C</td>
<td>1</td>
<td>Year-end 2021 or later</td>
<td>Evaluate the proposal changes from the Affiliated Investment Ad Hoc Group related to P/C RBC Affiliated Investments</td>
<td>6/10/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>P&amp;C</td>
<td>1</td>
<td>2022 Summer Meeting or later</td>
<td>Continue working with the Academy to review the methodology and revise the underwriting (Investment Income Adjustment, Loss Concentration, LOB UW risk) charges in the PRBC formula as appropriate.</td>
<td>6/10/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Cat R &amp; C</td>
<td>1</td>
<td>Year-end 2022 or later</td>
<td>Evaluate the possibility of allowing additional third party models or adjustments to the vendor models to calculate the cat model losses</td>
<td>7/15/21 - The SG is continue evaluating this item.</td>
<td>12/6/2019</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>P&amp;C</td>
<td>1</td>
<td>2022 Spring Meeting</td>
<td>Evaluate if changes should be made to the P/C formula to better assess companies in runoff.</td>
<td>1/29/20 - received a referral from the Restructuring Mechanisms (E) WG 4/27/21 - The SG forwarded a response to the Restructuring Mechanisms (E) WG.</td>
<td>2/3/2020</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>P&amp;C</td>
<td>1</td>
<td>2022 Summer Meeting</td>
<td>Evaluate the Underwriting Risk Line 1 Factors in the P/C formula.</td>
<td>7/30/2020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Cat R &amp; C</td>
<td>1</td>
<td>2021 Spring Meeting</td>
<td>Modify instructions to PR027 Interrogatories that clarify how insurers with no gross exposure to earthquake or hurricane should complete the interrogatories</td>
<td>10/27/20 - expose the proposal for 30 day comment period 3/9/21 - The SG adopted the proposal 2020-08-EC at the Spring National Meeting. 3/15/21 - The WG adopted this proposal. 3/23/21 - The CADTF adopted this proposal.</td>
<td>10/19/2020</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>P&amp;C</td>
<td>1</td>
<td>2022 Summer Meeting</td>
<td>Evaluate R3 Adjustment for Operational Risk Charge</td>
<td>10/27/2020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Cat R &amp; C</td>
<td>1</td>
<td>2022 Spring Meeting or later</td>
<td>Implement Wildfire Peril in the RCat component (For Informational Purpose Only)</td>
<td>7/15/21 - The SG is continue studying this item.</td>
<td>3/8/2021</td>
<td></td>
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</table>

**Ongoing Items – Health RBC**
<table>
<thead>
<tr>
<th>Working Agenda Item</th>
<th>Source</th>
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<tbody>
<tr>
<td>Date Added to Agenda</td>
<td>11/4/2021</td>
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### Year-end

#### 2022

- **20 Health RBC WG**
  - **Priority:** Year-end
  - **Date:** 2022 or later
  - **Description:** Review the Managed Care Credit calculation in the Health RBC formula - Attachments: **C1**

#### 2023

- **21 Health RBC WG**
  - **Priority:** Year-end
  - **Date:** 2023 or later
  - **Description:** Review Managed Care Credit across formulas - Attachments: **C2**

### Carry-Over Items Currently Being Addressed - Health RBC

<table>
<thead>
<tr>
<th>Group</th>
<th>Priority</th>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
</table>
| Health RBC WG | Year-end | 2022 or later | Review the inclusion of the Health RBC formula in the annual statement changes - Attachments: **C3**

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## Capital Adequacy (E) Task Force
### Working Agenda Items for Calendar Year 2021

<table>
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<tr>
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<th>Expected Completion Date</th>
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<tbody>
<tr>
<td>27</td>
<td>Health RBC WG</td>
<td>1</td>
<td>2022 or later</td>
<td></td>
<td>Consider impact of COVID-19 and pandemic risk in the Health RBC formula.</td>
<td>HRCWG</td>
<td></td>
<td>7/30/2020</td>
</tr>
<tr>
<td>28</td>
<td>Health RBC WG</td>
<td>1</td>
<td>2022 or later</td>
<td></td>
<td>Work with the Academy to evaluate incorporating and including investment income in the Underwriting Risk component of the Health RBC formula. * Develop a process for reviewing investment income in the underwriting risk factors. * Determine the frequency for which the adjustment should be updated. * Determine if other lines of business should include investment income.</td>
<td>HRCWG</td>
<td>Referral Letter was sent to the Academy on Sept 21. - Adopted 5/25/21 by the WG</td>
<td>8/18/2020</td>
</tr>
<tr>
<td>29</td>
<td>Health RBC WG</td>
<td>-</td>
<td>2023 or later</td>
<td></td>
<td>Discuss and determine the bond factors for the 20 designations.</td>
<td>Referral from Investment RBC</td>
<td>Working Group will use two- and five-year time horizon factors in 2020 impact analysis. Proposal 2021-09-41 - Adopted 5/25/21 by the WG</td>
<td>9/11/2020</td>
</tr>
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</table>

### New Items – Health RBC:

<table>
<thead>
<tr>
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<tr>
<td>30</td>
<td>Health RBC WG</td>
<td>1</td>
<td>2022 or later</td>
<td></td>
<td>Work with the Academy to perform a comprehensive review of the H2 - Underwriting Risk component of the Health RBC formula including the Managed Care Credit review (Item 18 above)</td>
<td>HRCWG</td>
<td></td>
<td>4/23/2021</td>
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### New Items – Task Force:

<table>
<thead>
<tr>
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### Ongoing Items – Task Force:

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<tbody>
<tr>
<td>31</td>
<td>CADTF</td>
<td>2</td>
<td>2022</td>
<td></td>
<td>Affiliated Investment Subsidiaries Referral Ad Hoc group formed Sept. 2016</td>
<td>Ad Hoc Group</td>
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### Carry-Over Items not Currently being Addressed – Task Force:

<table>
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</thead>
<tbody>
<tr>
<td>32</td>
<td>CADTF</td>
<td>2</td>
<td>2022 or Later</td>
<td></td>
<td>Supplementary Investment Risks Interrogatories (SIRI)</td>
<td>Blackrock and IL DOI</td>
<td>The Task Force received the referral on Oct. 27. This referral will be tabled until the bond factors have been adopted and the TF will conduct a holistic review of all investment referrals.</td>
<td>11/19/2020</td>
</tr>
<tr>
<td>33</td>
<td>CADTF</td>
<td>3</td>
<td>2021</td>
<td></td>
<td>Receivable for Securities factor</td>
<td></td>
<td>Consider evaluating the factor every 3 years. (2021, 2024, 2027, etc.) Factors are exposed for comment. Comments due May 28, 2021 for consideration on June 30th. Factors adopted for 2021</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>CADTF</td>
<td>2</td>
<td>2022 or Later</td>
<td></td>
<td>NAC-Designation for Schedule D, Part 2 Section 2 - Common Stocks Equity investments that have an underlying bond characteristic should have a lower RBC charge? Similar to existing guidance for SVO-identified ETFs reported on Schedule D-1, are treated as bonds.</td>
<td>SAPWG</td>
<td>Referral period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.</td>
<td>10/11/2018</td>
</tr>
<tr>
<td>35</td>
<td>CADTF</td>
<td>2</td>
<td>2022 or Later</td>
<td></td>
<td>Structured Notes - defined as an investment that is structured to resemble a debt instrument, where the contractual amount of the instrument to be paid at maturity is at risk for other than the failure of the borrower to pay the contractual amount due. Structured notes reflect derivative instruments (i.e. put option or forward contract) that are wrapped by a debt structure.</td>
<td>SAPWG</td>
<td>Referral period ending 11/8/2019 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.</td>
<td>8/4/2019</td>
</tr>
</tbody>
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## Working Agenda Items for Calendar Year 2021

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<tbody>
<tr>
<td>36</td>
<td>CADTF</td>
<td>2</td>
<td>2022 or Later</td>
<td>Comprehensive Fund Review for investments reported on Schedule D Pt 2 Sn2</td>
<td>Referral from VOSTF 9/21/2018</td>
<td>Discussed during Spring Mtg. NAIC staff to do analysis. 10/8/19 - Exposed for a 30-day comment period ending 11/8/19 3-22-20 - Tabled discussion pending adoption of the bond structure and factors.</td>
<td>11/16/2018</td>
</tr>
</tbody>
</table>

### Carry-Over Items Currently being Addressed – Task Force

- Comprehensive Fund Review for investments reported on Schedule D Pt 2 Sn2
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Guidance for Evaluating the Accessibility and Transferability of Policyholder Data (Attachment Four-E) ......... 10-1035
Ransomware Guidance Document (Attachment Four-F) .................................................................................... 10-1044
The Examination Oversight (E) Task Force met Dec. 1, 2021. The following Task Force members participated: Judith L. French, Chair, represented by Dwight Radel (OH); Carter Lawrence, Vice Chair, represented by Joy Little (TN); Jim L. Ridling represented by Sean Duke (AL); Lori K. King-Heier represented by David Pfifer (AK); Alan McClain (AR); Evan G. Daniels represented by David Lee (AZ); Ricardo Lara represented by Susan Bernard and Laura Clements (CA); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by William Arfanis (CT); Karima M. Woods represented by N. Kevin Brown (DC); Dean L. Cameron represented by Eric Fletcher (ID); Amy L. Beard represented by Roy Eft and Jerry Ehlers (IN); Doug Ommen represented by Dan Matthiis (IA); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Jeff Gaither (KY); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by John Turchi (MA); Anita G. Fox represented by Judy Weaver (MI); Chlora Lindley-Myers represented by Shannon Schmoeger (MO); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Lindsay Crawford (NE); Chris Nicolopoulos represented by Colin Wilkins (NH); Russell Toal represented by Leatrice Geckler (NM); Glen Mulready represented by Eli Snowbarger (OK); Larry D. Deiter represented by Johanna Nickelson (SD); Cassie Brown represented by Shawn Frederick (TX); Scott A. White represented by David Smith and Doug Stolte (VA); Mike Kreidler represented by John Jacobson (WA); Mark Afable represented by Amy Malm (WI); and Jeff Rude represented by Linda Johnson and Doug Melvin (WY).

1. Adopted its Sept. 30 and Summer National Meeting Minutes

The Task Force conducted an e-vote that concluded on Sept. 30 to: 1) adopt its Summer National Meeting minutes; and 2) adopt its 2022 proposed charges.

Ms. Bernard made a motion, seconded by Ms. Malm, to adopt the Task Force’s Sept. 30 (Attachment One) and Aug. 5 (see NAIC Proceedings – Summer 2021, Examination Oversight (E) Task Force) minutes. The motion passed unanimously.

2. Adopted the Reports of its Working Groups

a. Electronic Workpaper (E) Working Group

Ms. Bernard provided the report of the Electronic Workpaper (E) Working Group. She stated that the Working Group met Nov. 16 in regulator-to-regulator session, pursuant to paragraph 4 (internal or administrative matters of the NAIC or any NAIC member) of the NAIC Policy Statement on Open Meetings, to continue work on its goals. She said the Working Group has continued to oversee and receive updates on the transition of the state insurance regulators’ workpaper documentation application. She encouraged state insurance regulators who wish to follow the progress of the transition to request to be added as an interested state insurance regulator.

b. Financial Analysis Solvency Tools (E) Working Group

Ms. Weaver provided the report of the Financial Analysis Solvency Tools (E) Working Group. She stated that the Working Group met Nov. 15 and conducted an e-vote that concluded on Oct. 12 to adopt revisions to the Financial Analysis Handbook on the following topics:

1. Liquidity Stress Test (LST): A new procedure and high-level guidance for the Lead State holding company analysis chapter was added to the previously adopted LST Framework and related Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450) revisions. This requests that the lead state review and determine if any concerns exist and, if necessary, seek further explanation from the insurer.

2. Group Capital Calculation (GCC): Guidance was included to incorporate the GCC into the analysis process, specifically to be utilized as an analysis tool, rather than a set of ratios.
c. **Financial Examiners Coordination (E) Working Group**

Mr. Radel provided the report of the Financial Examiners Coordination (E) Working Group. He stated that the Working Group met Nov. 29 in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

d. **Financial Examiners Handbook (E) Technical Group**

Ms. Bernard provided the report of the Financial Examiners Handbook (E) Technical Group. She stated that the Technical Group met Nov. 17 and Oct. 5 to adopt guidance for inclusion in the *Financial Condition Examiners Handbook* on the following topics:

1. Coordination Framework: The Coordination Framework was revised to clarify and simplify the roles and responsibilities of states that are or could be involved in a coordinated examination. As part of these revisions, the Technical Group expects to recommend that the Committee update its guidance related to the use of Exhibit Z for documenting exam coordination.

2. Completeness and Accuracy: The reserves and underwriting repositories were updated to enhance the procedures used for testing the completeness and accuracy of data. These updates reflect a broader range of testing procedures that auditors are using to test the completeness and accuracy of data, including placing more reliance on control testing and using analytical procedures.

e. **Information Technology (IT) Examination (E) Working Group**

Mr. Ehlers provided the report of the IT Examination (E) Working Group. He stated that the Working Group met Nov. 18 and Oct. 13 to adopt revisions on the following topics:

1. **Guidance within the Financial Condition Examiners Handbook:**
   a. Quality and Portability of Policyholder Data, in response to a referral from the Receivership Financial Analysis (E) Working Group:
      i. Sections 1–3 revised to include new guidance describing the importance of insurance companies maintaining data in a manner that would allow for the timely and efficient transfer of policyholder data, as well as tools that may be used in conducting this assessment.
      ii. Exhibit C – IT Planning Questionnaire and Instructional Notes were updated to include inquiries regarding comingled data and the accessibility and transferability of significant company data sets, as well as references to procedures within the IT work program that could be used in addressing related risks.
      iii. Exhibit C – Work Program was updated to include common controls, preliminary information requests, and possible test procedures regarding the accessibility and transferability of data.
   b. Ransomware and Other Cybersecurity Risks:
      i. Sections 1–3 revised to include new guidance describing ransomware and considerations for assessing an insurer’s overall cyber hygiene.
      ii. Exhibit C – Work Program was updated to include common controls, preliminary information requests, and possible test procedures regarding the nature of company backup systems and whether those backups are air-gapped and immutable.

2. **Cybersecurity Vulnerability Response Plan:** The *Cybersecurity Vulnerability Response Plan*, a new sound practices document which will be published on the Working Group’s public website, was developed in response to a referral from the Chief Financial Regulator Forum. This document provides additional guidance for assessing cyber vulnerabilities, including possible questions to ask insurers and procedures to perform if a cyber vulnerability is discovered in the period between full-scope examinations.

Mr. Kaumann made a motion, seconded by Mr. McClain, to adopt reports of the Electronic Workpaper (E) Working Group, the Financial Analysis Solvency Tools (E) Working Group (Attachment Two), the Financial Examiners Coordination (E) Working Group, the Financial Examiners Handbook (E) Technical Group (Attachment Three), and the IT Examination (E) Working Group (Attachment Four). The motion passed unanimously.

Having no further business, the Examination Oversight (E) Task Force adjourned into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities or individuals) of the NAIC Policy Statement on Open Meetings, to receive reports on exams open past 22 months.
The Examination Oversight (E) Task Force conducted an e-vote that concluded Sept. 30, 2021. The following Task Force members participated: Jim L. Ridling (AL); Alan McClain represented by Mel Anderson (AR); Ricardo Lara represented by Susan Bernard (CA); Andrew N. Mais represented by William Arfanis (CT); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Anita G. Fox represented by Judy Weaver (MI); Chlora Lindley-Myers represented by Shannon Schmoeger (MO); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Lindsay Crawford (NE); Chris Nicolopoulos represented by Doug Bartlett (NH); Russell Toal (NM); Glen Mulready represented by Eli Snowbarger (OK); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Larry D. Deiter represented by Johanna Nickelson (SD); Cassie Brown represented by Shawn Frederick (TX); Jonathan T. Pike represented by Jake Garn (UT); Scott A. White represented by David Smith (VA); Mark Afable represented by Amy Malm (WI); and Jeff Rude (WY).

1. **Adopted its 2022 Proposed Charges**

The Task Force conducted an e-vote to consider adoption of its 2022 proposed charges (see NAIC Proceedings – Fall 2021, Financial Condition (E) Committee, Attachment One-D).

The Electronic Workpaper (E) Working Group revised its existing charges to reflect that a replacement for the TeamMate AM workpaper application has been selected, and the Working Group will shift its focus to overseeing the transition process and monitoring the use of the new application (TeamMate+) going forward.

The Information Technology (IT) Examination (E) Working Group added a new charge to reflect a growing need to monitor cybersecurity trends and develop guidance for IT examiners, as necessary.

The motion passed unanimously.

Having no further business, the Examination Oversight (E) Task Force adjourned.
The Financial Analysis Solvency Tools (E) Working Group of the Examination Oversight (E) Task Force met Nov. 15, 2021. The following Working Group members participated: Judy Weaver, Chair (MI); Patricia Gosselin, Vice Chair (NH); Shelia Travis (AL); Kurt Regner (AZ); Michelle Lo (CA); Kathy Belfi (CT); Carolyn Morgan (FL); Eric Moser (IL); Roy Eft (IN); Debbie Doggett (MO); Dwight Radel (OH); Kimberly Rankin (PA); Jack Broccoli (RI); Amy Garcia (TX); and Kristin Forsberg (WI).

1. **Adopted its Oct. 12 Minutes**


Ms. Doggett made a motion, seconded by Mr. Radel, to adopt the Working Group’s Oct. 12 minutes (Attachment Two-A). The motion passed unanimously.

2. **Discussed and Adopted Exposed Liquidity Stress Test (LST) Revisions to the 2021/2022 Handbook**

Ms. Weaver summarized the Liquidity Stress Test (LST) Framework exposure draft guidance revisions for the 2021/2022 edition of Handbook. The LST Framework and the related holding company models revisions were adopted by the NAIC earlier in 2021. Ms. Weaver provided two possible solutions to the text for consideration.

Ms. Weaver said a comment letter was received from America’s Health Insurance Plans (AHIP) on the proposed revisions to the draft LST guidance.

Tom Finnell (AHIP) summarized AHIP’s concerns and recommended additional guidance to caveat the scope criteria section of the guidance to clarify that the criteria would not be appropriate to health insurers and property/casualty (P/C) insurers as the LST guidance is more related to life insurers. Ms. Belfi agreed that a caveat may be needed to clarify the textual guidance for the Handbook. Mr. Eft also agreed that a caveat may be appropriate.

Todd Sells (NAIC) clarified that the LST Framework guidance on scope criteria was drafted so that the insurer group determined whether a P/C or health insurer entity is deemed to pose a material liquidity risk to the U.S. insurer group that triggered the scope criteria in a future year; then the P/C and health legal entity insurer within the group will perform the LST.

Mr. Finnell recommended a textual clarification to the scope criteria of the LST guidance to include the text “by the insurer group” to further clarify the scope criteria. The Working Group agreed with the clarification to the guidance.

Ms. Forsberg made a motion, seconded by Mr. Eft, to adopt the LST guidance (Attachment Two-B) with the recommended revision (Attachment Two-C). The motion passed unanimously.

3. ** Adopted GCC Framework Guidance to the Handbook**

Ms. Weaver summarized the Group Capital Calculation (GCC) Framework guidance developed by the Group Capital Calculation Drafting Group and recently adopted by the Group Capital Calculation (E) Working Group. Ms. Weaver explained that the guidance was envisioned as more of an analytical tool and beneficial to incorporate the GCC framework guidance into the analysis process. The GCC guidance was considered for inclusion in the 2021/2022 edition of the Handbook revisions. There were no comments received.
Ms. Belfi made a motion, seconded by Ms. Travis, to adopt the GCC guidance as adopted by the Group Capital Calculation (E) Working Group (Attachment Two-D and Attachment Two-E) and incorporate the guidance into the 2021/2022 Handbook revisions. The motion passed unanimously.

Having no further business, the Financial Analysis Solvency Tools (E) Working Group adjourned.
The Financial Analysis Solvency Tools (E) Working Group of the Examination Oversight (E) Task Force conducted an e-vote that concluded Oct. 12, 2021. The following Working Group members participated: Patricia Gosselin, Vice Chair (NH); Kurt Regner (AZ); Michelle Lo (CA); Lynn Beckner (MD); Debbie Doggett (MO); John Sirovetz (NJ); Tim Biler (OH); Kimberly Rankin (PA); Jack Broccoli (RI); Amy Garcia (TX); and Kristin Forsberg (WI).

1. **Adopted Exposed Revisions to the 2021/2022 Financial Analysis Handbook**

The Working Group conducted an e-vote to consider adoption of the exposed revisions to the 2021/2022 Financial Analysis Handbook.

A majority of the Working Group members voted in favor of adopting the revisions. The motion passed.

Having no further business, the Financial Analysis Solvency Tools (E) Working Group adjourned.
VI.C. Group-Wide Supervision – Insurance Holding Company System Analysis Guidance (Lead State)

Liquidity Stress Test

In 2021 the NAIC Executive Committee and Plenary adopted revisions to the *Insurance Holding Company System Model Act* (Model #440) that introduce a new filing requirement for a Liquidity Stress Test (LST). While insurer and insurer groups within the scope of the LST will submit required filings in 2021 under states’ examination authority, states are beginning the process of adopting Model #440 amendments into state laws. Additional lead state and non-lead state guidance will be developed in future years as regulators gain experience reviewing the LST filing.

Scope Criteria and LST Framework

- The Scope Criteria for insurers or insurance groups required to perform and file the LST and the instructions for the filings are outlined in the *NAIC 2020 Liquidity Stress Test Framework* which is located on the Financial Stability (E) Task Force webpage of the NAIC’s Website at: https://content.naic.org/cmte_e_financial_stability_tf.htm. Once an insurance group with two or more life insurers triggers the Scope Criteria for a specific year, then the LST is performed at the legal entity insurer level within the group. Results are aggregated at the group level.
- Property/Casualty and Health: Although the property/casualty and health insurers are not subject to the scope criteria in 2021, if a property/casualty or health legal entity insurer is deemed, by the insurer group, to pose material liquidity risk to a U.S. group that triggered the scope criteria in a future year, then the property/casualty and health legal entity insurer within the group will perform the LST.

Regulatory Goals of the LST per the *NAIC 2020 Liquidity Stress Test Framework*

The primary goal of the LST, and the specific stress scenarios utilized, are:

- First, for macroprudential uses – to allow the Financial Stability (E) Task Force to identify amounts of asset sales by insurers that could impact the markets under stressed environments. Thus, the selected stress scenarios are consciously focused on industry-wide stresses – those that can impact many insurers within a similar timeframe.
- Second, the liquidity stress testing is also meant to assist regulators in their micro prudential supervision, in the context of being helpful for domiciliary and lead state regulators to better understand liquidity stress testing programs at those legal entities’ insurers and insurance groups. The LST requires filing of reporting templates and other narrative disclosures referenced in the LST Framework to be submitted to the lead state by September 30.

Non-Lead State Reliance on the Lead State Analysis of LST

- The LST must be reviewed by the lead state and significant findings should be incorporated into the GPS branded risk assessments.
- To reduce duplication, non-lead domestic states may rely on the analysis work performed by the lead state.
- Because the LST is performed at a legal entity insurer level and aggregated on an insurance group level, if material risks and concerns are identified for a legal entity insurer, the lead state should communicate those concerns to the non-lead domestic state.
While the LST filing may provide good insights into a legal entity insurer’s assumptions, processes and worst case stress scenario results; a domestic state’s assessment of liquidity risk for the legal entity insurer should not rely solely on the LST. It is acceptable that a legal entity insurer may have its own liquidity stress test scenarios and manage liquidity differently from what is reported for the LST.

11. Liquidity: Evaluate the insurance holding company’s liquidity and document any negative trends and overall strength.

Liquidity Risk—e.g., assessment of cash flow trends; cash and short-term investments held; indications of liquidity shortfalls reflected in quantitative ratios (i.e., liquidity ratio); liquidity needs for high surrender activity impacted by economic changes; liquidity needs created by catastrophic events; liquidity requirements for future debt payments; available lines of credit; stress testing.

PROCEDURE #11 assists analysts in evaluating the liquidity of the group. Liquidity is important for any type of organization, but can be more important for others, including certain insurers or types of insurers who may have products or other aspects of their business plan that make them susceptible to immediate withdrawals. Having said that, most insurers’ cash flows are predictable, and it is an area that insurance regulation or business practices already address, including asset/liability matching required for life/annuity writers and the maintenance of very liquid assets. But this procedure requires an analysis that can generally only be conducted through understanding information developed by the group, which may be available through the risk-focused examination or otherwise requested by analysts. Updated information may be the best obtained in the periodic meeting with the group as discussed within Section VI.F. Own Risk and Solvency Assessment (ORSA) Procedures, unless the group is more susceptible to immediate withdrawals, in which case analysts may want to obtain/discuss the issue with the group sooner. Generally, issues impacting liquidity that are identified through holding company analysis should be presented within the Liquidity Risk classification of branded risk assessments.

12. Liquidity Stress Test (LST):

a. If the insurance group is subject to the requirements to perform and file an LST, review and determine if any concerns or material risks exist regarding the liquidity of the insurance group or any of its insurance legal entities performing the LST.

b. If concerns or material risks are identified, consider requesting further explanation from the insurance group about its liquidity risk management framework and internal liquidity stress tests.

PROCEDURE #12: The procedure instructs the analyst to review the results of the stress test scenarios included in the Liquidity Stress Test (LST) filing to supplement the assessment of the insurance group’s overall liquidity. Because the LST is performed at a legal entity level and risks are aggregated for the group, assess if the results of the LST identifies material risks at the insurance legal entity that should be included in the analysis and/or communicated to the non-lead state domestic state insurance regulator.

The instructions for the LST filings are outlined in the NAIC 2020 Liquidity Stress Test Framework which is located on the Financial Stability (E) Task Force webpage of the NAIC’s Website at: https://content.naic.org/cmte_e_financial_stability_tf.htm.
October 27, 2021

Judy Weaver, Chair
Financial Analysis Solvency Tools (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

By e-mail to Ralph Villegas at: RVillegas@NAIC.org


Dear Ms. Weaver;

This submission is in response to the September 28, 2021, exposure by the Financial Analysis Solvency Tools (E) Working Group (FASTWG). The exposure relates to proposed guidance about Liquidity Stress Test (LST) filings that has been drafted for inclusion in the NAIC’s Financial Analysis Handbook (FAH) for eventual use by financial analysts of state insurance departments.

We understand that the intended focus of LST filings is on life insurers or groups that have triggered the activity-based scope criteria which has been set forth in the NAIC 2020 Liquidity Stress Test Framework. Indeed, and as noted in the exposure, “….property/casualty and health insurers are not subject to the scope criteria in 2021…” However, the proposed text then says as follows: “…if a property/casualty or health legal entity insurer is deemed to pose material liquidity risk to a U.S. group that triggered the scope criteria in a future year, then the property/casualty and health legal entity insurer within the group will perform the LST.”

While the text cited above refers to both health and property/casualty insurers, the following comments pertain specifically to health insurers and health plans, many of which are members of AHIP.

AHIP and its members find it difficult to foresee any plausible situation where a health insurer would “pose material liquidity risk to a U.S. group.” The business model of health insurers is very much focused on generating and managing cash flows from insured individuals and groups that is then used almost immediately to pay claims. To illustrate, based on 2020 data for the health sector, of claims incurred during the full calendar year, less than two months of those incurred claims remained unpaid and in reserve liabilities at the end of the year.

Put differently, there is very little need for health plans to accumulate and hold invested assets other than to support surplus and to cover unanticipated or emerging risks. As a result, health plans do not participate to any material degree (if at all) in the type of activities that the LST scope criteria has targeted, i.e., fixed and indexed annuities, funding agreements, derivatives, securities lending, repurchase agreements, and borrowing of money.
The LST scope criteria has identified those specific criteria as relevant to life insurers, has previously subjected them to testing, and has also included defined activity levels or dollar thresholds that would trigger an insurer or group being “in scope” for LST. That however is not the case for health insurers. Neither the exposure nor the NAIC 2020 Liquidity Stress Test Framework suggests any health-specific activities that could plausibly indicate liquidity stress of a health plan, much less indicate a level of such activity that might signal potentially material risk or subject either to testing. Consequently, an analyst’s determination that a “health legal entity insurer is deemed to pose material liquidity risk to a U.S. group” would, by necessity, be arbitrary inasmuch as there would be no pertinent guidance in the Financial Analysis Handbook.

Accordingly, AHIP objects to the language proposed by the exposure that could “scope-in” health insurers if they are “deemed to pose material liquidity risk to a U.S. group.”

If there are specific concerns that the FASTWG has about potential liquidity risks that health insurers might pose, AHIP would be glad to engage with members to address them. If we know what those concerns are, AHIP could suggest changes to the text that would provide criteria relevant to health plans and which would address those concerns. But as stated previously, and at the current time, AHIP and its members cannot foresee any plausible situation where a health insurer would “pose material liquidity risk to a U.S. group.”

We thank you again for the opportunity to comment and for your consideration of our views. We look forward to discussing them with you and the Working Group members.

Sincerely,

Bob Ridgeway
Bridgeway@ahip.org
501-333-2621
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

Review of the Group Capital Calculation

Consideration of the Insurance Holding Company System Structure

As the lead state begins to review the annual Group Capital Calculation filing for a particular group, it is important for the lead state to do so with consideration of the existing knowledge of both the organizational structure of the group, including changes in the structure from year to year, but more importantly the overall activities of each of the entities in the group which otherwise have the potential to transmit material risk to the insurers within the group. While the GCC will provide additional quantitative information on the entities in the group, the actual activities of the entities are also important in determining the scope of application of the GCC. The lead state is responsible for determining if any of the entities in the holding company structure should be excluded from the calculation, resulting in a smaller “scope of application” for the entities included in the GCC ratio. The filing includes a column for the group to propose what should be excluded as well as an additional column for the final determination made by the lead state. In general, the determination of scope of the application is suggested by the group but made in consultation and agreement with the lead state. This exercise should be undertaken in a manner that yields a clearly documented rationale for excluding entities or subgroups of the larger group. The Group Capital Calculation Instructions describes the basis for making this determination and the calculation itself is structured to facilitate this determination, with the inclusion in Schedule 1 of financial data for all entities within the holding company. Related to exclusion from the calculation itself is review of data for cases in which subgroups are completely excluded from the larger group, particularly with regard to Schedule 1; the rationale for the exclusion(s) should be provided in the GPS. The concept is that this Schedule 1 data should be utilized by the lead state in conjunction with its existing knowledge of the group and its activities (obtained from the Schedule Y, ORSA, Forms B/C, Form F, the non-insurance grid, etc.), and therefore likely material risks, to make this determination. To the extent the entities included in Schedule 1 differ from the analyst’s knowledge of the Group, further discussion and follow-up should be held with the group.

In the initial year(s) of a GCC filing, to help the analyst get comfortable with the Inventory and Schedule 1 process, consider the following:

- Gather appropriate background information for your group(s) (e.g., Group Profile Summary, ORSA, RBC Reports, Schedule Y)
- Determine that all Schedule Y entities are listed in schedule 1 or in the schedule BA list in the other information tab or that an entity’s omission is understood/explained
- Evaluate requests for exclusion of non-insurance/non-financial entities without material risk to determine if you agree with exclusion.
- Confirm that all insurers and financial entities are de-stacked in the inventory tab.
- Determine if grouping has been properly applied.
- Evaluate the level of risk assigned by the filer to financial entities without regulatory capital requirements.
- On a sample basis, check that the numbers reported in Schedule 1 and Inventory Tab look reasonable, especially for the insurers. A sample check should be sufficient.

The holding company structure and activities should also be utilized by the lead state in determining how to understand the GCC ratio. More specifically, information on structure can help in understanding the flow of capital used by the group among entities within the holding company structure. Also, understanding the following can assist in evaluating the flow of capital resources:
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

- Domestic insurance operations
- International insurance operations
- Banking or other financial services operations subject to regulatory capital requirements
- Financial and non-financial operations not subject to regulatory capital requirements*

*The GCC instructions provide examples of financial versus non-financial entities in this category. All financial entities should be included in the scope of application of the GCC. However, there can be a broad array of entities that could be considered financial. The lead state should document the rationale for cases in which it concludes that an entity that may be financial in nature can nonetheless be classified in the group’s GCC filing as “non-financial” and thus excluded from the scope of the group for the GCC.

The GCC is intended to be used as an input into the GPS. The expectation is that the GCC summary section will help to document a high-level summary of the analyst’s take away of the GCC, as well as the Strategic branded risk. The manner in which the analyst determines what else should be documented beyond the GCC Summary and the Strategic branded risk should be based upon the following steps, since these steps contemplate the previously mentioned concept that the existing evaluation of the financial condition should be used in evaluating the depth of review of the GCC.

The GCC is a new analytical tool for use by regulators and it will take a number of years before there is both (1) sufficient data for any given group to provide the trend identification ultimately anticipated for the GCC; and (2) experience by regulators with its use. Analysts should be mindful that any stated threshold in the following procedures is for analysis purposes only and DOES NOT constitute a trigger for regulatory action. Rather, the stated threshold should be used as an opportunity for an analyst to understand issues and concerns that may be emerging and address them with the group, if needed. Nonetheless, the following procedure steps provide analysts with a framework to consider the GCC results in conjunction with other data and tools at their disposal, and to begin to gain and benefit from experience in utilizing the GCC as a new analytical tool.

- Procedure Step 1 suggests that a review of the components of the GCC is appropriate when the GCC ratio is trending downward.

- When Procedure Step 1 identifies the need to look further, Procedure Step 2 suggests determining, at a high level, the drivers of any decreases in the total available capital pursuant to the GCC. While there are numerous benefits of the GCC over consolidated approaches, the ability to drill down on the drivers is one of the more significant and is consistent with the states’ approach to not just looking at capital, but to the drivers of capital issues.

- When Procedure Step 1 identifies the need to look further, Procedure Step 3 suggests determining, at a high level, the driver of any increases in operating leverage, which is typically what drives insurance capital requirements up, be it asset risk/leverage or writings leverage. Similar to drivers of capital decreases, the GCC has detailed information on financial figures and ratios that can be used to isolate the issues.

- When either Procedure Step 2 or Step 3 identify the need to understand the situation better, Procedure Step 4 is similar in that it utilizes detailed information on capital allocation patterns used by the group over time that are necessary for the analyst to understand if there are any future negative trends in the GCC.

- When Procedure Steps 2, 3 and 4 together identify the need to understand the situation better, Procedure Steps 5, helps understand the steps the group/company is already taking or plans to take in order to address the issues they feel are appropriate, if any, considering existing capitalization levels may drive the group’s
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

evaluation and therefore when steps may not be necessary. The guidance provided in these procedures is not intended to be exhaustive, but rather should give the analyst a starting point in better understanding the various issues.

- The guidance in these procedures is not intended to be exhaustive, but rather should give the analyst a starting point in better understanding the various issues.

- If the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document their understanding of the material risks of the group observable from the GCC (as well as the required information to be included in all GPS from the GCC), the rational for this determination should be documented by the analyst in any workpapers deemed appropriate by the state. In making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner and judgement based upon and existing understanding of the group and existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that decision.

Procedure Step 1-Understand the Adequacy of Group Capital

1. Determine if the group capital position presents a risk its insurance subsidiaries based upon its recent trends and/or current measures in the GCC ratio.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Has there been a decrease in the GCC ratio over last two or more years? If “yes”, determine the cause(s) of the decline.</td>
<td>ST</td>
</tr>
<tr>
<td>b. Has there been a decrease in the GCC Total Available Capital from prior year? If “yes”, determine the cause(s) of the decline.</td>
<td>ST</td>
</tr>
<tr>
<td>c. Has there been a negative trend in the GCC ratio over the past five years suggesting an overall pattern of declining capital?</td>
<td>ST</td>
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</tbody>
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If the answer to any of the above questions is “yes”, but it is obvious that the negative trend is caused by something such as a restriction on the allowable debt, or a change in a corporate tax rate, or some other factor external to the group’s operations, note as such but do not proceed to step 2. In addition, if it is obvious that the negative trend is clearly driven from one entity in the group, understand the cause and document as such but do not proceed to step 2. However, in all other cases if the answer to any of the above questions is “yes”, the analyst should proceed with procedure step 2, understanding decreases in total GCC available capital and/or procedure step 3, understanding increases in leverage to determine the cause(s) of the negative trends.
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

Procedures Step 2-Understand Decreases in Total Available Capital

2. **Determine the source(s) of decreases in the GCC ratio or the GCC Total Available Capital**

Recognizing that not all declines in capital ratios are necessarily “negative”, i.e., they may be the result of sound capital management and ERM to more efficiently utilize capital, approved changes in the scope of application, or changes in underlying authority requirements, the intent of step 2 (and step 3) is to determine the actual source of the negative issues. In most cases, this equates to pinpointing the legal entity(ies) driving any negative trends. The analyst should proceed to steps 4 and 5, to understand more fully the actions the group, or the legal entity(ies) driving the negative trends, are already taking or plan to take to address the issues identified in step 2 that the group believes is needed. However, the analyst may already have a deep understanding of any such plans, and as a result, in some cases, it is possible that no further follow-up with the group will be necessary and that the lead state should simply update the GPS to be certain the main understanding of the issues is known to all of the regulators utilizing the GPS.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Review the ratio of available capital to calculated capital from each of the reported entities and compare to the same ratio from the prior year. Determine which entities may have led to the negative trends.</td>
<td>&lt;-10%</td>
</tr>
<tr>
<td>b. If the change in the GCC is not driven from a legal entity, and instead the change in allowable debt, note as such.</td>
<td>ST N/A</td>
</tr>
<tr>
<td>c. Review the levels of profitability for each of the reported entities in the GCC in the current and prior years (as reported in the GCC) to determine if there are particular entities showing losses or signs of material decreasing profitability which may eventually lead to future decreases in the GCC ratio or total available capital.</td>
<td>OP, PR/UW &lt;-10%</td>
</tr>
<tr>
<td>d. For each of the reported entities showing either 1) a meaningful decrease in the GCC due to a decrease in the total available capital, or 2) material negative profitability trends, request information that identifies the issues by inquiring of the legal entity regulator first or the group itself (e.g., non-insurance company), if applicable.</td>
<td>OP, PR/UW, ST N/A</td>
</tr>
<tr>
<td>e. If due to pricing or underwriting issues, understand if the issues are the result of known pricing policies that are currently being modified or if the business is in runoff, whether new product lines, or geographic or other concentrations, volume/growth business strain, or other issues. When considering pricing that is being modified, include those products for which the price is adjusted through crediting rates.</td>
<td>PR/UW N/A</td>
</tr>
<tr>
<td>f.</td>
<td>If due to reserve issues, understand the reserve development trends, whether reserve and pricing adjustments have been made as well as changes in business strategy apart from those products.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>g.</td>
<td>If due to market risk issues—i.e., capital losses—understand not only why the losses occurred, but the likely near-term impact given current and likely prospective economic conditions. Market issues include not only changes in equity prices, but also impact/exposure to interest rates and other rates such as foreign currency exchange rates or rates on various hedging products used by the group.</td>
</tr>
<tr>
<td>h.</td>
<td>If due to strategic issues such as planned growth, planned decline in writings or changes in the investment strategy, utilize the business plan from the Form F to better understand the anticipated changes and how the actual changes compare. Understanding the variance from the business plan is important in assessing the ongoing risk either in projected future profitability or in some cases the investments.</td>
</tr>
<tr>
<td>i.</td>
<td>If due to negative reputational issues, for example, have adversely impacted new business or retention of existing business, understand the issues more closely, whether potential ongoing changes in stock prices or financial strength ratings that may further impact market perception, or what the group is doing to address the potential future impact be it sales projections or access to the capital markets.</td>
</tr>
<tr>
<td>j.</td>
<td>If due to credit losses, understand the current and future concentration in credit risks, be it investments, reinsurance, or other source of credit losses.</td>
</tr>
<tr>
<td>k.</td>
<td>If due to operational issues, such as extremely large catastrophe events, IT or cybersecurity events or relationships, understand the current and prospective impact.</td>
</tr>
<tr>
<td>l.</td>
<td>If due to legal losses, understand the underlying issues and degree of potential future legal losses.</td>
</tr>
<tr>
<td>m.</td>
<td>If due to non-insurance reported entities in the group, understand the relationship of the non-insurance operations to the insurance entities and the potential impact to the insurance operations (i.e., intercompany agreements, services, capital needs, etc.).</td>
</tr>
</tbody>
</table>
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

**Procedure Step 3-Understand Increases in Operating Leverage**

3. **Determine the source(s) of any decreases in the GCC ratio due to increases in leverage**

Like step 2, the intent of step 3 is to determine the actual source of the negative issues. The difference between step 3 and step 2 is simply the types of issues. Step 2 is focused on issues that have resulted in negative capital trends. Step 3; however, is focused on the issues that impact the risk being considered in the GCC. In most cases that risk is either from the asset side or from the liability side where in both cases there has been an increase in such risk that has not been offset by a corresponding or equal increase in capital. In general, this is referred to as operating leverage, where this risk can manifest itself either through increased insurance writings (e.g., the ratio of premiums to capital or liabilities to capital), or through increased assets that also carry risk. The expectation is that other regulated entities also have capital requirements that increase as these different types of risks increase, similar to how the NAIC RBC considers different types of products and assets that carry more risk. It is also possible to have increased leverage outside of the insurance companies and other regulated entities. However, similar to other items noted in this document, such increases do not necessary represent negative trends; the analyst should further understand the drivers of such. In most cases, this equates to pinpointing the legal entity(ies) driving any negative trends. Similar to step 2, using an understanding of items in Procedure Step 4, to understand more fully the actions the group, or the legal entity(ies) driving the negative trends already being taken or planned to be taken by the group to address the issues identified in step 2 that the group believes is needed.

<table>
<thead>
<tr>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Review the ratio of available capital to calculated capital from each of the reported entities and compare to the same ratio from the prior year. Determine which entities may have led to the negative trends based upon corresponding increases in leverage (e.g., writings/capital ratios or liability to capital ratios).</td>
<td>MK, CR, RV, ST, OP, RP</td>
</tr>
<tr>
<td>b. Review the levels of operating leverage for each of the reported entities in the GCC as well as the same for the prior years as reported in the GCC to determine if there are particular entities showing signs of increasing operating leverage which may lead to future decreases in the GCC ratio or total available capital.</td>
<td>MK, CR, RV, ST, OP, RP</td>
</tr>
<tr>
<td>c. For each of the reported entities contributing to a meaningful decrease in the GCC due to an increase in operating leverage, request information that identifies the issues by inquiring first from the legal entity regulator or the group itself (e.g., non-insurance company), if applicable.</td>
<td>MK, CR, RV, ST, OP, RP</td>
</tr>
<tr>
<td>d. If operating leverage has increased, consider if growth may have resulted from underpriced products or a change in underwriting. Specifically inquire to determine if pricing was reduced to increase sales, or whether the growth is in new product lines or new geographic focus where the group may not have expertise. When considering pricing being modified, include those products that the price is adjusted through crediting rates.</td>
<td>PR/UW, OP, ST</td>
</tr>
</tbody>
</table>
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

<table>
<thead>
<tr>
<th></th>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.</td>
<td>RV</td>
<td>N/A</td>
</tr>
<tr>
<td>f.</td>
<td>CR, MK</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The analyst should proceed to steps 4 and 5 to understand more fully the actions by the group, or the legal entity(ies) driving the negative rend, are already taking or plan to take to address the issues identified in step 3, if that is not already clear from the information obtained in step 3. However, in some cases, it is possible that no further follow up with the group will be necessary, and that the lead state should simply update the GPS.

Procedure Step 4-Understand the Capital Allocation Patterns

4. Determine the capital allocation patterns to determine if some entities may put pressure on other legal entities.

Steps 2 and 3 are critical in understanding the issues faced by the group and in identifying the source of negative trends; and while additional follow up with the group is expected, before proceeding to Step 5, the lead state should understand the historical capital allocation patterns within the group and the future capital allocation actions that may be needed by the group if negative trends continue. The GCC includes data on historical capital allocation patterns (e.g., contributed capital received/paid or dividends received/paid), which help to illustrate which entities have historically needed more capital and which entities have capital that they have provided other entities in the group. While these patterns do not necessarily repeat themselves from one period to the next, there is often consistency in terms of entities that need capital or have excess capital, which may or may not be driven by losses, or by a change in strategy (e.g., increased writings at one company over another) by the group. These trends can also assist in discussions with the group about where capital may come from as a result of a future unexpected material event. Where similar information is also disclosed in Form F, the detail in the GCC may confirm what is already known by the analyst in this area and in some cases may provide greater detail.

<table>
<thead>
<tr>
<th></th>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>ST</td>
<td>N/A</td>
</tr>
<tr>
<td>b.</td>
<td>OP, ST</td>
<td>N/A</td>
</tr>
</tbody>
</table>
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

Procedure Step 5-Consider the Need for Company Discussions for Reductions in Risk

5. Determine the group’s plans for addressing source(s) of any meaningful decreases in the GCC ratio or total GCC available capital. Please note, in some cases, the plan may be as simple as actions designed by the group to reverse a single negative trend.

Steps 5 is designed to assist in understanding the group’s plans for addressing any meaningful decreases in the GCC ratio or total available capital that were not intended by the group (i.e., that are not the results of capital management so as to efficiently utilize capital while still maintaining sufficient levels for Enterprise Risk Management needs). The specific plans of the group may or may not fully address all the issues but to the extent the group believes they have addressed what is needed, ultimately what is most important is that such information and the regulators plan for evaluating and monitoring the situation is known to the other regulators. There is a multitude of possibilities, and this guidance is not intended to address all of those. This includes the possible actions by the group and its legal entities. This also includes the possible actions to be taken by the regulators of the individual legal entities, which may include regulators choosing to put their legal entity into supervision, conservation, or some other form of receivership (which, by necessity and intent, would presumably be done based upon existing legal entity authority since there is no authority provided under the GCC). Similar to other areas, where similar information is also disclosed in Form F, further information may already be known in this area.
### VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State) Procedures

<table>
<thead>
<tr>
<th>Step</th>
<th>Branded Risk</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>ST</td>
<td>N/A</td>
</tr>
<tr>
<td>b.</td>
<td>ST</td>
<td>N/A</td>
</tr>
<tr>
<td>c.</td>
<td>ST</td>
<td>N/A</td>
</tr>
<tr>
<td>d.</td>
<td>ST</td>
<td>N/A</td>
</tr>
<tr>
<td>e.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>f.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>g.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>h.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

- a. Obtain a copy of the group’s most recent business plan and compare it to the prior year plan for variances. (See Additional Procedures below for additional follow-up analysis)

- b. Request information from the group on how it intends to address the issues or negative trends (those that are not planned or due to approved changes to the GCC scope of application or the result of changes in underlying legal entity capital requirements) identified in Steps 1-3. More specifically, determine how the group intends to decrease risk, and by what means.

- c. Based on information received in S.b., determine the group’s capacity to reduce risks or raise additional capital.

- d. Where the remaining capital is adequate, document the findings in the GPS (or another document) and make available to the supervisory college and or domestic states with the presumption no further action is deemed necessary.

- e. Consider whether the collective information suggests that any of the U.S. legal entity regulators should deem the legal entity to be in a “Hazardous Financial Condition” and take appropriate action to address based upon the facts and circumstances and the provisions of the state’s law (similar to NAIC Model 385).

- f. Where appropriate, consider holding a meeting of the supervisory college or of all the domestic states to fully understand the group’s plans. Where appropriate, require the group to present its plans to the supervisory college or all the domestic states.

- g. Where appropriate, determine if the plans proposed by the group are considered inadequate by any of the legal entity regulators, and more specifically if any are considering taking action over their applicable legal entity. If this is the case, hold a meeting of the supervisory college or of all the domestic states to provide this information.

- h. Where appropriate, consider holding a broader meeting of all impacted jurisdictions in which the group is selling insurance. Where appropriate, require the group to present its plans to all such regulators and for the regulators to announce their plans.
Purpose of the Group Capital Calculation (GCC) in Holding Company Analysis

The following information is intended to provide background and context concerning the issues/considerations for analysts when utilizing the NAIC Group Capital Calculation (GCC) for an insurance holding company group (hereafter referred to as “group”) completing the GCC where required. The GCC is a tool to quantitatively understand the group’s capital and the mathematically calculated risks within the group. The GCC framework is built on the RBC model; however, while RBC, as a capital requirement, has triggers in states’ laws to take formal actions, the GCC is not designed for that purpose and is instead designed as an analytical tool.

Background Information

In 2008, the NAIC Solvency Modernization Initiative (SMI) began to consider whether there were any lessons learned from the financial crisis that would cause the solvency framework to be modified. The NAIC determined that changes should be made in the area of group supervision, starting with the new annual requirement for the Lead State of each group operating in the U.S. to complete a written holding company analysis. Since that time, other changes to state laws have been made to further enhance group supervision (e.g., Form F, ORSA, and Corporate Governance reporting). All of these new tools are inputs into the previously mentioned holding company analysis, which is now summarized into a consistent tool used by all states that is known as the Group Profile Summary (GPS).

Benefits of the GCC & Methods to Achieve Them

The Group Capital Calculation Instructions describes the background, intent, and calculation for the GCC in detail. As stated in the Group Capital Calculation Instructions, the GCC and related reporting provides more transparency about a group’s structure and related risks to insurance regulators and makes those risks more identifiable and more easily quantified. In this regard, this tool is intended to assist regulators in better understanding the risks that the non-insurance entities may pose to the group and ultimately regulated insurance entities, how capital is distributed across an entire group, and whether and to what degree insurance companies’ capital may be put at risk from the operations of non-insurance entities, potentially undermining the insurance company’s financial condition. An analyst is not expected to understand non-insurance industries represented within the group but is expected to understand through this calculation if a non-regulated entity could place pressure on or provide relief to a regulated entity.

The manner in which the GCC achieves some of these intentions varies. For example, with regard to understanding how capital is distributed across an entire group, this can be seen in two ways. One is by viewing the Tab titled “Input 4-Analytics” for the display of the “Ratio of Actual to Required Capital”. The other is by viewing the same Tab for the display of “Required Capital” in a separate column. The degree of capital movement can also be seen in the “Input 4-Analytics” tab, with the display of the columns as follows: 1) Capital Contributions Received/(Paid); 2) Net Income. While one year of information can provide insights, a better understanding will be obtainable after further years of the GCC are reported within the template. Once five years of data are displayed in this “Input 4-Analytics” tab, it will allow the analyst to better understand the financial condition of the group as a whole as well as the risks posed by non-insurance entities in the group. Of course, such conclusions can only be made once the analyst sees the data and understands from the group what is occurring that is leading to such figures.
Recognizing that legal entity supervision and related tools (e.g., RBC) are the primary means to address inadequate capital, the GCC may provide an additional early warning signal to regulators regarding risks or activities of non-insurers within the group that may pose material risk to the insurance operations. This early warning signal can be seen with the trending of the financial information in the “Input 4-Analytics” tab as well as through the application of sensitivity analysis in the Input 5 Tab and inclusion of other relevant information in the Input 6 Tab. However, the analyst should also understand that other qualitative tools, such as the Form F, are capable of also providing early warning signals if properly reported by the group. In addition, since most holding company systems may have a larger percentage of their operations in the insurance businesses, the insurance trends for the U.S. insurers in the group should already be known and made available to the lead-state by the legal entity regulator(s) of the insurer(s). However, in the context of added policyholder protection, this may largely come into play with respect to the added quantitative data about non-insurers.

The GCC is an additional reporting requirement with important confidentiality protections built into the legal authority to require such reporting. State insurance regulators already have broad authority to take action when an insurer is financially distressed, and the GCC is designed to provide regulators with further insights to allow them to make informed decisions on both the need for action, and the type of action to take, as to the regulated entity, or additional requests for information from other entities. That said, the GCC and its related provisions in the NAIC’s Model Holding Company Act and corresponding regulation are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group’s GCC. Regulators will use other existing tools and authorities to take action, primarily at the legal entity level.

While the new information from the GCC may offer new insights, it is equally important to understand that it will be up to the analyst to work with the insurance group to actually understand what is leading to the figures reported in the GCC, and from that perspective, especially in the early years of the GCC, it will require learning by both the analyst and the group to really be able to utilize the GCC in a manner as suggested in these introductory paragraphs.

Other Considerations When Considering Such Benefits

Unforeseen events and economic conditions (e.g., pandemic, recession, etc.) may also create stresses on a group, reinforcing the value of the quantitative data included in the GCC. Some stresses are similar to those experienced during the financial crisis and others are more unique. However, because the GCC is based upon a methodology that gets its inputs from individual legal entities, the capital calculated for each legal entity certainly can only capture the allowed capital resources of the legal entities in the group. While such an aggregation-based methodology is an appropriate group-level capital measure, until experience is gained with the GCC, it is not known how the GCC will behave in response to business cycles and various risk events, in part because it only recognizes limited diversification benefits among entities in the group except for the diversification embedded in existing entity specific regulatory capital requirements. And while the GCC is not meant to be used in a way that compares groups to each other, it is also true that it is unknown how it will behave across groups, peers and even sectors. This is true because of its limited diversification benefit, the differences between group types (mutual v. stock holding company), grouping of entities, and scope of entities included in the calculation. It is also true because application of jurisdictional accounting principles and use of scalars could have an impact on this as well via the foreign insurer profile of the group. The quantitative data collected in the GCC will evolve as state insurance regulators and groups increase their understanding of the impact on available capital and calculated capital.
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

The following guidance on the GCC is intended to be utilized in a manner that allows the GCC to enhance group-wide financial analysis and to be used as an additional input into the GPS. The GCC provides the quantification of risk within the group and when combined with the information from the ORSA on the amount of capital needed to run the company’s current business model and related risk appetite, puts the regulator in a much better position to understand the available capital and calculated capital within a group, as well as the financial condition of the group. Both are complementary tools to each other. The ORSA provides management’s internal approach to capital management and an understanding of the economics of the group. The GCC provides a standard model that can better enable the analyst to understand where the entire group stands with respect to existing legal entity requirements as well as broad measures of risk for non-insurers. Analysts should be mindful of the differences between the ORSA and the GCC. For example, in the case of a group with predominantly U.S. operations, the GCC will largely be based on the standard model/RBC of the U.S. subsidiaries. However, the ORSA is not constrained by a standard model and will reflect management’s internal approach to capital management and may utilize or benefit from an economic capital model, other internal models, stress testing and other means. As a result, while the GCC is an additional input into the GPS, it may provide data and signals that don’t align with the risk measures within the ORSA.

Overall Theme of Remaining Guidance

The previous information describes the purpose for considering the GCC within the context of the state’s holding company analysis and corresponding GPS. In general, the remainder of this guidance provides more depth to the specific information to be included in the GPS, and provides the analyst with a basic understanding of the GCC including why the entities included within the GCC may be a subset of those entities that are within the holding company structure; whether the trends within the GCC suggests questions should be raised with the group’s management; whether the underlying data suggests trends exist that should likewise be raised with the group or with the respective legal entity’s supervisor; whether the information in the GCC filing is generally aligned with other information available to the analyst, and if not, why not, and whether that evidences other questions or concerns that should be addressed, or how they may already have been resolved. Notably, the purpose of the GCC is NOT to trigger regulatory action. Thus, even though the GCC is intended as a group-wide measure and provides insights as to capital adequacy and risks across the group, any regulatory action would have to result from other information made available to the regulator and based on legislative authority.

Utilization of the Group Capital Calculation in the Lead State’s Responsibilities

The lead state is responsible for completing the holding company analysis and documenting a summary of that analysis in the GPS. The depth and frequency of the holding company analysis will depend on the characteristics (i.e., sophistication, complexity, financial strength) of the insurance holding company (group) system (or parts thereof), and the existing or potential issues and problems found during review of the insurance holding company filings.

Similarly, in the analysis of the GCC, the depth of the review in the “five-step process” and specific inquiries will vary based on each group’s unique situation. For example, in some groups, very little if any work (inquiries of the group) will be done after the first step due to generally positive trends of the ratio over time. In other groups, the analyst may need to proceed through each of the five steps. Exactly how the analyst proceeds through the guidance will be dictated by a multitude of factors and requires judgement and as a result, the steps and subprocedures should not be used as checklist, but rather as a guide in how to utilize the GCC to increase the analyst’s understanding of the group.
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GCC Construction That Also Impact its Utilization and Review

Some decision points may be addressed prior to the submission of a GCC template. These include: the scope of application (e.g., whether segments of the holding company system (group) should be excluded for financial conglomerates); whether a limited filing will be allowed (as permitted in Model Law #440 and Model Regulation #450); and whether subgroup reporting (as defined in the GCC instructions) of a foreign insurance group will be required. In general, the analytics provided by the GCC will be similar for all entities included in the template. See the Primer on the Group Capital Calculation Formula) at the end of this section to better understand these points.

These factors are also a consideration in determining the depth of the analysis of the GCC and subsequent correspondence with the group. Refer to chapter VI.B. Roles and Responsibilities of Group-wide Supervisor/Lead State for details on responsibilities for completing the GPS.

The utilization of the GCC can be summarized as an additional input into the GPS. More specifically, once the analyst completes their review of the GCC and trend of the ratio, a summary should be incorporated into the GPS to help support the assessment of strategic risk.

Documentation of Review of the GCC in the Group Profile Summary (GPS)

The purpose of these procedures is to explain how to document the GCC into the GPS. The following provides an example of a GCC Summary that represents the minimum expected input of the GCC into the GPS, with new information reported within the Strategic branded risk classification. The other purpose of this section is to determine if more follow-up with the group should be performed and, if so, to assess the information obtained from that additional review. The following is intended to assist in documenting the analyst’s understanding of the group’s GCC in the GPS.
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

Group Capital Calculation (GCC) Summary

Summarize your assessment of the GCC both quantitatively and qualitatively, including any such items as may not be applicable to a branded risk category. For example, it may be appropriate to indicate “The review of the group’s GCC indicated the scope of the application is consistent with the lead state’s determination” and if possible, to summarize succinctly, the general scope of the GCC. For example, “the GCC includes all U.S. and Bermuda operations, but excludes ABC non-insurance operations in South American countries”. It may also be appropriate to identify key drivers of risks for the group within the GCC that are discussed later in the branded risk categories, as those risks supplement existing risk assessments derived from holding company analysis or are new risks that warrant further review. “The group’s GCC of 201% in the current year was impacted by a decline in Total Available Capital of $X which is related to group’s non-insurance operations in Bermuda and as well as the negative impact of market risks in the U.S. insurance legal entity ratio components, which based on further analysis has resulted from the recent financial market volatility”.

Branded Risk Assessment

**Strategic:** The group’s Group Capital Calculation is assessed as low-risk and stable and is a positive consideration in the overall assessment of strategic risk. The GCC has generally been reasonable and consistent over the past five years as illustrated in the following table. Additionally, refer to the GCC Summary for further details.

<table>
<thead>
<tr>
<th>GCC Ratio</th>
<th>CY</th>
<th>PY1</th>
<th>PY2</th>
<th>PY3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>201%</td>
<td>207%</td>
<td>163%</td>
<td>202%</td>
</tr>
</tbody>
</table>

GCC Summary and Strategic Branded Risk Documentation:
The above information documented in a summary section of the GPS and into the strategic branded risk classification is expected to be the primary type of information that is always documented into the GPS. The GCC provides a capital measurement of the group and, consistent with the branded risk categories, should be reported in the strategic risk section. Similar to how RBC for an individual insurance entity is helpful in allowing the analyst to better understand other potential issues, given capital represents a relative measure of cushion for adverse risks, the GCC (and its inclusion in the GPS) helps regulators to understand the same, relative to a group. While the GCC is not a capital requirement, with specified ladders of intervention, each of the insurance legal entity figures are relative to individual company requirements, and therefore the GCC can provide a relative measure of risks in terms of the minimum capital levels of the insurers.

Other Branded Risk Documentation:
To the extent the GCC ratio is trending negatively, or GCC available capital is decreasing, the analyst may choose to include more information in the strategic branded risk section of the GPS that summarizes any key drivers of such findings if they did not fall into one of the branded risk categories. Those drivers of the change might be documented in other specific branded risk categories, for example Pricing/Underwriting if driven by group-wide weak insurance underwriting, or reserving if the group-wide drivers were reserve deficiencies, etc. References to other branded risk categories may also be appropriate. However, this may not always occur or be possible for the analyst to pinpoint given the multitude of risks within any insurer’s regulatory capital requirement formulas.
This guidance is simply meant to suggest that if the GCC does in fact appear to show particular trends that are noteworthy on specific risks, further documentation into that (applicable) branded risk may be appropriate.

A determination for when documentation of risks from the GCC into other branded risk categories may be appropriate is driven by whether any of the thresholds in Procedures 1 were met, and by the rest of the GCC information as described in Procedures 2-4. The GCC Summary is intended to be high-level, therefore other more detailed observations from reviewing the GCC should generally not be documented into the GPS unless they are specifically insightful, add to a high-level understanding of the group’s financial condition, or are specific to a branded risk category as stated.

Other Considerations:
In addition to the broad guidance provided herein on the documentation of the GCC in the GPS, the analyst should also understand the following more general points that could impact the GCC result for a particular group. Judgement is required when considering these points:

- Asset-liability accounting or economic mismatches may lead to volatility within components of the GCC ratio, and potentially in the GCC ratio as a whole. For instance, if an entity is in a market-based regime, and if economic risks are unhedged, the entity’s solvency ratio may fluctuate with economic conditions. As another example, if an insurance entity’s liabilities are subject to U.S. RBC and statutory valuations, and if associated hedging is subject to a market-based valuation, volatility may result due to accounting mismatches. The factors that create volatility will be significantly influenced by the accounting standards used in each applicable regime.
- Regime changes may lead to noticeable changes in the GCC ratio that are not necessarily reflective of changes in the entity’s underlying business. Regime changes can include changes in valuation, risk-based capital, available capital, tax rates, or the use/discontinuation of permitted or prescribed practices. In some jurisdictions a regime change could involve the use/discontinuation of an “internal model” or “partial internal model,” which is a tailored set of risk charges and/or risk correlations and is intended to align insurer and regulatory perspectives of risk and capital.
- The GCC provides a means for analysts to identify non-insurance operations outside of the insurance group and to determine the extent of risk they may pose to the insures within the group. However, in doing so, analysts should understand that findings from review of Forms B, D and F might be equally valuable in these situations.
- When understanding capital requirements for non-insurer financial entities that are not subject to regulatory capital requirements, consideration should be given to the appropriateness of the GCC’s capital charge for a specific entity’s financial operations (e.g., an entity conducting a large volume or large dollar of complex transactions but with little net revenue or equity).
- When understanding capital requirements for non-insurer / non-financial entities, consideration should be given to the appropriateness of the level of risk assigned to specific entities.

Detailed Observation Documentation:
More detailed observations shall be documented separately from the GPS and in a form not dictated by this handbook. As in all holding company analysis, the level of documentation is determined by the lead state insurance department and is dependent on the characteristics and complexity of the group and its risks. These detailed observations generally need to only note the drivers of trends and/or actions being taken by the group to mitigate risks. In some cases, these points can be easily summarized into the GPS. In other cases they are too
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

Detailed and should be documented instead within a separate document not dictated in form by this handbook. The analysts should not spend time documenting either subtle changes within the GCC or individual company movements that do not create a trend at the group level or identify a growing weakness in the group. However, judgment is required to make this determination. For example, a 10% (not point change) decrease in an RBC ratio of one of the smaller insurers within the group generally would not be documented. By contrast, a 10% decrease (not point change) in an RBC ratio in one of the larger insurers in the group that causes, either alone or jointly with other insurers, a 10% decrease in the GCC should be noted. However, it should be understood also that this 10% threshold is not intended to be used as a “bright-line.” In fact it is possible the 10% is not necessarily indicative of any negative trends at all. This could be the case when for example there was a change in the regulatory capital requirement. Therefore, again, judgement is required in making these determinations and this, as well as other thresholds used in this guidance, are not meant to be bright lines. As the GCC is used more, both by the individual analyst and by the various states, using judgement around these thresholds is expected to become easier as the judgement is informed by experience.

**Specific Procedures for Completing Review and Understanding of the GCC**

The following procedures should be used by the analyst in their review and documentation of results of the GCC. However, if the analyst determines after completing any of the above procedures (steps), that no further work is deemed necessary to fully document the material risks of the group observable from the GCC (as well as the required information to be included in the GPS from the GCC), this should be documented by the analyst in any workpapers deemed appropriate by the state along with the general reasons supporting that conclusion. In making this determination, it should be reiterated these procedures are not intended to be used in a checklist manner and judgement based upon existing information on the group obtained from the Form F, ORSA, or any other source is certainly part of that decision.

**Procedures Step 1**

The purpose of procedures 1 is to assess the GCC level, and to identify the drivers of any changes in the GCC, in order to summarize and to document that overall assessment in the GPS and its strategic risk category, which is the minimum expected input of the GCC into the GPS. However, the analyst should understand that in the early years of the GCC, a limited amount of prior year(s) comparative data will be available, therefore requiring more judgement in determining if or where further analysis is warranted. Such judgement may need to be based upon various factors, including but not limited to other known information regarding the applicable group obtained from other sources (ORSA, Form F, Form B, etc.).

Procedure 1 is also intended to help the analyst determine if more follow-up review work should be performed. However, if the answer to any of the questions in 1 is “yes”, the analyst should proceed with step 2, understanding decreases in total available capital and/or step 3, understanding increases in leverage to determine the cause(s) of the negative trends. In the example provided above, the trends are positive with no decreases in the base ratio except in PY1; presumably the analyst may have performed some level of inquiry to the holding company to understand the driver of the drop.

**Procedures Step 2a-2m**

Unlike step 1, the intent of step 2 (and 3) is to determine the actual source of the negative issues and where they should be documented in the GPS. Procedure 2a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by looking at the ratio of actual-to-required capital for the legal entity insurers over the available years reported. The following sample of
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

A table from the GCC calculation completed by the group from the data in Schedule 1 can be helpful in determining the source of the issues.

<table>
<thead>
<tr>
<th>Insurance Capital Table Template Groupings</th>
<th>Ratio of Actual to Required Capital</th>
<th>2025</th>
<th>2025</th>
<th>2023</th>
<th>2022</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>[1]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>[2]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>[3]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>[4]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>[5]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
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<td></td>
</tr>
<tr>
<td>Canada - Life</td>
<td>[6]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>[7]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>[8]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>[9]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Japan - Life</td>
<td>[10]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>[12]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solvency II -- Composite</td>
<td>[13]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
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<tr>
<td>Solvency II - Non-Life</td>
<td>[14]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia - All</td>
<td>[15]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>[16]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>[17]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Procedure 2b recognizes that the GCC does allow some debt to be included in capital up to a predetermined limit and can drive the overall GCC ratio. The following sample table taken from the GCC calculation using the data in Schedule 1 can be helpful in making this determination. Cases where debt is issued to address risk-driven reductions in the GCC ratio may not offset those reductions. This data metric may not be available in the case of a “limited filing”.

<table>
<thead>
<tr>
<th>Debt/Equity Table Template Groupings</th>
<th>Debt/Equity ($)</th>
<th>2025</th>
<th>2024</th>
<th>2023</th>
<th>2022</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>[8]</td>
<td>XXXX</td>
<td>XXXX</td>
<td>XXXX</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Procedure 2c recognizes that profitability (e.g. net income/net loss) is generally one of the biggest drivers of changes in capital and utilizing the following table from the GCC can assist in identifying if there are entities reporting net losses that may be driving the decreases in capital. The following table taken from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues.
### VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

<table>
<thead>
<tr>
<th>Income &amp; Leverage Table Template Groupings</th>
<th>Net Income ($)</th>
<th>Return on Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2025</td>
<td>2024</td>
</tr>
<tr>
<td>US Ins [1]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Non-US Ins [2]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Bank [4]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Asset Manager [5]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Other Financial w/Capital Requirement [6]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Financial Entities w/o Capital Requirements [7]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total [8]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
</tbody>
</table>

If the source of the issues is the insurers, the following sample from a table from the GCC using the data in Schedule 1 can be helpful in determining the source of the issues among the insurers.

<table>
<thead>
<tr>
<th>Core Insurance Table 1 Template Groupings</th>
<th>Net Income ($)</th>
<th>Return on Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2025</td>
<td>2024</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C) [1]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life) [2]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health) [3]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive) [4]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer [5]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canada - Life [6]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C [7]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Bermuda - Other [8]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers [9]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Japan - Life [10]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Life [12]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Composite [13]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Non-Life [14]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Australia - All [15]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Switzerland - Life [16]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>Switzerland - Non-Life [17]</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
</tbody>
</table>
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

Procedure 2d is focused on requesting more specific information from the legal entity regulator or the group to better identify the source of the issue(s). Procedures 2e-2l simply contemplates that if the source of the issues can be identified into one of the branded risk categories, it should be documented in the detailed workpapers and into the appropriate branded risk category of the GPS. However, it is recognized that the source of issues may be in multiple branded risk categories, in which case documentation of each of the sources into the detailed workpapers is still appropriate. However, documentation into one of the single branded risk categories of the GPS is only appropriate if that risk category is a material driver of the negative trends. Procedure 2m is intended to identify if the source of issues is related to non-insurance operations. The GCC is intended to provide for more consistent analysis of risks to an insurer that may originate from non-insurance entities within the holding company system.

Procedures Step 3a-3f

Procedure 3a is specifically focused on identifying the category of legal entities (and subsequently the individual legal entities) that might be driving the issues by looking at indicators of leverage, e.g., leverage ratios, where this risk may manifest itself either through increased writings or exposure, or through increased balances relative to capital and surplus. The following sample of a table from the GCC calculation using the data in Schedule 1 can be helpful in determining the source of the issues.

<table>
<thead>
<tr>
<th>Insurance Leverage Table</th>
<th>Net Premium Written ($)</th>
<th>Liabilities ($) / Capital &amp; Surplus</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>XXXX</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>[2]</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>[3]</td>
<td>XXXX</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>[4]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Non-RBC filing US. Insurer</td>
<td>[5]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>[6]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>[7]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>[8]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>[9]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>[10]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>[12]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Composite</td>
<td>[13]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>[14]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Australia - All</td>
<td>[15]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>[16]</td>
<td>XXXX</td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>[17]</td>
<td>XXXX</td>
</tr>
</tbody>
</table>
VI.H. Group-Wide Supervision – Group Capital Calculation (Lead State)

<table>
<thead>
<tr>
<th></th>
<th>[18]</th>
<th>[19]</th>
<th>[20]</th>
<th>[21]</th>
<th>[22]</th>
<th>[23]</th>
<th>[24]</th>
<th>[25]</th>
<th>[26]</th>
<th>[27]</th>
<th>[28]</th>
<th>[29]</th>
<th>[30]</th>
<th>[31]</th>
<th>[32]</th>
<th>[33]</th>
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</thead>
<tbody>
<tr>
<td>Hong Kong - Life</td>
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<td>XXXX</td>
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<td>Hong Kong - Non-Life</td>
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<td>Singapore - All</td>
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<tr>
<td>Chinese Taipei - All</td>
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<td>South Africa - Composite</td>
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<td>Brazil</td>
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<tr>
<td>TOTAL</td>
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</tr>
</tbody>
</table>

Procedure 3b is more forward-looking by suggesting the analyst look at the same leverage ratios used in 3a to determine if the trends might continue and lead to further decreases in the GCC ratio. Procedure 3c simply requests the analyst use the leverage information to target questions to the group to better identify the drivers. Procedure 3d-3f are all questions designed to help the analyst consider whether the changes in leverage will lead to greater underwriting risk, reserving risk, or market and credit risk. Procedures 3d-3f provide general inquiries for additional information for the analyst. However, these inquiries may also appropriately provide a basis for the analyst to hold conversations with the group on the same topics to understand how the group views these topics and how the group is managing and monitoring these risks. For groups filing an ORSA, see also documentation within the ORSA report for additional information on the identified risks and the group’s monitoring of risks, as well as consistency of the discussion with management and management’s observations in the ORSA Summary report.

Procedures Step 4a-4b. Procedure 4a is intended to help the lead state understand the historical capital allocation patterns or the likely future needed capital allocation patterns by simply documenting those in the detail analysis workpapers. This includes, for example, noting that there is consistency in the entities generating net income and distributing it further through the group, and in some cases may require distribution through other insurers, which in the US often requires approval if considered extraordinary. Procedure 4a is intended to utilize that knowledge, along with other planned actions of the group, to understand whether problems with repaying debt or other obligations in the group could occur. The intent is to be in a better position for discussions with the group on where the group may expect capital to come from to support future expected activity or future unexpected material events. The following sample of tables from the GCC calculation using data in Schedule 1 can be helpful in determining the source of the issues.
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<table>
<thead>
<tr>
<th>Insurance Capital Table Template Groupings</th>
<th>Intragroup Dividends $ Received/(Paid)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2025</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (P&amp;C)</td>
<td>[1]</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Life)</td>
<td>[2]</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Health)</td>
<td>[3]</td>
</tr>
<tr>
<td>RBC Filing U.S. Insurer (Captive)</td>
<td>[4]</td>
</tr>
<tr>
<td>Canada - Life</td>
<td>[6]</td>
</tr>
<tr>
<td>Canadian - P&amp;C</td>
<td>[7]</td>
</tr>
<tr>
<td>Bermuda - Other</td>
<td>[8]</td>
</tr>
<tr>
<td>Bermuda - Commercial Insurers</td>
<td>[9]</td>
</tr>
<tr>
<td>Japan - Life</td>
<td>[10]</td>
</tr>
<tr>
<td>Solvency II - Life</td>
<td>[12]</td>
</tr>
<tr>
<td>Solvency II -- Composite</td>
<td>[13]</td>
</tr>
<tr>
<td>Solvency II - Non-Life</td>
<td>[14]</td>
</tr>
<tr>
<td>Australia - All</td>
<td>[15]</td>
</tr>
<tr>
<td>Switzerland - Life</td>
<td>[16]</td>
</tr>
<tr>
<td>Switzerland - Non-Life</td>
<td>[17]</td>
</tr>
</tbody>
</table>

**Procedures Step 5a-5h.** Procedures 5a-5h are designed for those uncommon situations where the group believes they need to reduce risk because raising capital may be unlikely (see appendix for further discussion on that topic). Before performing this procedure, Procedure Step 2 (Evaluating Decreases in Total Capital) and Procedure Step 3 (Evaluating Increases in Operating Leverage) will have already been performed to determine whether capital is decreasing, or operating leverage is increasing. As such, after considering information that may already be available to the regulator on the business plan, Procedure 5b is largely focused on better understanding directly from the group the group’s reaction to the apparent negative trends. The analyst should understand that some of these trends may have already been known, through for example the ORSA review and discussions.
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of the ORSA by the lead state. In fact, the key takeaways may already be documented in the GPS and therefore the remaining procedures in this section may be irrelevant and could be skipped if recently considered and understood. In addition, such trends from Procedure Steps 2 and 3 may suggest no additional information is necessary. It is for this reason that the first procedure is focused on the group's existing business plan as it is possible these trends may have been expected. Further, Procedure 5a is based on the belief that reducing risk by the group may have been previously incorporated into the group's latest business plan, which may have been obtained from the Annual Form F Filing.

Procedure 5b on the other hand contemplates that the manner to address any unexpected negative trends may not have been incorporated into the latest business plan and thus further contemplates that the analyst speaks with the group or identified insurer causing the negative trend to understand how the issue is to be addressed. However, it should be recognized that some trends that may appear to be "negative", e.g., a decline in the reported GCC, may actually be the result of a conscious decision by the group to more efficiently deploy capital while remaining at sufficient levels from an ERM perspective. This procedure is not meant to suggest action must be taken by a regulator, but only to help the analyst understand whether a trend is in fact "negative" or not, and if so, what the group has already decided or plans on doing to address the issue, if any, and appropriately document. Some of what the group is currently doing may already be known by the lead state, either through the ORSA, the Form F, or a periodic meeting with the group that some states conduct annually. However, the procedure provides an opportunity for the analyst to ensure they understand the drivers and what if anything the group is already doing to address the underlying issues as the group thinks is appropriate. To be clear, increases in operating leverage are often planned, and often come with expected future actions by the group, such as capital injections or future transactions that may reduce risk. On the other hand, decreases in capital sometimes are not expected, and may not result in immediate action, but it is possible that they may lead the group to contemplate future actions to take. Therefore, these discussions would allow these potential actions to be better understood by the analyst and documented.

Procedure 5c contemplates assessing if the group has the ability and resources to either reduce its risks or to raise additional capital. See the section below for further Considerations of the Group's Capacity to Raise Capital. This procedure is not intended to suggest the analyst has the capacity to make this determination on their own, but rather to question the reasonableness of the possibility. Further, the GCC and related provisions in the NAIC's Model Holding Company Act and corresponding regulation are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group's GCC; regulators will use other existing tools and authorities to take action, primarily at the legal entity level.

Procedure 5d contemplates that the group or legal entity may believe no action is necessary because it believes current capital is adequate to meet its business plan, which is more likely to be the case when a one-time reduction of capital as opposed to a growth in leverage that may continue. Procedure 5e is for the rare situation where the legal entity insurers have been strained or face impending pressure contemplated within NAIC Model 385—Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition that would suggest one or more of the insurers may be in a hazardous financial condition. Procedure 5f is designed to suggest the analyst bring the collective supervisors of the legal entity insurers together for a supervisory college to fully understand what is occurring and the identified legal entity's plans for addressing the underlying issues. Procedure 5g is an extension of Procedure 5f as it contemplates the regulators discussing whether the proposed actions from the legal entity(ies) in the group is adequate. This action could represent something either informally done before an insurer is in a regulatory action level, or formally once an insurer is in a regulatory action level. Procedure 5h is similar to the other actions contemplated
Additional Procedures – Business Plans

While there is a multitude of possibilities which are beyond the scope of this guidance to address, the following provides some of the related issues that may be helpful to the analyst to consider.

**Group’s Business Plan (or collective legal entities):**

**Planning Process:**

- Understand the overall planning process (who is involved, how frequently it occurs, etc.) and how the overall initiatives are determined
- Understand the estimate of the impact of the proposed actions on financial results
- Review the plan’s assumptions for reasonableness. Consider the likelihood of variations in the assumptions and the resulting impact on the future financial results
  - Consider subcategories of changes including:
    - Overall potential changes in investment strategy
    - Overall potential changes in underwriting strategy or risk concentrations
    - Overall impact on financing matters (e.g., debt, requirements, etc.)
    - Overall impact on derivatives to mitigate economic conditions
    - Overall changes in governance or risk management procedures
    - Increased ceded reinsurance transactions (common approach to reducing risk/increasing surplus):
      - Details regarding the revised strategy
      - Specifics on types of coverage such as assumption reinsurance, loss portfolio transfers
      - Transfer of risk considerations

**Variances to Projections:**

- Consider the history of explanations regarding variances in projected financial results and the insurer’s actual results. If analysts determine the goals of the business plan are not attainable and/or projections are unreasonable, a revised business plan may be requested.
- Identify any internal or external issues not considered in the plan that may affect future financial results. Examples of such issues include the following: 1) the existence of competitors to limit future sales levels; 2) recent state legislation restricting the company’s product designs; or 3) the loss of key marketing personnel.
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#### Evaluating a Business Plan:

Analyzers should consider further detail where necessary in evaluating the proposed revised business plan but also monitor, on a periodic basis, the insurer’s progress in achieving the initiatives included in the group’s plan. Assuming that the analyst has determined that a decline in the GCC is material and to considered a negative event, i.e., it was not the result of capital management and planning to more efficiently utilize capital while staying within sound levels to achieve ERM objectives, the goal of the plan would then be to address the underlying causes that led to the issues and an improvement in subsequent GCC ratio results. Detail considerations for improving the plan may include the following (where considered inadequate):

- Trending comparative measures of targeted risk exposures including (where applicable):
  - Asset mix by detailed types
  - Credit risk by detailed types
  - Business writings/ratios by detailed product
- Impacts on financing items:
  - Projected cash flow movements for ongoing principal and interest payments on debt
  - Impact on debt interest coverage ratio, other debt covenants, rating agency ratings
  - Discussion of impact on parental guarantees and/or capital maintenance agreements
  - Expected source and form of liquidity should guarantees be called upon
- Impact of reasonable possible stress scenarios
- How the individual legal entities’ capital will be maintained at required levels

#### Consultation with Other Regulators

- Consult with members of the supervisory college (if applicable) or other domestic states for input in evaluating the revised business plan

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### Considerations Regarding Ability of the Entities in the Group to Raise Capital

The following is designed simply as a reminder of considerations the lead state would contemplate when discussing the group system response to the issues identified in this section. More specifically, in most situations a group will first consider ways to reduce risk. In limited situations, it may consider trying to raise additional capital. While this is typically not an option for a group that is currently not performing as it anticipated, in some situations alternative sources of capital may be raised if the holders of the newly issued equity securities are given rights that are attractive to the holder. In addition, in some cases the group may have the ability to issue other forms of capital (e.g., debt), which can be used to inject into the insurance subsidiaries. While these facts are not unique to the utilization of the group capital calculation, they are worth a reminder along with relevant other related details.
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New Equity Considerations

Public Holding Company
While no two groups are the same, issuing public stock may be limited for the reasons previously identified. In addition, regulators are reminded that a public holding company may be obligated to pay dividends in order to maintain expectations of their shareholders, making the reduction of risk a more viable action under the circumstances.

Private Holding Company
While no two groups are alike, a private company has some of the same characteristics as a public company in terms of owners’ expectations, but usually such expectations differ from a public company, and it may be more feasible for a private company given their access to specific individuals that may have a higher interest in additional capital rights.

Mutual Insurance Company
A mutual insurer is limited in terms of its access to capital because it cannot issue new stock but can issue surplus notes.

Mutual Holding Company
Because mutual holding companies have characteristics of both public companies and mutual companies, there are implications of how such a structure affects its operations.

Non-profit Health Company
Insurers that are non-profits are generally charitable organizations and it is not uncommon for some types of insurers, particularly those that provide health insurance, to have some history as a non-profit. It may be helpful to understand these types of dynamics when considering a group structure.

Fraternal Associations
Regulators often find similarities between a fraternal benefit society and a mutual insurer because both can be limited in terms of their ability to raise additional funds but can issue surplus notes. If allowed within state law and the charter, the fraternal could assess members or adjust members policy values.

Reciprocal Exchanges
Regulators often find similarities between reciprocal exchanges and fraternal benefit societies and mutual insurers because they can be limited in terms of their ability to raise additional funds. Although this is a general consideration for the regulator when evaluating the group system, there is generally much more that must be understood because in some cases, the reciprocal may be able to assess policies that can serve a similar purpose as raising capital.

New Debt Considerations

Through discussions with the group, understand the potential impact of any new debt on the group system, including specifically the extent of future additional reliance on the insurance operations and whether those insurers have the capacity for such. Also consider an updated review of the following:

- Total debt service requirements.
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- Revenue streams expected to be utilized to service the debt.
- Any new guarantees for the benefit of affiliates.
- Any new pledge of assets for the benefit of affiliates.
- Any new contingent liabilities on behalf of affiliates.

General Holding Company Considerations

International Holding Company Structure
This section is applicable only to those international groups that are required to complete the GCC, which may be relatively few considering many international holding companies have a non-US groupwide supervisor and are exempt from the GCC. Those foreign groups that are required to complete the GCC will generally file a “subgroup” GCC that includes insurance entities that are part of the group’s U.S. operations. In those situations, the analysts should understand the structure to determine if it has any impact on this analysis. Analysts should direct any regulatory concerns to the appropriate organization contact to ensure a prompt reply or resolution. In some organizations, the appropriate organization contact will often be associated with the U.S. insurance operations, while in others, an advisory board may have been established to communicate with regulators.

Capital / Operational Commitment to U.S. Operations
Some holding companies may consider their U.S. insurance enterprises non-core and may be less invested in their ongoing business operations or financial support. Analysts should be aware of a holding company’s stated commitment to ensure the continued stability of U.S. insurance operations. This commitment may include a written or verbal parental guarantee.
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Primer on the Group Capital Calculation Formula

The National Association of Insurance Commissioners (NAIC) began development of the Group Capital Calculation (GCC) in late 2015 following extensive deliberation on potential measurement models and methodologies. The GCC uses a bottom-up aggregation approach, accounting for all available capital/financial resources, and the required regulatory capital based on the measurement of assets and liabilities of the various corporate entities, including insurers, other financial entities, and non-financial businesses.

The GCC Aggregation Methodology

As illustrated in the sample tables above, the proposed GCC is an aggregation or grouping of the available financial resources and calculated capital of all legal entities that potentially could pose material risk to the insurers in the group. The GCC allows some discretion in determining what entities under common control but outside of the defined Insurance Group may be excluded from the scope of application in the GCC. When reviewing a group’s choice of entities to be excluded from application of the GCC, the following points should be considered:

- The regulatory evaluation should be based on the criteria for material risk (e.g., structural separation, no history of cross subsidies, or other criteria as defined in the GCC instructions).
- Group requests for reducing the scope of application of the base GCC should be based on supporting information and a rationale provided by the group.
- Information on excluded entities should be made available upon request from the analyst.

The GCC includes the following types of entities (listed with the general approach of calculated capital toward each).

U.S. Insurers – The available capital of U.S. domiciled insurers is determined by statutory accounting principles (SAP) as defined by state law and the NAIC Accounting Practices and Procedures Manual, which defines assets, liabilities, and net available capital/financial resources, sometimes referred to as policyholder surplus. The calculated capital for these insurers is subject to state law that requires these insurers to maintain minimum capital based on the applicable NAIC Risk-Based Capital formula at 200% x Authorized Control Level.

Non-U.S. insurers – Similar to the available capital and calculated required capital of U.S. insurers, the available and calculated capital of non-U.S. insurers is determined by reference to the home jurisdiction’s basis of accounting and capital requirements converted to U.S. dollars. While most non-U.S. jurisdictions do not possess the same level of industry specific technical guidance as included in the NAIC Accounting Practices and Procedures Manual, all jurisdictions have established accounting standards that insurers are required to follow to determine available capital/financial resources. In some cases, this represents local Generally Accepted Accounting Principles (GAAP), which may or may not be consistent with International Financial Reporting Standards (IFRS).

DRAFTING NOTE: While the GCC utilizes the available capital and home jurisdictions’ capital requirement, for jurisdictions where data is available, the use of appropriate scalars is currently being explored to produce more comparable measures for risk which can be aggregated into the group-wide measure. One such scaling methodology is included as part of a sensitivity analysis in the GCC template. That scalar methodology uses aggregated data from the U.S. and other jurisdictions at the first intervention level to recognize that (for...
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example) state regulators often have much higher reserve requirements, incorporating amounts that are required to be carried as capital in other jurisdictions. For jurisdictions where the data is not available, the full jurisdictional requirement at the first intervention level is used.

U.S. Insurers Not Subject to RBC – Some types of U.S. insurers are not subject to an RBC formula (e.g., Financial Guaranty Insurers, Title Insurers). For these entities, the available capital/financial resources are determined by reference to state law and the NAIC Accounting Practices and Procedures Manual. However, since an RBC formula does not exist, calculated capital is determined by reference to the minimum capital requirements set out in state law (or 300% of reserves for Title insurers). For U.S. captive insurers, available capital is determined based upon the states accounting requirements, but the calculated capital is required to be calculated using the applicable RBC formula even if RBC does not apply to that entity in its state of domicile.

Banking or Other Financial Service Operations Subject to Regulatory Capital Requirements – Non-insurers such as banks are subject to their own regulatory valuation methods (typically GAAP with tiering of available capital) and their own regulatory capital requirements (e.g., OCC, Federal Reserve, FDIC, or other requirements for banks). These regulatory values are used for the GCC.

- Financial and non-financial operations not subject to regulatory capital requirements – In general, financial entities (as defined in the GCC Instructions) are subject to a higher capital charge in the GCC than the non-financial entities. However, the GCC does require available capital/financial resources and calculated capital to be gathered for all such entities that pose a material risk to insurers. In both cases the GCC will utilize the valuation used by such legal entities (typically U.S. GAAP) and a calculated capital based upon a risk factor. All entities within the defined insurance group (definition included in GCC Instructions) must be included
- All financial entities (definition included in GCC Instructions) must be included
- The level of risk (low / medium / high) and associated capital calculation assigned to a financial entity will be selected by the group and evaluated by the lead -state reviewer
- Non-financial entities that are subsidiaries of U.S. insurers, foreign insurers, or banks where a capital charge for the non-financial entity is included in the regulated Parent’s capital formula will remain with the Parent and will not be inventoried. Regulators already have access to the financials of these entities if needed (if causing unrealized losses within the insurer).

Eliminations
The GCC uses an aggregation and elimination approach, where each of the above legal entities’ available capital/financial resources and calculated capital are combined, then eliminations are utilized to prevent any double counting of available capital/financial resources or calculated capital. The following example illustrates the use of eliminations for both available capital/financial resources and calculated capital. However, in practice the GCC only requires the foreign insurers and other financial entities owned by an insurance company to be “de-stacked” so if AA Holding Company was a U.S. insurer (e.g., AA Insurance Company) the capital required and calculated capital for DD Insurance Agency as a nonfinancial entity would remain in the values of AA Insurance Company and not be de-stacked.
In the above example, available capital/financial resources are referred to as available regulatory capital (ARC) and total authorized capital (TAC1) and minimum calculated capital is referred to as minimum regulatory capital (MRC) and authorized control level (ACL2). The GCC will allow non-insurance / non-financial entities owned by RBC filers in the group to remain within the available capital and calculated capital of the parent, so no eliminations are required for these entities. As shown, since AA Holding Company owns each of the other business entities in the organizational chart, $38 million (which is the amount of available capital/financial resources in the subsidiaries of AA) is eliminated from the TAC column since accounting methods include those as an asset on AA Insurance Company’s balance sheet. Also, the GCC includes capital calculations for AA Holding Company and DD Insurance Agency as part of the MRC in addition to the regulatory capital already included for the insurance subsidiaries. The MRC of the subsidiaries is eliminated from the parent’s (AA Holding Company) calculated capital. Therefore, in this example $4.81 million of calculated capital is eliminated from the MRC. Finally, the MRC of U.S. insurance subsidiary is multiplied by 2 in order to reflect Company Action Level (CAL) RBC as required in the GCC.
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Debt - It is important to note that the available capital used in deriving the GCC recognizes a portion of the group’s senior and hybrid debt as capital. This allowance recognizes that debt that is not already recognized as available capital/financial resources under all known accounting principles (SAP, U.S. GAAP or IFRS) may have some value to the group under the U.S. insurance regulatory requirements where debt proceeds are contributed down to the insurance companies and where extraordinary dividends must be approved by the state. Qualifying debt along with limitations thereon are described in the GCC instructions as is the calculation for the additional available capital. In addition to looking at the group’s debt leverage, consideration should be given to how the allowance for additional capital from debt interacts with changes in available capital and capital requirements from year to year. The impact of procyclical changes in the allowance for debt as capital should be assessed.

Other Information Included in the GCC
The GCC includes selected financial information (net income, premiums, liabilities, debt, etc.) that is captured in Schedule 1 and in the “Analytics” tabs of the GCC, which is meant to be used to help isolate potential strengths and weaknesses of the group and more specifically where such exist among the entities in the group. Some important information related to other features in the GCC also should be considered and are discussed below. Schedule 1, a simplified version of the Inventory Tab, and most analytics are required in the case of a limited filing. However, data is not required for the capital instruments, sensitivity analysis and other information tabs in a limited filing.

Grouping - The GCC separately allows certain financial entities (e.g., asset managers) and non-financial entities included in the GCC to have their values and capital calculation combined (grouped) for more efficient reporting and analysis. Although the GCC instructions set parameters for such grouping, the general expectation is that regulators will work with each applicable GCC filer in determining where grouping is and is not appropriate outside of what is allowed within the GCC instructions. Grouping should be viewed in the context of materiality. A single entity conducting a given activity may not be material, but when all entities conducting the same activity are combined, they may then be material.

Excluded entities – The GCC provides two mechanisms for the exclusion of non-financial entities in Schedule 1 and in the Inventory Tab at the discretion of the lead state. State regulators should consider whether any of the information collected in the GCC template, should be collected for an entity or group of similar entities that would otherwise be excluded from the GCC ratio calculation. Regulators should separately monitor increases in the level of activity of an “excluded” entity or group of similar entities for purposes of materiality and potential subsequent inclusion in the GCC.

Sensitivity analysis - A tab devoted to sensitivity analysis is included in the GCC. These informational items provide the regulator with impact of discretion in excluding listed entities and alternative perspectives on risk charges for non-financial entities and foreign insurers. Monitoring of these items can help the regulator identify areas where the GCC may be improved, or capital calculations adjusted in the future. One item included in the sensitivity analysis is a “sensitivity test” that increases the overall calibration of the calculated capital in the GCC from its normal 200% x ACL RBC calibration to 300% x ACL RBC.

Accounting Adjustments - The impact of accounting adjustments and related detailed information is collected in the GCC template in the Inventory Tab and in the Other Information Tab respectively. Such adjustments can be material during the de-stacking process. For example, a consolidated holding company may include GAAP values for entities that would otherwise be valued under regulatory accounting rules (e.g., Statutory Accounting Principles - SAP) on a stand-alone basis. When the regulated entity is de-stacked the difference between the GAAP values and SAP values will be removed from the group’s available capital. These “lost” values can result in a material reduction in the inventoried available capital compared to consolidated available capital. Understanding
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the impact and the components of this adjustment can help the regulator when considering the impact of issuing new debt or when evaluating the allowance for debt as capital calculated in the GCC template.

Intangible Assets – Acquisitions, mergers and reorganization often create significant intangible assets at a holding company level or possibly at an operating company (other than a regulated entity) level. The GCC template collects information on intangible assets held by inventoried entities in the Other Information Tab. The available capital associated with the value of entities whose assets are materially comprised of intangible assets should be evaluated in the context of fungible resources and in assessing the adequacy of the capital calculation assessed on such entities.

Dividend pass-thru (gross view of dividends) – Schedule 1D collects information on dividends paid and received within the group. It also includes a column that indicates whether dividends were declared but not yet paid, as well as cases where dividends received where retained or “passed through” to another affiliate or paid out in dividends to shareholders. This information will assist the regulator in evaluating the movement of capital within the group to fund strategic insurance and non-insurance operations or activities (e.g., expansion of activities) or to fund entity specific capital shortfalls. It also provides a window to capital leaving the group (e.g., debt repayment, stock repurchase, or dividends to shareholders).

Considerations When Exempting Groups

As stated elsewhere within this guidance, the GCC and its related provisions in the NAICs Model Holding Company Act and corresponding regulation are not designed or otherwise intended for regulators to take regulatory action based on the reported level of a group’s GCC. Rather, the GCC is intended to be a tool to better understand the risks of the group, mostly through the trending of the financial information in the “Input 4-Analytics” tab. However, specific to the provisions of the NAICs Model Holding Company Act and corresponding regulation, the Group Capital Calculation (E) Working Group did believe that the GCC might be more helpful for some groups and not as much for others when it developed criteria within the Act and the regulation for exemptions. On this point, the Working Group believed that in general the GCC would be more helpful for those groups that had 1) non-U.S. insurers within the group; 2) a bank within the group, or 3) a more material degree of non-insurers. Specific to the point regarding non-U.S. insurers or banks, the GCC is based upon the premise that the most relevant measure of capital is the actual legal entity requirements of capital from the applicable regulator. On this point, the required capital, as well as the trending of information on these particular legal entities might be the most valuable, particularly if the relative operations and assets of these entities compared to the U.S. RBC filers is material. Similarly, while the calculated capital on the non-insurance entities may not be as relevant as required capital on regulated insurers or banks, if the operations and assets of non-insurers relative to those of US RBC filers are material, the GCC may provide greater value to such types of groups.

To these points, the NAICs Model Holding Company Act and corresponding regulation contain possible exemptions for groups that have less than $1 billion in premium and that do not possess any of the three characteristics just described. The possible exemptions exist after the GCC has been filed once, because without seeing the completed GCC at least once for a group, it may be difficult for the lead-state to determine if the GCC has value. However, it should also be understood that these three criteria of non-U.S. insurer, bank, or non-material non-insurers are not the only situations where the GCC would be valuable to the lead-state. As a reminder, all states are required to assess the sufficiency of capital within the holding company structure; prior to the GCC, this was done using various methods (e.g., debt to equity ratios, interest coverage ratios, existing RBC ratios and relative size of insurance). The GCC is expected to enhance a state’s ability to make this assessment more easily. Therefore, in deciding if a group should be exempted, the lead-state will need to consider a number of factors, including how easily it can make this assessment without the GCC. For small groups where the U.S. RBC operations and assets are much larger than the non-insurance operations, it is likely the GCC would provide a smaller degree of value and exempting from the GCC may be appropriate. However, the analyst should also consider the fact that
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the simpler the holding company structure, the more easily the GCC can be completed. Specifically, given all of the data included in the GCC is existing data and therefore readily available to the company, a smaller and simple structured group should be able to accumulate into the GCC template in a short period of time. Also worth considering is that if such operations are contained within a number of different U.S. insurers where it is difficult to determine the degree of double counting of capital, the GCC may provide more value. To be clear, these are not the only situations where the GCC might be helpful even with a relatively small group. This is because the value may come from figures the GCC requires that the state may have otherwise not been aware of. Specifically, the GCC may identify non-RBC filers who may be experiencing some level of financial difficulties. This possible identification of information the lead-state was not otherwise aware of is the primary reason the Working Group suggested the GCC be filed once before deciding on whether a group should be exempted. While the NAIC Accreditation program may not require a state to have such authority to have the GCC filed once before exempting, this background information provided herein is intended to encourage the state to consider such possibilities before deciding on exempting a group, particularly since it may be difficult to stop an exemption in a given year once it’s provided. In summary, as with everything else described in this documentation, the GCC requires judgement on behalf of the analyst and the lead-state which is based upon multiple factors including the lead-state’s existing knowledge of the group. The same applies when considering whether a group should be exempt.
The Financial Examiners Handbook (E) Technical Group of the Examination Oversight (E) Task Force met Nov. 17, 2021. The following Technical Group members participated: Susan Bernard, Chair (CA); John Litweiler, Vice Chair (WI); Blasé Abreo (AL); William Arfanis (CT); N. Kevin Brown (DC); Cindy Andersen (IL); Grace Kelly (MN); Shannon Schmoeger (MO); Andrea Johnson (NE); Colin Wilkins (NH); Tracy Snow (OH); Eli Snowbarger (OK); Matt Milford (PA); and John Jacobson (WA).

1. **Adopted its Oct. 5 Minutes**

The Financial Examiners Handbook (E) Technical Group met Oct. 5 and took the following action: 1) exposed handbook guidance related to completeness and accuracy repository revisions and coordination framework revisions.

Mr. Litweiler made a motion, seconded by Mr. Snow, to adopt its Oct. 5 minutes (Attachment Three-A). The motion passed unanimously.

2. **Adopted Handbook Guidance**

   a. **Completeness and Accuracy Revisions**

Ms. Bernard said the first set of revisions to consider for adoption relate to enhancements to examination repositories to address the completeness and accuracy of claims data. She said one comment letter was received from Connecticut (Attachment Three-C) during the exposure period. The comment letter recommended that the proposed phase 5 procedure on the Life Reserves repository related to obtaining policyholder confirmations be removed. Ms. Bernard stated that there was some debate on the last call regarding whether this procedure would typically be performed by examiners. NAIC staff updated the Life Reserves repository to reflect this deletion proposed by Connecticut.

   b. **Coordination Framework Revisions**

Ms. Bernard said the next set of revisions to consider for adoption relate to the exam coordination framework and are intended to clarify and simplify the roles and responsibilities of states that are, or could be, involved in a coordinated examination. She said one formal comment letter was received during the exposure period from America’s Health Insurance Plans—AHIP (Attachment Three-E). The comment letter and informal feedback received resulted in minor amendments to the coordination framework revisions. Ms. Bernard said the comment letter included one suggestion that was not accepted regarding additional guidance for safeguarding and maintaining the confidentiality of information in examination files. As standards for protection and confidentiality of sensitive data are typically prescribed at the state level and may vary significantly from state to state, no revisions were made as a result of this recommendation.

Tom Finnell (AHIP) said he appreciates the Technical Group’s review and efforts to make clarifying amendments to the coordination framework revisions in response to AHIP’s comment letter. He indicated that he understands why the specific confidentiality and security guidance recommendation was not included within these revisions, but he noted that he hopes there is a central place within NAIC materials where there is sufficient guidance to ensure that proper security measures are being used.

Mr. Litweiler made a motion, seconded by Mr. Arfanis, to adopt the guidance related to: 1) completeness and accuracy revisions (Attachment Three-B); and 2) coordination framework revisions (Attachment Three-D). The motion passed unanimously.

Having no further business, the Financial Examiners Handbook (E) Technical Group adjourned.

FEHTG 11-17-21 Minutes_FINAL.docx
The Financial Examiners Handbook (E) Technical Group of the Examination Oversight (E) Task Force met Oct. 5, 2021. The following Technical Group members participated: Susan Bernard, Chair (CA); John Litweiler, Vice Chair (WI); Richard Russell (AL); William Arfanis (CT); N. Kevin Brown (DC); Gracy Kelly (MN); Shannon Schmoeger (MO); Justin Schrader (NE); Colin Wilkins (NH); Juan Collado (NJ); Tracy Snow (OH); Eli Snowbarger (OK); Matt Milford (PA); and John Jacobson (WA).

1. **Exposed Handbook Guidance**
   
a. **Completeness and Accuracy Revisions**

Ms. Bernard said the first set of revisions to consider for exposure relate to enhancements to examination repositories to address the completeness and accuracy of claims data. She said external auditors’ approach to testing the completeness and accuracy of data has evolved and now consists of a broader range of testing procedures than are accounted for in the existing examination repositories, including greater reliance on control testing and performance of analytical procedures. She said proposed updates will help ensure that the examination repositories reflect examples of common controls that may be in place at the insurer, as well as provide examples of the type of testing that examiners may perform to address those risks or that may be available for the exam team to leverage in its assessment.

Elise Klebba (NAIC) said revisions were made to the Reserves/Claims Handling – Health, Reserves/Claims Handling – Life, Reserves/Claims Handling – P&C, and Underwriting examination repositories. These revisions primarily focused on the addition of analytical procedures and enhanced collaboration with an actuarial specialist to identify specific data elements and/or lines of business to focus testing on areas of greater concern or risk.

Ms. Klebba explained that the existing Phase 5 detail test procedures for risks addressing completeness and accuracy are robust and direct examiners to review large samples of data to validate those assertions. While this extent of testing is appropriate in some circumstances, there may be times when analytical procedures are more appropriate based on the calculated residual risk. Additionally, examiners are encouraged to utilize the work of external auditors, when appropriate, to reduce the examiner’s review of financial reporting risks during an examination so they can instead focus on risk more directly related to a company’s solvency position. Aligning the example procedures within the examination repositories with the type of procedures external auditors perform during financial statement audits may assist examiners in identifying where they may be able to leverage existing audit work.

Ms. Klebba said some risks are written in a way that suggests both completeness and accuracy exam assertions are addressed through the corresponding test procedures. However, she noted that in practice, the testing performed during examinations may only address one of the exam assertions, rather than both, resulting in a risk not being fully addressed.

Mr. Milford and Mr. Schmoeger affirmed the perception that examiners may look at one assertion or the other, and clarifying the intent of the risk statement or the corresponding procedures would likely be helpful to examiners. While the Technical Group discussed whether separating the applicable risks such that each risk is focused on one exam assertion would help alleviate this issue, the Technical Group ultimately determined that clearer risk statements may be sufficient.

Ms. Klebba noted that one of the proposed revisions included a new detail test procedure to obtain policyholder confirmations to validate completeness of in-force balances. Although this is a procedure commonly performed by external auditors, she asked if this is a procedure state insurance regulators would be comfortable performing, or if it would cause confusion or raise questions by policyholders and/or companies under examination. Mr. Litweiler and Mr. Milford indicated that this is not a procedure they would likely perform. Ms. Bernard suggested that the procedure remain for consideration during the exposure period, and she asked that others weigh in on the appropriateness of including this procedure in the examination repository.

Mr. Arfanis asked if adding analytical procedures as optional Phase 5 procedures implies that an analytical procedure could be used to mitigate a high residual risk. Bailey Henning (NAIC) said testing performed in Phase 5 of an examination should be commensurate with the residual risk rating; therefore, a high residual risk rating may warrant in-depth, substantive testing to
be performed (e.g., taking a large sample of policies and validating certain information from within the policy). However, analytical procedures may be appropriate for a risk with a moderate residual risk rating. She said the Financial Condition Examiners Handbook (Handbook) provides additional detail for differentiating the nature, timing, and extent of procedures to be performed based on a residual risk rating, including the examiners professional judgment. Bruce Jenson (NAIC) added that external auditors are doing more analytical procedures, particularly around completeness testing. For example, external auditors may rely on analytical procedures to evaluate claim cutoff by looking at claim counts from month to month.

b. Coordination Framework Revisions

Ms. Bernard said the next set of revisions to consider for exposure relate to the exam coordination framework. She said the Financial Examiners Coordination (E) Working Group has received feedback from state insurance regulators and industry on aspects of exam coordination that could be improved. In response to this feedback, the Working Group formed a drafting group to review the feedback provided and the existing guidance to determine how best to implement the suggestions.

Ms. Henning said the drafting group sought to simplify the guidance within the coordination framework and clarify the roles and responsibilities of each state that has a company in a holding company group. She said throughout this process, the drafting group did not create new requirements; however, in some cases, the existing requirements were embedded in lengthy paragraphs or otherwise overlooked. Therefore, some of these requirements were made more prominent through the proposed revisions. Ms. Henning also noted that the proposed revisions add context to some of the existing requirements, including relevant timing for certain responsibilities to take place and additional considerations for the states involved. She also said the responsibilities for each state with a company in a holding company group have been re-ordered to flow in a manner consistent with how each step typically occurs in real time.

Ms. Henning gave an example of a requirement that was made more prominent through the proposed revisions. She said existing guidance directed examiners to provide informal and formal notifications when a coordinated examination was expected to be conducted in the future. These two different notifications serve different purposes and have different timing requirements. Therefore, the drafting group proposed separating these two notifications into two separate steps and adding additional context describing when each notification should be provided, for what purpose, and to whom. Ms. Henning said many of the revisions proposed throughout the document are similar in nature.

Ms. Henning said the drafting group also suggests that the Technical Group consider a recommendation to the Financial Regulation Standards and Accreditation (F) Committee to revise its guideline related to the use of Exhibit Z – Exam Coordination, as a key purpose of Exhibit Z is to facilitate communication with other states regarding exam coordination. The Handbook states that Exhibit Z should be completed when a holding company group includes companies from multiple states, whereas the Accreditation Manual states that Exhibit Z should be completed when a holding company group includes multiple insurance companies. Ms. Henning said although no revisions to Exhibit Z are proposed at this time, the Working Group expects to revisit this exhibit in the future after a replacement workpaper program has been implemented in order to synchronize the exhibit with the work program procedure steps.

Jeff Martin (UnitedHealthcare—UHC) expressed his appreciation for the work completed by the drafting group, and he indicated a willingness to collaborate with the Technical Group on this subject in the future.

The Technical Group agreed to expose the proposed revisions for a 30-day public comment period ending Nov. 5.

Ms. Bernard recommended that the Technical Group project related to updating the capital and surplus repository to incorporate high-level internal capital model review procedures be deferred until 2022. She said the Technical Group adopted extensive revisions related to the review and utilization of the Own Risk and Solvency Assessment (ORSA) summary report during 2020, and it would like more states to have the opportunity to conduct an examination using those updated procedures before the Technical Group proposes additional revisions in this area.

Having no further business, the Financial Examiners Handbook (E) Technical Group adjourned.
EXAMINATION REPOSITORY – RESERVES/CLAIMS HANDLING (HEALTH)

Annual Statement Blank Line Items

Listed below are the corresponding Annual Statement line items that are related to the identified risks contained in this exam repository:

Claims Unpaid (Less Reinsurance Ceded)
Accrued Medical Incentive Pool and Bonus Payments
Unpaid Claims Adjustment Expenses
Aggregate Health Policy Reserves
Aggregate Life Policy Reserves
Property/Casualty Unearned Premium Reserves
Aggregate Health Claim Reserves

Relevant Statements of Statutory Accounting Principles (SSAPs)

The relevant SSAPs related to the health insurance reserving process, regardless of whether or not the corresponding risks are included within this exam repository, are listed below:

No. 5R Liabilities, Contingencies and Impairments of Assets – Revised
No. 50 Classifications of Insurance or Managed Care Contracts
No. 54R Individual and Group Accident and Health Contracts
No. 55 Unpaid Claims, Losses and Loss Adjustment Expenses
No. 61R Life, Deposit-Type and Accident and Health Reinsurance – Revised
No. 66 Retrospectively Rated Contracts
No. 107 Risk-Sharing Provisions of the Affordable Care Act
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<tr>
<th>Identified Risk</th>
<th>Branded Risk</th>
<th>Exam Asrt.</th>
<th>Critical Risks</th>
<th>Possible Controls</th>
<th>Possible Test of Controls</th>
<th>Possible Detail Tests</th>
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<td>Other Than Financial Reporting Risks</td>
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<td>The board of directors (or committee thereof) is not involved in establishing and/or reviewing the insurer’s overall reserving practices.</td>
<td>OP ST RV</td>
<td>Other</td>
<td>RA</td>
<td>The insurer’s board of directors (or committee thereof) has adopted and/or reviewed the insurer’s overall reserving practices.</td>
<td>Verify that the insurer has established overall reserving practices that have been adopted and/or reviewed by the board of directors (or committee thereof).</td>
<td>Obtain information on the insurer’s overall reserving practices, including meeting materials, and forward it to the insurance department actuary or an independent actuary for review.</td>
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<td>The board of directors (or committee thereof) regularly discusses reserving issues and receives reports from the appointed actuary. The reports include an explanation of the reserving policy and methodology, as well as an analytical review of the insurer’s reserves.</td>
<td>Review board of directors (or committee thereof) minutes to ensure discussion of reserving. Review meeting materials to determine if materials would properly facilitate BOD oversight.</td>
<td>Discuss with members of the board of directors (or committee thereof) their level of involvement in the monitoring of reserving practices.</td>
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<td>The insurer monitors and revises its reserving practices as needed.</td>
<td>Observe that revisions made by the insurer to its reserving practices are reviewed and/or approved by the board of directors (or committee thereof).</td>
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<td>Financial Reporting Risks</td>
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<td>New claims are not entered into the claims management system (i.e., claims population is not complete).</td>
<td>RP LG</td>
<td>AC CT CO</td>
<td>RD</td>
<td>Segregation of duties exists between the claim notification and the input of claims data into the claims system.</td>
<td>Observe that segregation of duties exists between the claim notification and the input of claims data into the claims system.</td>
<td>Select a sample of items from the exception reports and verify that the claim was appropriately accounted for.*</td>
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<td>Control reports exist to ensure all claims reported to the insurer electronically or manually have been entered into the claims system.</td>
<td>Obtain the exception report and ensure management reviews the report and resolution of any exceptions</td>
<td>Select a sample of claim and expense payments made subsequent to year-end to verify that claims were recorded in the proper</td>
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<td>Identified Risk</td>
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<td>Exceptions are identified and resolved timely.</td>
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<td>Test the operating effectiveness of the automated claims posting process through reperformance and observation, which could include IT testing of batch totals to ensure completeness of transactions processed.</td>
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<td>Perform analytical procedures to verify the claims were recorded in the correct period (i.e. average claim count before and after period-end).</td>
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<td>The insurer reviews the Type II SOC 1 reports and ensures compliance with user-control considerations for any outsourcing companies that enter claims on behalf of the insurer.</td>
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<td>Obtain documentation of management’s review of the Type II SOC 1 reports.</td>
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<td>Review Type II SOC 1 reports, including bridge letters, to ensure there are no significant control deficiencies or internal control weaknesses related to processing new claims into the claims system.</td>
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<tr>
<td>Claims data (e.g., claim attributes) in the claims database are inaccurate or incomplete, or incorrectly entered into the claims management system.</td>
<td>OP LG</td>
<td>AC CT CO EX</td>
<td>RD</td>
<td>Claims data is subject to independent verification or quality assurance (QA) reviews.</td>
<td>Obtain documentation of independent claim verification or QA review. Ensure reviews performed address the completeness and accuracy of underlying claims information entered into the system.</td>
<td>Perform data validation tests to verify the accuracy of claim information maintained in the claims system, such as coverage terms, demographic data, date of service, provider name, service description or code, insured name, claim number, paid claim date, paid claim amount and coverage period by vouching the information to the claimant’s insurance contract, claims form and any other underlying support. Utilize an actuary to determine the most significant lines of business and data points used in the estimate and focus accuracy.</td>
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<td>populate select policy data. System edits will identify data that does not meet the predetermined criteria, such as an invalid social security format or missing provider name, resulting in inclusion on a system-generated exception report.</td>
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<td>reperformance and observation.</td>
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<td>testing on those *</td>
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<td>Segregation of duties exists between individuals responsible for new claim set-up and those responsible for setting up new policies.</td>
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<td>Obtain claims set-up and new policy set-up authorization listings and cross-reference the listings to ensure that there are no employees with conflicting authority.</td>
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<td>Scan the database(s) for internal inconsistencies, such as missing claim amounts, unusually small amounts and claims misclassified by type (e.g., Medicare).</td>
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<td>In situations where adequate segregation of duties is not apparent, obtain data to determine whether any claims were set up by the same user who created the corresponding policy in the master file. If any instances are identified, investigate the claim to ensure the claim exists and is supported by underlying data.</td>
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<td>Perform analytical procedures over the population of claims data (i.e., paid claims) at the appropriate disaggregation level to identify any unusual trends or anomalies pertaining to the accuracy of claims data that should be further investigated.</td>
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The third-party administrators (TPAs), or managing general agents (MGAs), are not processing claims in

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<td>The third-party administrators (TPAs), or managing general agents (MGAs), are not processing claims in</td>
<td>LG OP RP</td>
<td>AC CM</td>
<td>RD</td>
<td>The insurer performs regular audits of its TPAs/MGAs to determine whether insurer claims handling standards and additional contract</td>
<td>Review audit reports and other documentation to determine whether the insurer provides sufficient oversight of its TPAs/MGAs.</td>
<td>Determine, by a review of selected claims, whether the insurer is settling its claims accurately and in accordance with the contract, based on</td>
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<td>accordance with the insurer’s claims procedures as outlined in the TPA agreement.</td>
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<td>provisions are being consistently followed by the TPA.</td>
<td>Verify that the insurer has obtained and reviewed the TPA’s Type II SOC 1 report, if available.</td>
<td>information contained in the claim file.*</td>
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<td>Management obtains a Type II SOC 1 report for all TPAs and reviews the report to verify whether the TPA has adequate controls and that the insurer is adhering to user control considerations.</td>
<td>Determine whether the insurer is adhering to user control considerations.</td>
<td>Review the Type II SOC 1 report to determine whether the controls outlined in the report are adequate to ensure that claims are being processed in accordance with the TPA agreement.</td>
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<td>Management performs necessary reviews to comply with applicable state MGA regulations.</td>
<td>Obtain evidence of management’s review of compliance with applicable state MGA regulations.</td>
<td>Test for compliance with applicable state MGA regulations.</td>
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<tr>
<td>Claims are not being processed accurately and in accordance with insurer guidelines.</td>
<td>OP ST LG</td>
<td>AC CM CO</td>
<td>RD</td>
<td>The insurer has administrative policies and maintains a claims procedures manual that outlines the following requirements:</td>
<td>Review the claims procedures manual to determine its appropriateness, including management approval.</td>
<td>Perform tests to determine whether claims were accurately processed in accordance with the claims procedures manual, approved authority limits and administrative policies through review of the claimant’s insurance contract, claims form and any other underlying support.</td>
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<td>- Maximum benefit to be paid based on procedure type.</td>
<td>Review policyholder complaints and investigate significant issues.</td>
<td>Review a sample of denied claims to ensure compliance with contract provisions.*</td>
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<td>- Usual, customary and reasonable (UCR) limitations.</td>
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<td>- Proper application of deductibles.</td>
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<td>- Reserving and payment authority and approval levels.</td>
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<td>- File documentation and tracking.</td>
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<td>- Procedures for handling suspicious and/or fraudulent claims.</td>
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<td>- Compliance with</td>
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<td>applicable state fair claims practices laws and/or regulations.</td>
<td>Test the operating effectiveness of system edit checks to ensure procedures are implemented through reperformance and observation.</td>
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<td>Automated controls are in place to ensure that paid losses are not to exceed policy limits, cover ineligible loss causes/types and/or apply to a policy period for which insurer is not contractually responsible. Any consideration to pay a loss must be processed in accordance with the insurer’s procedures. As part of the claims processing procedures, the insurer obtains adequate documentation and coverage of benefits before a claim is settled. Claims approval is subject to approved authority limits. A QA review is periodically performed for each claims processor to ensure compliance with the claims handling policies.</td>
<td>Review assessments of the claims handling process performed by internal/external auditors, reinsurers and/or others for significant issues. Test the operating effectiveness of controls to ensure adequate documentation is obtained before payment is made. Test the controls in place to ensure that claims are approved in accordance with documented authority limits. Review documentation of QA reviews to determine that the QA function is being executed as outlined in the insurer’s policies. On a sample basis, reperform the QA testing to ensure that the testing was completed accurately.</td>
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<td>The claims data utilized by the actuary to estimate reserves does not correspond to the data in the insurer’s claims system and to the data in the insurer’s accounting records.</td>
<td>OP RV</td>
<td>AC CO</td>
<td>RD</td>
<td>The insurer has established procedures to reconcile actuarial data and claims triangles to the insurer’s claims system, the data in the insurer’s accounting records and appropriate annual financial statement schedules and/or exhibits (3-way match). Such reconciliations are reviewed by supervisory personnel. Inventories of reported and unpaid claims are maintained and periodically reconciled to the general ledger.</td>
<td>Review the insurer’s reconciliation reports of actuarial data and claims triangles to the insurer’s claims system and the insurer’s accounting records. Ensure evidence of supervisory review. Review the insurer’s reconciliation of reported and unpaid claims to the general ledger.</td>
<td>Test any reconciling items within the reconciliations for appropriateness. Reconcile the insurer’s actuarial report for claims paid and claims adjustment expenses (CAE) to supporting insurer reports (trace into claim lags), general ledger and annual financial statement schedules and exhibits as of the valuation date. Vouch payment of claim into bank statement. Test completeness of the data by gap testing sequences of checks and investigating any gaps as well utilizing bank reconciliations and testing any outstanding checks. Perform analytical procedures to review the reasonableness of paid claims.</td>
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<td>Reinsurance is not properly taken into account in accumulating claims data.</td>
<td>RV</td>
<td>AC CO</td>
<td>RD RRC</td>
<td>The insurer has established procedures to prepare the claims data for actuarial review in accordance with the insurer’s reinsurance treaties.</td>
<td>Review the insurer’s reconciliation reports of actuarial data to the insurer’s claims system, reinsurance reports, and accounting records. Test the operating effectiveness of the insurer’s established procedures to include</td>
<td>Test reconciling items relating to reinsurance claims data for appropriateness. Verify assumed reinsurance claims data accumulated for actuarial review by comparing to the data provided by the ceding insurer for completeness.</td>
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<td>Initial claim reserves are not established or reviewed in accordance with insurer standards.</td>
<td>RV CR</td>
<td>AC VA CO</td>
<td>RA</td>
<td>The insurer has a claim reserving philosophy and qualified actuaries are involved in establishing and reviewing the reserving policy. Initial reserves are made in accordance with the insurer’s reserving philosophy and within a specified time frame. Claim adjusters/supervisors are required to review significant initial case reserves on a timely basis and make adjustments as necessary. Committees are formed to evaluate and strategize claims involving serious injuries, complex claims law, and large or unusual loss reserve determinations or settlements.</td>
<td>Obtain documentation supporting the insurer’s reserving philosophy. Review reserving philosophy for actuary review and policy adequacy. For a sample of loss reserves, determine whether loss reserve reviews were performed and documented in accordance with insurer policy. Obtain periodic new claims reports and verify the insurer reviews significant initial case reserves and makes adjustments, if necessary, in a timely manner. Obtain minutes and other meeting materials from the meetings of the committee to determine whether the committee provided appropriate oversight.</td>
<td>For a sample of reserves verify that the calculation is in accordance with the reserving philosophy and that reserves are calculated on a timely basis.* For a sample of reserves meeting the criteria to go to a claims committee, determine whether the reserves were referred to this committee.* Confirm a sample of unpaid claims with major providers.</td>
</tr>
<tr>
<td>Claim reserves (other than IBNR) are not updated accurately.</td>
<td>RV CR</td>
<td>CO VA</td>
<td>RA</td>
<td>The insurer has a policy requiring open claims to be reviewed regularly. When new information is received, case reserves are reviewed and adjusted, if necessary.</td>
<td>From a sample of claim reserves (other than IBNR), determine whether the reserves are updated regularly and are appropriately updated when new information is received.</td>
<td>Select a sample of paid claims and compare the final overall claims settlement with the case reserve to determine whether the reserves are adequate and/or updated.</td>
</tr>
</tbody>
</table>

*Note: Details tests marked with an asterisk (*) are specific and may require additional context or clarification based on the unique circumstances of the insurer or the scope of the examination.
<table>
<thead>
<tr>
<th>Identified Risk</th>
<th>Branded Risk</th>
<th>Exam Asrt.</th>
<th>Critical Risks</th>
<th>Possible Controls</th>
<th>Possible Test of Controls</th>
<th>Possible Detail Tests</th>
</tr>
</thead>
</table>
| The assumptions and methodologies used by the insurer for the health, long-term care and long-term disability business are not accurate and appropriate. | RV VA AC PD RA | The insurer uses consistent assumptions and methodologies that have been based on historical results (to the extent appropriate), adequately documented, approved by senior management and in accordance with statutory accounting principles (SAPs), Actuarial Standards of Practice (ASOPs), and applicable state statutes and/or regulations. Senior management uses either internal or independent actuaries to conduct reserve analyses of all major lines of business on an annual basis. Actuarial analysis is subject to a peer review process. | Gain an understanding of the insurer’s assumptions and methodologies and compare with prior periods. Verify that senior management signs off on assumptions and methodologies used by the insurer, including any changes. Verify senior management review of reports from actuaries and that reports include reserve analyses of all major lines of business. If performed in-house, review and test the actuarial peer review process and related sign-offs. | Obtain copies of the reserve reports, noting management approval. Perform analytical procedures to determine whether the actual reserves were adequate and appropriately updated based upon the amount paid. Verify that the information contained in the reports is accurate and determine whether the appropriate analyses are being used to evaluate the reserves. Review assumptions and methodologies for reasonableness, appropriateness and accuracy, with assistance from the insurance department actuary or an independent actuary. Verify that reserving assumptions are in accordance with the relevant SSAPs related to health reserving, as well as any applicable state statutes, regulations, actuarial guidelines, pronouncements and/or bulletins. Review prior history of claims development, as well as subsequent claims development data to analyze the reasonableness of assumptions and
<table>
<thead>
<tr>
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<th>Exam Asrt.</th>
<th>Critical Risks</th>
<th>Possible Controls</th>
<th>Possible Test of Controls</th>
<th>Possible Detail Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management receives regular reports on loss ratios by line or class of business, as well as other key ratios and operational reports (e.g., claim count, per member per month ratio, etc.), and reviews unusual fluctuations on a timely basis to review reserves for adequacy.</td>
<td>Verify management review of reserve reporting and test the operating effectiveness of procedures in place.</td>
<td>methodologies and identify any management judgments/assumptions related to estimates that indicate possible bias.</td>
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<tr>
<td>The insurer utilizes a fully staffed, well-qualified actuarial department that is under the direction of a fellow of the Society of Actuaries (FSA) or member of the American Academy of Actuaries (MAAA) and is experienced in the lines of business written by the insurer.</td>
<td>Review the credentials, background and responsibilities of the insurer’s actuarial department (internal or external) for appropriateness.</td>
<td>Determine whether the appropriate disclosures have been made in the Notes to the Financial Statements for the changes in reserve methodologies.</td>
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<tr>
<td>The reserving actuarial unit’s responsibilities are segregated from the pricing actuarial unit, but there is regular communication between the two units.</td>
<td>Request and review the insurer’s organizational chart and job descriptions to determine whether the functions are separate and distinct.</td>
<td>Review actuarial reports and compare reports to prior periods. Investigate significant variations.</td>
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<tr>
<td>The insurer’s organizational structure limits the influence that management can have on the appointed actuary.</td>
<td>Interview the appointed actuary during the planning phase of the examination to determine whether the insurer’s organizational structure is appropriate in this area.</td>
<td>Utilize the insurance department actuary or an independent actuary to perform an independent calculation/estimate of the reserves.</td>
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<td></td>
<td>Review insurer processes in place to calculate the reserve calculations to ensure consideration is</td>
<td>Review correspondence related to peer review for appropriate depth of review.</td>
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<td>Compare the opining actuary’s assumptions and estimates with those in other available actuarial analyses.</td>
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<td>Determine whether the Actuarial Opinion was changed by the appointed actuary after meeting with insurer management.</td>
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</tr>
<tr>
<td>Identified Risk</td>
<td>Possible Controls</td>
<td>Possible Test of Controls</td>
<td>Health Reserve Repository</td>
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</tr>
<tr>
<td>Critical Risks</td>
<td>Exams Asrs.</td>
<td>Details Tests</td>
<td>Review the process in place to estimate the claims unpaid, claim reserves, policy reserves and premium deficiency reserves on an annual basis.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Branded Risk</td>
<td></td>
<td></td>
<td>Review the credentials, background and responsibilities of the insurer's actuarial department staff for appropriateness.</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td>Obtain actuarial reports to verify insurer is using either independent or in-house actuaries to perform the reserve calculations on all major lines of business annually and verify senior management review.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>The actuarial calculations are subject to a peer review process.</td>
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</tr>
</tbody>
</table>

The insurer has appropriately established procedures to include policy lapse rates when calculating the reserving estimates. Given to policy lapse rates.

The insurer has an established process (although assumptions and methodologies may change) to estimate the claims unpaid, claim reserves, policy reserves and premium deficiency reserves on an annual basis.

The insurer maintains a fully staffed, well-qualified actuarial department that is under the direction of a fellow of the Society of Actuaries (FSA) or member of the American Academy of Actuaries (MAAA) and is experienced in the lines of business written by the insurer.

Senior management uses either internal or independent actuaries to conduct reserve analyses of all major lines of business annually. If performed in-house, review and test the actuarial peer review process.
<table>
<thead>
<tr>
<th>Identified Risk</th>
<th>Branded Risk</th>
<th>Exam Asrt.</th>
<th>Critical Risks</th>
<th>Possible Controls</th>
<th>Possible Test of Controls</th>
<th>Possible Detail Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>The claims adjustment expense (CAE) computations are not performed correctly.</td>
<td>OP RV</td>
<td>AC VA CO</td>
<td>RA</td>
<td>The insurer has established processes to estimate both the cost containment and other claim adjustment reserves on an annual basis. The insurer maintains a fully staffed, well-qualified actuarial department that is under the direction of a fellow of the Society of Actuaries (FSA) or member of the American Academy of Actuaries (MAAAA) and is experienced in the lines of business written by the insurer.</td>
<td>Review the processes (which could include a walkthrough) in place to calculate both the cost containment and other claim adjustment reserves. Review the credentials, background and responsibilities of the insurer’s actuarial department staff for appropriateness. Obtain actuarial reports to verify the insurer is using either independent or in-house actuaries to perform</td>
<td>Utilize the insurance department actuary or an independent actuary to perform an independent calculation/estimate of the CAE. Perform analytical procedures to review the reasonableness of CAE calculations.</td>
</tr>
</tbody>
</table>

The insurer’s board of directors (or committee thereof) receives an annual presentation on the actuarial analysis process.

Management receives regular reports on claims ratios (including claims unpaid, claims reserve, policy reserve and premium deficiency reserve) by line or class of business for accident year and calendar year, as well as other key ratios, and reviews unusual fluctuations on a timely basis to review reserves for adequacy.
<table>
<thead>
<tr>
<th>Identified Risk</th>
<th>Branded Risk</th>
<th>Exam Asrt.</th>
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<th>Possible Detail Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in the legal environment or changes in the insurer’s</td>
<td>OP RV ST VA PD AC RA</td>
<td></td>
<td></td>
<td>Senior management uses either internal or independent actuaries to conduct separate cost containment and other claim adjustment reserve analyses on an annual basis.</td>
<td>Verify senior management review of reports from actuaries.</td>
<td>If the analyses are performed in-house, review and test the actuarial peer review process and related sign-offs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The actuarial analyses are subject to a peer review process.</td>
<td></td>
<td>Review the board of directors’ (or committee thereof) meeting minutes to verify whether a presentation was given on the actuarial analysis process.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The insurer’s board of directors (or committee thereof) receives an annual presentation on the actuarial analysis process.</td>
<td></td>
<td>Verify management review of reserve reporting and test the operating effectiveness of procedures in place.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Management receives regular reports on loss ratios by line or class of business, as well as other key ratios, and reviews unusual fluctuations on a timely basis to review reserves for adequacy.</td>
<td></td>
<td>Through a review of the actuarial reports, determine whether changes in the legal environment and/or changes</td>
</tr>
<tr>
<td>Changes in the legal environment or changes in the insurer’s</td>
<td>OP RV ST VA PD AC RA</td>
<td></td>
<td>The insurer has procedures in place for its legal department to monitor and communicate changes in the</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Identified Risk</td>
<td>Branded Risk</td>
<td>Exam Asrt.</td>
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</tr>
<tr>
<td>underwriting, reserving or claims handling processes are not appropriately considered within the insurer’s reserving assumptions and methodologies.</td>
<td></td>
<td></td>
<td></td>
<td>legal environment (e.g., changes in case law, award amounts, trends in the number of claims being litigated) are being taken into consideration by the reserving unit in a timely manner.</td>
<td>process.</td>
<td>in the insurer’s internal processes have been properly incorporated in the insurer’s reserving assumptions and methodologies.</td>
</tr>
<tr>
<td>The computations of reinsurance credits within the reserves are not performed correctly. (See also Examination Repository – Reinsurance Ceding Insurer)</td>
<td>CR RV</td>
<td>AC CO</td>
<td>RA RRC</td>
<td>The reserving actuary calculates the reserve on a gross basis and determines the net basis by estimating the reinsurance credits and applying them to the gross reserve.</td>
<td>Test the operating effectiveness of the insurer’s process for reviewing the reserve analysis to determine whether reserves have been estimated on a gross basis, including management approval and sign-off.</td>
<td>Compare the annual financial statement net and gross incurred and paid loss presentation for consistency with reinsurance treaties in place at the insurer. Consider the reasonableness of reinsurance credits taken, based on a review of the insurer’s reinsurance program and treaties in place.</td>
</tr>
<tr>
<td>The insurer is not properly recording case reserves (assumed or ceded) for contracts subject to reinsurance.</td>
<td>RV CR LG</td>
<td>CO AC</td>
<td>RA RRC</td>
<td>The insurer has policies in place to verify that case reserves subject to reinsurance are valid and accurate (within contract time frame, covered under</td>
<td>Review insurer policies to determine appropriateness, noting management approval.</td>
<td>Utilize the NAIC Examination Jumpstart report to determine whether case reserves recorded by the insurer agree with the case reserves of the</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td>process.</td>
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</tbody>
</table>

**Identified Risk**

- underwriting, reserving or claims handling processes are not appropriately considered within the insurer’s reserving assumptions and methodologies.

**Critical Risks**

- legal environment (e.g., changes in case law, award amounts, trends in the number of claims being litigated) are being taken into consideration by the reserving unit in a timely manner.

- The insurer has procedures in place for the underwriting, case reserving and claims handling units to communicate changes in their processes to the reserving unit in a timely manner.

- The computations of reinsurance credits within the reserves are not performed correctly. (See also Examination Repository – Reinsurance Ceding Insurer)

- The insurer applies reinsurance credits to reserves by reviewing reinsurance treaties in place at the insurer, as well as historical results.

- The insurer is not properly recording case reserves (assumed or ceded) for contracts subject to reinsurance.

**Possible Controls**

- The reserving actuary calculates the reserve on a gross basis and determines the net basis by estimating the reinsurance credits and applying them to the gross reserve.

- The insurer applies reinsurance credits to reserves by reviewing reinsurance treaties in place at the insurer, as well as historical results.

- The insurer has policies in place to verify that case reserves subject to reinsurance are valid and accurate (within contract time frame, covered under

**Possible Test of Controls**

- Test the operating effectiveness of the insurer’s process for reviewing the reserve analysis to determine whether reserves have been estimated on a gross basis, including management approval and sign-off.

- Test the operating effectiveness of the insurer’s process to estimate reinsurance credits for reserves, including management approval and sign-off.

- Review documentation of reinsurance treaties in place.

**Possible Detail Tests**

- in the insurer’s internal processes have been properly incorporated in the insurer’s reserving assumptions and methodologies.

- Compare the annual financial statement net and gross incurred and paid loss presentation for consistency with reinsurance treaties in place at the insurer.

- Consider the reasonableness of reinsurance credits taken, based on a review of the insurer’s reinsurance program and treaties in place.
<table>
<thead>
<tr>
<th>Identified Risk</th>
<th>Branded Risk</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Management books reserves that are materially different than the actuary’s best estimate.</td>
<td>OP ST LG</td>
<td>VA PD RA</td>
<td>the contract, etc.).</td>
<td>insurer’s review of claim validity.</td>
<td>assuming (ceding) insurer.</td>
<td></td>
</tr>
<tr>
<td>The insurer has a process in place to ensure that reserves are recorded based on the actuary’s best estimate, or documents an appropriate reason for any deviations.</td>
<td></td>
<td></td>
<td>Review management guidelines regarding the recording of actuarially determined reserves. Verify that deviations from the actuary’s best estimate are properly documented, if applicable.</td>
<td></td>
<td>Review the actuarial report, as well as the annual financial statements and other appropriate documentation, to determine whether the insurer has booked the actuary’s best estimate.</td>
<td></td>
</tr>
<tr>
<td>The board of directors (or committee thereof) reviews management’s best estimate of booked reserves and challenges such estimates based on reports received, including the actuarial report from the appointed actuary.</td>
<td></td>
<td></td>
<td>Review the board of directors (or committee thereof) meeting minutes for evidence of a presentation and review of information supporting management’s best estimate of the booked reserves (i.e., the actuarial report).</td>
<td></td>
<td>Review the documentation supporting a deviation from the actuary’s best estimate for reasonableness, if applicable.</td>
<td></td>
</tr>
<tr>
<td>The insurer’s organizational structure limits the influence that management can have on the appointed actuary.</td>
<td></td>
<td></td>
<td>Interview the appointed actuary during the planning phase of the examination to determine whether the insurer’s organizational structure is appropriate in this area.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The insurer does not maintain an adequate premium deficiency reserve.</td>
<td>RV LQ OP</td>
<td>VA CO CM RA</td>
<td>The insurer has a process in place to review for premium deficiencies on an annual basis in accordance with SSAP No. 54.</td>
<td>Review the process in place and verify key controls surrounding the calculation of premium deficiency reserves.</td>
<td>Perform an analytical review of loss ratios.</td>
<td></td>
</tr>
<tr>
<td>Independent actuaries review and sign off on premium deficiency reserve calculations.</td>
<td></td>
<td></td>
<td>Obtain the actuarial opinion and verify approval of premium deficiency reserve calculations.</td>
<td></td>
<td>If necessary, utilize the insurance department actuary or an independent actuary to perform a detailed review or an independent calculation/estimate of the premium deficiency reserves.</td>
<td></td>
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</tbody>
</table>
EXAMINATION REPOSITORY – RESERVES/CLAIMS HANDLING (LIFE)

Annual Statement Blank Line Items
Listed below are the corresponding Annual Statement line items that are related to the identified risks contained in this exam repository:

- Aggregate Reserve for Life Contracts
- Aggregate Reserve for Accident and Health Contracts
- Liability for Deposit-Type Contracts
- Contract Claims

Relevant Statements of Statutory Accounting Principles (SSAPs)
All of the relevant SSAPs related to the life insurance reserving process, regardless of whether or not the corresponding risks are included within this exam repository, are listed below:

- No. 5R Liabilities, Contingencies and Impairments of Assets – Revised
- No. 50 Classifications of Insurance or Managed Care Contracts
- No. 51R Life Contracts
- No. 52 Deposit-Type Contracts
- No. 54R Individual and Group Accident and Health Contracts
- No. 55 Unpaid Claims, Losses and Loss Adjustment Expenses
- No. 61R Life, Deposit-Type and Accident and Health Reinsurance – Revised
- No. 63 Underwriting Pools
## Other Than Financial Reporting Risk

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>The board of directors (or committee thereof) is not involved in establishing and/or reviewing the insurer’s overall reserving policy.</td>
<td>ST</td>
<td>Other</td>
<td>RA</td>
<td>The insurer’s board of directors (or committee thereof) has adopted and/or reviewed the insurer’s overall reserving policy.</td>
<td>Verify that the insurer has established overall reserving policy that have been adopted and/or reviewed by the board of directors (or committee thereof).</td>
<td>Obtain information on the insurer’s overall reserving policy and forward it to the insurance department actuary or an independent actuary for review.</td>
</tr>
<tr>
<td></td>
<td>RV</td>
<td></td>
<td></td>
<td>The board of directors (or committee thereof) regularly discusses reserving issues and receives reports from the appointed actuary. The reports include an explanation of the reserving policy and methodology, as well as an analytical review of the insurer’s reserves.</td>
<td>Review board of directors (or committee thereof) minutes to ensure discussion of reserving. Review meeting materials to determine if materials would properly facilitate BOD oversight.</td>
<td>Discuss with members of the board of directors (or committee thereof) their level of involvement in monitoring the implementation of reserving policy.</td>
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<td></td>
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<td></td>
<td>The insurer monitors and revises its reserving policy as needed.</td>
<td>Obtain information on revisions made by the insurer to its reserving practices and verify the revisions were appropriately reviewed and/or approved by the board of directors (or committee thereof).</td>
<td></td>
</tr>
<tr>
<td>The insurer has not taken appropriate steps to prepare for the implementation of Principle-Based Reserving (PBR).</td>
<td>RV</td>
<td>Other</td>
<td>RA</td>
<td>The insurer has a PBR implementation plan that includes consideration of staffing needs and appropriate expertise in current and/or future budgets and strategic plans.</td>
<td>Verify that budgets and/or strategic plans contain consideration of PBR implementation needs including qualified staff.</td>
<td>Review the insurer’s PBR implementation plan for reasonableness.</td>
</tr>
<tr>
<td>Note: Under the requirements of the Valuation Manual, companies have until 1/1/2020 to implement PBR requirements. See Section 1, VI, for further information on</td>
<td>ST</td>
<td></td>
<td>RD</td>
<td>Determine if the company has adequate suitability requirements in place for the actuarial department that requires the actuarial staff to be qualified to implement and practice a PBR methodology.</td>
<td>Review actuarial department staff qualifications to determine if suitability requirements are met and/or determine if actuarial staff has adequate training available for implementation of PBR. Consider involving an IT specialist in a review of system capabilities</td>
<td></td>
</tr>
<tr>
<td>Identified Risk</td>
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<tr>
<td>the implementation of PBR.</td>
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<td></td>
<td></td>
<td></td>
<td>Review the insurer’s procedures to determine if pending PBR implementation needs are continuously monitored by company personnel. Consider if certain products have been exempted and the appropriateness of that determination.</td>
<td>necessary for PBR implementation.</td>
</tr>
</tbody>
</table>

**Financial Reporting Risks**

<p>| In-force data is not complete or accurate nor consistent with accounting records | OP | RV | CO | AC | RD | The insurer has established appropriate internal controls over the input and maintenance of in-force data as outlined in the Examination Repository – Underwriting. The in-force data is tested periodically by the insurer’s quality assurance (QA) function for completeness and accuracy. The insurer’s system is programmed to issue insurance contracts utilizing sequential policy numbers. In-force database is | Perform tests to verify the operating effectiveness of policy in-force controls as outlined in the Examination Repository – Underwriting. Review the QA reports relating to the testing of in-force data to verify the operating effectiveness of the controls. Verify through observation and/or reperformance that system parameters prohibit the issuance of non-sequential policy numbers. Ensure management review of exceptions. Test reconciliation process | Obtain a copy of the listing detailing in-force insurance contracts provided to the insurer’s actuary. Perform procedures to verify the completeness of this listing by tracing to the database a sample of contracts selected from sources outside the reserve system (e.g., premium cash collections). Use control totals for face amount, benefits, and policy count in order to detect use of incorrect files.* In conjunction with the testing performed in the Examination Underwriting Repository, select a sample of in-force insurance contracts within the system to trace to the underlying... |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>The data utilized in the company’s PBR model is not representative and consistent with the company’s in-force data.</td>
<td>OP RV</td>
<td>AC CO</td>
<td>RD</td>
<td>Reconciled records on a periodic basis.</td>
<td>For supervisory review, appropriateness and operating effectiveness.</td>
<td>Contract in order to verify that the system data reflects the actual insurance contract provisions and relevant attributes that are deemed significant by the actuary.*</td>
</tr>
</tbody>
</table>

- Review complaint logs for misapplied payments, missing policy documentation and investigate the status of the complaint.
- Reconcile data elements to AS reporting.
- Send confirmation to policyholder to verify accuracy of significant attributes.
- Perform analytical procedures to verify the completeness and accuracy of in-force data.
- Compare in-force aggregation and statistics for products under scope of PBR to model output reports at period zero for attributes such as:
  - Average issue age
  - Gender distribution
  - Total policy counts
  - Total face amounts
  - Total fund values
  - Total annualized premium
<table>
<thead>
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<th>Possible Detail Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-force data is not appropriately restricted and protected to maintain accurate and complete data.</td>
<td>OP</td>
<td>AC CO EX</td>
<td>RA RD</td>
<td>Data utilized in the PBR model is reconciled to in-force records on a periodic basis.</td>
<td>*Fund values  *Annualized premium</td>
<td>Test reconciliation process for supervisory review, appropriateness and operating effectiveness. If concerns are noted, select a sample of policies from the company’s PBR model and obtain the valuation system audit trail (cash flows discounted back to the reserve value). With the help of an actuary, identify significant attributes of the policyholder and validate them by agreeing back into the administrative system.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The insurer maintains logical access controls, including password protection and active directories, to properly restrict access to in-force data.</td>
<td>Test the operating effectiveness of logical access controls by reviewing documentation relating to requests for access and by attempting to have unauthorized individuals access the in-force data.</td>
<td>Test the operating effectiveness of segregation controls by attempting to have individuals authorized to access in-force data access claims processing or other systems. Perform a walkthrough to gain an understanding of the insurer’s process to make changes to in-force policies.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>The insurer has appropriately segregated its duties to ensure that individuals with the ability to update in-force data do not have conflicting responsibilities.</td>
<td></td>
<td>Test a sample of changes made to in-force policies during the year by reviewing supporting documentation.*</td>
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<td></td>
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<td></td>
<td>The insurer has established policies and procedures for making accurate, timely changes to policies.</td>
<td></td>
<td>Test a sample of changes to policies reviewed by the QA</td>
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<td></td>
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<td></td>
<td>The insurer has established a QA process to review</td>
<td></td>
<td>Select a sample of in-force policy data at the examination as of date for accuracy and completeness testing. *</td>
</tr>
</tbody>
</table>

*Test a sample of changes made to in-force policies during the year by reviewing supporting documentation.*
<table>
<thead>
<tr>
<th>Identified Risk</th>
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<th>Possible Controls</th>
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<th>Possible Detail Tests</th>
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<tbody>
<tr>
<td>Reinsurance is not properly taken into account in accumulating in-force data. (See also Examination Repository – Reinsurance Assuming Insurer.)</td>
<td>RV</td>
<td>AC</td>
<td>RD</td>
<td>The insurer has established procedures to prepare the in-force data for actuarial review in accordance with the insurer’s reinsurance treaties.</td>
<td>Review the insurer’s reconciliation reports of actuarial data to the insurer’s in-force system, reinsurance reports, and accounting records.</td>
<td>Test reconciling items relating to reinsurance in-force data for appropriateness. Verify the assumed reinsurance in-force data accumulated for actuarial review by comparing to the data provided by the ceding insurer for completeness. Utilize the NAIC Examination Jumpstart report to compare in-force amounts reported by the assuming insurer to those amounts reported by the ceding insurer.</td>
</tr>
<tr>
<td>The insurer does not properly monitor XXX/AXXX reserve development related to its ceded reinsurance transactions.</td>
<td>RV</td>
<td>AC</td>
<td>RA</td>
<td>The insurer monitors actual experience on ceded reinsurance relative to the initial or most recent projections and monitors underlying assumptions to evaluate asset adequacy and report any material adverse deviations to management.</td>
<td>Review the insurer’s process to monitor experience on ceded reinsurance transactions and verify that material adverse deviations are reviewed by management.</td>
<td>Determine whether the insurer’s ceded reinsurance transactions are tracking appropriately relative to the initial or most recent projections and underlying assumptions. For example, compare actual deaths under the reinsurance transaction with expected deaths assumed in the reserve under the reinsurance transaction. Consider utilizing an actuarial specialist to assist in this determination.</td>
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<td>Identified Risk</td>
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<tr>
<td>related reserves.</td>
<td>RV</td>
<td>VA AC PD</td>
<td>RA</td>
<td>The insurer uses consistent assumptions and methodologies that have been based on guidelines outlined in the <em>Valuation Manual</em> (VM) and Appendix A and Appendix C of the NAIC <em>Accounting Practices and Procedures Manual</em> (to the extent appropriate), adequately documented, approved by senior management, and in accordance with statutory accounting principles (SAP) and applicable state statutes and/or regulations.</td>
<td>Gain an understanding of the insurer’s assumptions and methodologies and compare with prior periods.</td>
<td>Review assumptions and methodologies for reasonableness, appropriateness, accuracy, and compliance with the <em>Valuation Manual</em> and Appendix A and Appendix C of the NAIC <em>Accounting Practices and Procedures Manual</em>, with assistance from the insurance department actuary or an independent actuary. Compare actual investment, mortality, morbidity, lapse, interest crediting strategy and expense experience to assumptions, by line of business and to prior-period assumptions.</td>
</tr>
<tr>
<td>The assumptions and methodologies used by the insurer for determining the reserves for life, A&amp;H and deposit-type contracts are not accurate or appropriate.</td>
<td></td>
<td></td>
<td></td>
<td>Senior management uses internal or independent actuaries to conduct reserve analyses of all major lines of business.</td>
<td>Verify that senior management signs off on assumptions and methodologies used by the insurer, including any changes.</td>
<td>Verify senior management review of reports from actuaries and that reports include reserve analyses of all major lines of business.</td>
</tr>
<tr>
<td>The insurer maintains a fully staffed, well-qualified actuarial department</td>
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<td></td>
<td></td>
<td>Actuarial analysis is subject to a peer review process.</td>
<td>Review the credentials, background and responsibilities of the insurer’s actuarial department staff or independent actuaries.</td>
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<tr>
<td>Management receives regular reports on claim liabilities (including IBNR) by line or class of business,</td>
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<td>If performed in-house, review and test the actuarial peer review process and related sign-offs.</td>
<td>Verify management review of contract claim liabilities reporting, including analysis</td>
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<tr>
<td>The assumptions used by the insurer to calculate reserves for policies subject to Principle-Based Reserving are not accurate or appropriate.</td>
<td>RV</td>
<td>VA AC PD</td>
<td>RA</td>
<td>as well as other key ratios, and reviews unusual fluctuations on a timely basis to review claim liabilities for adequacy.</td>
<td>of fluctuations, and test the operating effectiveness of procedures in place.</td>
<td>Determine whether the appropriate disclosures have been made in the Notes to the Financial Statements for any changes in reserve methodologies. Review actuarial reports and compare reports to prior periods. Investigate significant variations. Review correspondence related to any peer reviews performed for appropriate depth of review.</td>
</tr>
<tr>
<td>The company utilizes the prescribed valuation assumptions of the Valuation Manual to calculate PBR reserves. The company has established a process for determining appropriate margins. The company maintains credible experience data to support all assumptions utilized in PBR reserving, including:</td>
<td>Utilize a Department actuary, independent actuary or NAIC Actuarial Modeling support staff to review company documentation that provides support for assumptions and evidence that they are developed in accordance with the requirements of PBR as published in the Valuation Manual.</td>
<td>Utilize a Department actuary, independent actuary or NAIC Actuarial Modeling support staff to verify and validate that the company has followed the requirements of PBR as prescribed in the Valuation Manual in developing assumptions.</td>
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</table>
| The assumptions used by the insurer to calculate reserves for long-term care insurance (LTCI) policies are not accurate or appropriate to meet reserve adequacy requirements. | RV | VA AC | RA | The company maintains credible experience data to support all assumptions utilized in calculating reserves for LTCI policies, including:  
- Lapse  
- Mortality  
- Morbidity  
- Interest rate  
- Etc. | Select a sample from experience studies to verify support for and consistency with assumptions used by the company. | Utilize the insurance department actuary or an independent actuary to review assumptions and methodologies for reasonableness, appropriateness, accuracy and compliance with the Valuation Manual.  
Compare actual investment, mortality, morbidity and lapse experience to assumptions.  
Compare reserving assumptions to rate increase assumptions, (e.g., review the Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51) filing and compare against rate increase requests) to ensure that assumptions used for pricing and reserving do not materially conflict.  
Review the company’s AG 51 filing and compare assumptions utilized by the company in LTCI reserving against industry standards and those of its competitors.  
Review the company’s AG 51 reporting to identify assumptions underlying the asset adequacy testing. |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Policies with supplemental or accelerated benefits have not been properly separated and reserved for in accordance with SAP.</td>
<td>OP RV</td>
<td>AC</td>
<td>RA RD</td>
<td>The insurer has a process in which supplemental and accelerated benefits are properly identified and reserved.</td>
<td>Test the process surrounding the identification and reserving of supplemental and accelerated benefits.</td>
<td>Utilize the insurance department actuary or an independent actuary to perform an independent calculation of the reserves of supplemental and accelerated benefits. Verify that reserves are in accordance with SAP.</td>
</tr>
<tr>
<td>Policies subject to Principle-Based Reserving are not properly identified or exclusion testing is not appropriately</td>
<td>RV</td>
<td>VA AC PD</td>
<td>RA</td>
<td>Company conducts and reviews exclusion testing in accordance with Valuation Manual instructions.</td>
<td>Review company support and supervisory sign-off for exclusion testing.</td>
<td>Utilize a Department actuary, independent actuary or NAIC Actuarial Modeling support staff to conduct or reperform exclusion testing.</td>
</tr>
<tr>
<td>Identified Risk</td>
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</tr>
<tr>
<td>The life, A&amp;H and deposit-type reserve and IBNR contract claim liability computations are not performed correctly or the selected estimates are unreasonable.</td>
<td>OP RV</td>
<td>AC VA</td>
<td>RA</td>
<td>The insurer has an established process that is consistent with the method adopted by the NAIC to calculate the life reserves on an annual basis. The insurer maintains a fully staffed, well-qualified actuarial department. Senior management uses internal or independent actuaries to conduct reserve analyses of all major lines on an annual basis. The actuarial calculations are subject to a peer review process.</td>
<td>Review the process in place (which may include performance of a walkthrough) to estimate the life reserves. Review the credentials, background and responsibilities of the insurer’s actuarial department staff. Obtain actuarial reports to verify whether the insurer is using independent or in-house actuaries to perform the reserve calculations on all major lines of business annually and verify senior management review of reports from actuaries. If performed in-house, review and test the actuarial peer review process and related sign-offs.</td>
<td>Utilize the insurance department actuary or an independent actuary to perform an independent estimate of the life reserves and IBNR contract claims liability. Perform analytical procedures to review the reasonableness of reserve calculations.</td>
</tr>
<tr>
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<tr>
<td>The methodologies utilized in PBR are not appropriate or the reserve computations are not performed correctly.</td>
<td>RA</td>
<td>Review evidence that the company followed its process in developing and validating its model for use in PBR.</td>
<td>Utilize a Department actuary, independent actuary, or NAIC Actuarial Modeling support staff to review and evaluate results of the company's model.</td>
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<tr>
<td>The company has a formal process in place to develop and validate a model for use in PBR. Governance of the actuarial model includes:</td>
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<td>- Security Process</td>
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<td>- Software Change Process</td>
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<td>- Parameter Setting Process</td>
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<td>- Validation Process</td>
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<td>- Oversight of Overall Model Processes</td>
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<tr>
<td>Model results have undergone peer review and are subject to reasonableness tests, such as:</td>
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<tr>
<td>- The insurer manually calculates Net Premium Reserve (NPR) on selected policies.</td>
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<td>- The insurer does movement analysis comparing reserves per 1,000 of face amount with prior periods.</td>
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</table>

**Attachment Three-B**
Examination Oversight (E) Task Force
12/1/21

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<table>
<thead>
<tr>
<th>Identified Risk</th>
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</tr>
</thead>
<tbody>
<tr>
<td>The computation of reinsurance credits within life, A&amp;H and deposit-type reserves are not performed correctly. (See also Examination Repository – Reinsurance Ceding Insurer.)</td>
<td>CR RV</td>
<td>AC VA CO</td>
<td>RA RRC</td>
<td>• The insurer performs sensitivity testing on key non-prescribed assumptions.</td>
<td>Test the operating effectiveness of the insurer’s process for reviewing the reserve analysis to determine whether life reserves have been estimated on a gross basis, including management approval and sign-off.</td>
<td>Compare the annual financial statement net and gross incurred for consistency with reinsurance treaties in place at the insurer.</td>
</tr>
<tr>
<td>The insurer does not properly adjust the terminal reserve computation back to the reporting date.</td>
<td>OP RV</td>
<td>AC VA</td>
<td>RA</td>
<td>The insurer has a process in place whereby reserve computations are adjusted back to the reporting date.</td>
<td>Test the key controls surrounding the process by which reserve computations are adjusted back to the reporting date.</td>
<td>Utilize the insurance department actuary or an independent actuary to perform an independent estimate of the reserve adjustment back to the reporting date.</td>
</tr>
<tr>
<td>The initial reserves calculated by the actuary do not adequately reflect reserve liabilities.</td>
<td>OP RV</td>
<td>AC VA</td>
<td>RA</td>
<td>The insurer has a process in place by which it computes an asset adequacy test on the calculated life reserves.</td>
<td>Test the key controls surrounding the process by which the reserve adequacy test is calculated.</td>
<td>Utilize the insurance department actuary or an independent actuary to perform an independent estimation of the reserve</td>
</tr>
</tbody>
</table>

The insurer applies reinsurance credits to life reserves by reviewing reinsurance treaties in place at the insurer, as well as historical results.

Test the operating effectiveness of the insurer's process to estimate reinsurance credits for life reserves, including management approval and sign-off.

Consider the reasonableness of reinsurance credits taken, based on a review of the insurer's reinsurance program and treaties in place.

Compare the corresponding reserve held by the reinsurer with the credit taken by the insurer and identify all reasons for differences.
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>The insurer has a process in place to ensure that the correct assumptions and methodologies are used to estimate the adequacy of the life reserves.</td>
<td>OP ST LG VA AC RA</td>
<td></td>
<td></td>
<td>Test the key controls surrounding the assumptions and methodologies used to estimate reserve adequacy.</td>
<td>adequacy test to determine whether the overall reserve liability is adequate.</td>
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<tr>
<td>Management reviews the asset adequacy test for reasonableness of the reserve amount.</td>
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<td>Verify management review of asset adequacy test.</td>
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<tr>
<td>Management books reserves that are materially different than the actuary’s best estimate.</td>
<td>OP ST LG VA AC RA</td>
<td></td>
<td></td>
<td>Review management’s guidelines regarding the recording of actuarially determined reserves. Verify that deviations from the actuary’s best estimate are properly documented, if applicable.</td>
<td>Review the actuarial report, as well as the annual financial statement and other appropriate documentation, to determine whether the insurer has booked the actuary’s best estimate.</td>
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<tr>
<td>The insurer’s organizational structure limits the influence that management can have on the appointed actuary.</td>
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<td>Review meeting minutes of the board of directors (or committee thereof) for evidence of a presentation and review of the actuarial report.</td>
<td>Review the documentation supporting a deviation from the actuary’s best estimate for reasonableness, if applicable.</td>
<td></td>
</tr>
<tr>
<td>The insurer is not properly accounting for cash surrender value (CSV) on life (including annuities) contracts.</td>
<td>OP LG OB/OW VA RA</td>
<td></td>
<td></td>
<td>Ensure the policies for the process used to report CSVs on life (including annuities) contracts is periodically reviewed and approved by</td>
<td>For a sample of life (including annuities) contracts with cash surrenders, determine whether the CSV is being</td>
<td></td>
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<tr>
<td>Contract claim liabilities are not established or reviewed in accordance with the insurer’s standards and applicable statutory guidelines.</td>
<td>RV</td>
<td>AC</td>
<td>RA</td>
<td>The insurer has a policy for recording contract claim liabilities and actuaries are involved in establishing and reviewing the policy.</td>
<td>Obtain documentation supporting the insurer’s contract claim liability policy to ensure actuary review and policy adequacy.</td>
<td>For a sample of contract claim liabilities, verify that the calculation is in accordance with the insurer’s policy, applicable statutory guidelines, and are calculated on a timely basis.</td>
</tr>
<tr>
<td></td>
<td>OP</td>
<td>VA</td>
<td></td>
<td>Contract claim liabilities are recorded in accordance with the insurer’s policy, applicable statutory guidelines and within a specified time frame.</td>
<td>For a sample of contract claim liabilities, determine whether contract claim reviews were performed and documented in accordance with the insurer’s policy and applicable statutory guidelines.</td>
<td>From the sample selected above, identify any claims included on the detail for which the liability recorded is not consistent with the contract terms. Identify claims that appear to have not been paid in a reasonable or fair time frame. Investigate the status of these claims/benefits with the insurer’s management.*</td>
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<tr>
<td></td>
<td>LG</td>
<td>CO</td>
<td></td>
<td>Committees evaluate and strategize claim liabilities involving large or unusual loss contract claim determinations and/or settlements.</td>
<td>Obtain minutes and other meeting materials from the meetings of the committee to determine whether the committee provided appropriate oversight.</td>
<td>Verify that the claims/benefits liability is complete and properly recorded at year-end.</td>
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<td>Obtain a detail of resisted claims and claims closed without payment. Perform procedures to verify the grounds for the resisted claims.</td>
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<td>For a sample of contract claim liabilities meeting the criteria to go to a loss/benefits committee, determine whether the liabilities were referred to...</td>
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<td>The insurer does not maintain an adequate deficiency reserve.</td>
<td>RV OP</td>
<td>VA CO CM</td>
<td>RA</td>
<td>The insurer has a process in place to review for premium deficiencies on an annual basis in accordance with SSAP No. 54. Independent actuaries review and sign off on deficiency reserve calculations.</td>
<td>Review the process in place and verify key controls surrounding the calculation of premium deficiency reserves. Obtain the actuarial opinion and verify approval of deficiency reserve calculations.</td>
<td>Perform an analytical review of loss ratios. If necessary, utilize the insurance department actuary or an independent actuary to perform a detailed review or an independent calculation/estimate of the premium deficiency reserves.</td>
</tr>
</tbody>
</table>
Annual Statement Blank Line Items

Listed below are the corresponding Annual Statement line items that are related to the identified risks contained in this exam repository:

Losses
Loss Adjustment Expenses
Ceded Reinsurance Case Loss and Loss Adjustment Expense Reserves
Supplemental Reserve (Title Companies)

Relevant Statements of Statutory Accounting Principles (SSAPs)

All of the relevant SSAPs related to the property and casualty insurance reserving process, regardless of whether or not the corresponding risks are included within this exam repository, are listed below:

No. 5R Liabilities, Contingencies and Impairments of Assets – Revised
No. 53 Property Casualty Contracts – Premiums (P&C Companies)
No. 54R Individual and Group Accident and Health Contracts
No. 55 Unpaid Claims, Losses and Loss Adjustment Expenses
No. 57 Title Insurance
No. 62R Property and Casualty Reinsurance – Revised
No. 63 Underwriting Pools
No. 65 Property and Casualty Contracts
No. 70 Allocation of Expenses
<table>
<thead>
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<td><strong>Other Than Financial Reporting Risks</strong></td>
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</tr>
<tr>
<td>The board of directors (or committee thereof) is not involved in establishing and/or reviewing the insurer’s overall reserving policy.</td>
<td>OP</td>
<td>RV</td>
<td>ST</td>
<td>RA</td>
<td>Verify that the insurer has established an overall reserving policy that has been adopted and/or reviewed by the board of directors (or committee thereof).</td>
<td>Obtain information on the insurer’s overall reserving policy and forward it to the insurance department actuary or an independent actuary for review.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td>RA</td>
<td></td>
<td>Review board of directors (or committee thereof) minutes to ensure discussion of reserving. Verify that the minutes indicate that the Appointed Actuary reported to the board of directors (or committee thereof) on the items within the scope of the actuarial opinion and identifies the manner of presentation.</td>
<td>Discuss with members of the board of directors (or committee thereof) their level of involvement in the monitoring of reserving policy.</td>
</tr>
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<td></td>
<td>The insurer monitors and revises its reserving policy as needed.</td>
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<tr>
<td><strong>Financial Reporting Risks</strong></td>
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<tr>
<td>New claims are not entered into the claims management system (i.e., claims population is not complete).</td>
<td>RP</td>
<td>AC</td>
<td>CT</td>
<td>RD</td>
<td>Observe that segregation of duties exists between the claim notification and the input of claims data into the claims system.</td>
<td>Select a sample of items from the exception reports and verify that the claim was appropriately accounted for.*</td>
</tr>
<tr>
<td></td>
<td>LG</td>
<td>Co</td>
<td></td>
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<td>Obtain the exception report and ensure management</td>
<td>Select a sample of claims and expense payments made</td>
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<td>Identified Risk</td>
<td>Branded Risk</td>
<td>Exam Asrt.</td>
<td>Critical Risk</td>
<td>Possible Controls</td>
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<tr>
<td>Claims data (e.g., claim attributes) in the claims database are inaccurate or incomplete, or incorrectly entered into the claims management system.</td>
<td>OP LG AC CT CO EX RD</td>
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<td>the insurer electronically or manually have been entered into the claims system. Exceptions are identified and resolved timely.</td>
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<td>review and exception resolution.</td>
<td>Test the operating effectiveness of the automated claims posting process through reperformance and observation, which could include IT testing of batch totals to ensure completeness of transactions processed.</td>
<td>Obtain documentation of the management’s review of the Type II SOC 1 report.</td>
<td>subsequent to year-end to verify that claims were recorded in the proper period.</td>
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<tr>
<td>The insurer reviews the Type II SOC 1 report and ensures compliance with user control considerations for any outsourcing companies that enter claims on behalf of the insurer.</td>
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<td></td>
<td>Obtain documentation of the management’s review of the Type II SOC 1 report.</td>
<td>Perform analytical procedures to verify the claims were recorded in the correct period (i.e., average claim count before and after period-end).</td>
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<td>Claims data is subject to independent verification or quality assurance (QA) reviews.</td>
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<td>The claims system has automated controls that will not allow a claim to be entered without a valid in-force policy.</td>
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<td>Test the operating effectiveness of automated controls (i.e., edit checks) through reperformance and observation.</td>
<td>Obtain the error report and ensure proper exception resolution.</td>
<td>Perform data validation tests to verify the accuracy of claim information maintained in the claims system — such as coverage terms, demographic data, loss occurrence and/or loss report date, date of service, insured name, claim number, paid claim date, paid claim amount and coverage period — by vouching the information to the claimant’s insurance contract, claims form and any other underlying support. Utilize an actuary to determine the most significant lines of business.</td>
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<td>Identified Risk</td>
<td>Branded Risk</td>
<td>Exam Asrt.</td>
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<td>Possible Controls</td>
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<td>claim data has been entered. Entering a valid active policy number will automatically populate select policy data. System edits will identify data that does not meet the predetermined criteria, such as an invalid social security format or missing provider name, resulting in inclusion on a system generated exception report.</td>
<td>Test the operating effectiveness of authority restrictions through reperformance and observation.</td>
<td>and data points used in the estimate and focus accuracy testing on those. *</td>
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<td>Segregation of duties exists between individuals responsible for new claim set-up and those responsible for setting up new policies.</td>
<td>Obtain claims set-up and new policy set-up authorization listings and cross-reference the listings to ensure that there are no employees with conflicting authority.</td>
<td>Scan the database(s) for internal inconsistencies, such as missing claim amounts, unusually small amounts and claims misclassified by type. In situations where adequate segregation of duties is not apparent, obtain data to determine whether any claims were set up by the same user who created the corresponding policy in the master file. If any instances are identified, investigate the claim to ensure the claim exists and is supported by underlying data.</td>
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</table>

The third-party administrators (TPAs) or managing general agents (MGAs) are not processing claims | Perform analytical procedures over the population of claims data (i.e. paid claims) at the appropriate disaggregation level to identify any unusual trends or anomalies pertaining to the accuracy of claims data that should be further investigated. | |

<p>| The insurer performs regular audits of its TPAs/MGAs to determine whether the insurer’s claims-handling standards | Review audit reports and other documentation to determine whether the insurer provides sufficient oversight of its claims | Determine, by a review of selected claims, whether the insurer is settling its claims accurately and in accordance with the... |</p>
<table>
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<tr>
<th>Identified Risk</th>
<th>Branded Risk</th>
<th>Exam Asrt.</th>
<th>Critical Risk</th>
<th>Possible Controls</th>
<th>Possible Test of Controls</th>
<th>Possible Detail Tests</th>
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<td>in accordance with the insurer’s claims procedures as outlined in the TPA agreement.</td>
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<td>and additional contract provisions are being consistently followed by the TPA.</td>
<td>TPAs/MGAs.</td>
<td>contract, based on information contained in the claim file.</td>
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<td>Management obtains a Type II SOC 1 report for all TPAs and reviews the report to verify the TPA has adequate controls and that the insurer is adhering to user control considerations.</td>
<td>Verify that the insurer has obtained and reviewed each TPA’s Type II SOC 1 report, if available. Determine whether the insurer is adhering to user control considerations.</td>
<td>Review the Type II SOC 1 report to determine whether the controls outlined in the report are adequate to ensure that claims are being processed in accordance with the TPA agreement.</td>
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<td>Management performs necessary reviews to comply with applicable state MGA regulations.</td>
<td>Obtain evidence of management’s review of compliance with applicable state MGA regulations.</td>
<td>Test for compliance with applicable state MGA regulations.</td>
</tr>
<tr>
<td>Claims are not being processed accurately and in accordance with the insurer’s guidelines.</td>
<td>OP ST LG</td>
<td>AC CM CO</td>
<td>RD</td>
<td>The insurer has administrative policies and maintains a claims procedures manual that outlines the following requirements:</td>
<td>Review the insurer’s claims manual to determine appropriateness including management approval.</td>
<td>Perform tests to determine whether claims were accurately processed in accordance with the claims procedures manual, approved authority limits and administrative policies, through review of the claimant’s insurance contract, claims form and any other underlying support.*</td>
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*Review policyholder complaints and investigate significant issues.

Review a sample of denied claims to ensure compliance with contract and timeliness provisions.
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<th>Identified Risk</th>
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<th>Exam Asrt.</th>
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<th>Possible Detail Tests</th>
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<tr>
<td>exceed policy limits, cover ineligible loss causes/types and/or apply to a policy period for which the insurer is not contractually responsible.</td>
<td>checks to ensure procedures are implemented through reperformance and observation.</td>
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<td>Any consideration to pay a loss that meets one or more of the aforementioned categories must be processed in accordance with the insurer’s procedures.</td>
<td>Review assessments of the claims-handling process performed by internal/external auditors, reinsurers and/or others for significant issues.</td>
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<td>As part of the claims processing procedures, the insurer obtains adequate documentation before a claim is settled.</td>
<td>Test the operating effectiveness of controls to ensure adequate documentation is obtained before payment is made.</td>
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<td>Claims approval is subject to approved authority limits.</td>
<td>Test the controls in place to ensure that claims are approved in accordance with documented authority limits.</td>
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<td>A QA review is periodically performed for each claims processor to ensure compliance with the claims-handling policies.</td>
<td>Review documentation of QA reviews to determine whether the QA function is being executed as outlined in the insurer’s policies.</td>
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<td>On a sample basis, reperform the QA testing to ensure that the testing was completed accurately.</td>
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</table>

Claims under claims-made liability policies are improperly triggered. The insurer has a policy in place whereby coverage is automatically triggered. Perform a walkthrough to verify that the adjuster properly applies tail. Perform data validation testing to ensure that claims under claims-made liability are properly handled.
<table>
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<tr>
<th>Identified Risk</th>
<th>Branded Risk</th>
<th>Exam Asrt.</th>
<th>Critical Risk</th>
<th>Possible Controls</th>
<th>Possible Test of Controls</th>
<th>Possible Detail Tests</th>
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<td>accepted (or rejected) by the claims adjusters.</td>
<td>ST</td>
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<td>under claims-made liability policies when a claim is first made during the policy period (as long as it did not occur prior to the retroactive policy date specified). A QA review is periodically performed for each claims processor to ensure compliance with claims-handling policies.</td>
<td>coverage to the claim and reallocates the claim to the correct policy year.</td>
<td>policies are being properly administered.</td>
</tr>
<tr>
<td>The claims data utilized by the actuary to estimate reserves does not correspond to the data in the insurer’s claims system and to the data in the insurer’s accounting records.</td>
<td>OP RV AC CO RD</td>
<td>The insurer has established procedures to reconcile actuarial data to the insurer’s claims system, the data in the insurer’s accounting records and appropriate annual financial statement schedules and/or exhibits. Such reconciliations are reviewed by supervisory personnel. Inventories of reported and unpaid claims are maintained and periodically reconciled to the general ledger. The company’s internal Appointed Actuary reconciles the claims data used in the analysis to Schedule P with proper</td>
<td>Review the insurer’s reconciliation reports of actuarial data to the insurer’s claims system and the insurer’s accounting records. Ensure evidence of supervisory review. Review the insurer’s reconciliation of reported and unpaid claims to the general ledger. Review the company’s internal Appointed Actuary’s reconciliation of the claims data used in the analysis to Schedule P.</td>
<td>Test any reconciling items within the reconciliations for appropriateness. Reconcile the insurer’s actuarial report for losses and loss adjustment expenses, among other significant data inputs (e.g. paid claims, case reserves, etc.) according to the actuary to supporting insurer reports/underlying documentation, general ledger, and annual financial statement schedules and exhibits as of the valuation date. Vouch payment of claim into bank statement. Test completeness of the data by gap testing sequences of checks and...</td>
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<td>Critical Risk</td>
<td>Possible Controls</td>
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<td>Identified Risk</td>
<td>PAC Reserves Repository</td>
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<tr>
<td>Noting the proper review and approval.</td>
<td>Test the effectiveness of the procedures to prepare the claims data for actuarial review.</td>
<td>Test the operating effectiveness of the insurer’s established procedures.</td>
<td>Reinsurance is not properly taken into account in accumulating claims data.</td>
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<tr>
<td>Review the insurer’s reconciliation reports of actuarial data to the insurer’s claims system, reinsurance reports, and accounting records.</td>
<td>Review the insurer’s reconciliation reports of actuarial data to the insurer’s claims system.</td>
<td>Review the insurer’s reconciliation reports of actuarial data to the insurer’s claims system.</td>
<td>Initial case reserves are not established or reviewed in accordance with the insurer’s standards.</td>
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<tr>
<td>Test the operating effectiveness of the insurer’s established procedures to include loss data from assumed reinsurance treaties within the claims data for actuarial review.</td>
<td>Test the operating effectiveness of the insurer’s established procedures to include loss data from assumed reinsurance treaties within the claims data for actuarial review.</td>
<td>Test the operating effectiveness of the insurer’s established procedures to include loss data from assumed reinsurance treaties within the claims data for actuarial review.</td>
<td>Initial case reserves are not established or reviewed in accordance with the insurer’s standards.</td>
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<tr>
<td>Verify assumed reinsurance loss data accumulated by the ceding insurer for completeness.</td>
<td>Verify that the calculation is in accordance with the insurer’s reserving policy.</td>
<td>Verify that the calculation is in accordance with the insurer’s reserving policy.</td>
<td>Initial reserves are made in accordance with the insurer’s reserving policy and within a specified time frame.</td>
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<tr>
<td>Perform analysis to review the reasonableness of paid claims.</td>
<td>Obtain documentation supporting the insurer’s reserving philosophy.</td>
<td>Observe the insurer’s reserving philosophy.</td>
<td>Initial reserves are made in accordance with the insurer’s reserving policy and within a specified time frame.</td>
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<tr>
<td>Test reconciling items relating to reinsurance loss data for appropriateness.</td>
<td>Test for a sample of reserves, determine whether the reserves were calculated on a timely basis.</td>
<td>Review the insurer’s reserving philosophy for actuarial review and policy adequacy.</td>
<td>Initial reserves are made in accordance with the insurer’s reserving policy and within a specified time frame.</td>
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<td>Identified Risk</td>
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<tr>
<td>Case reserves are not updated accurately.</td>
<td>RV CR VA RA</td>
<td>The insurer has a policy requiring open claims to be reviewed regularly. When new information is received, case reserves are reviewed and adjusted, if necessary and are subject to the necessary authority and approval levels outlined within the claims procedure manual. The claims management system generates analyses or reports that identify reserve increases and decreases, an outstanding reserve list, an outstanding reserve list by claims adjuster and a reserve</td>
<td>From a sample of case reserves, determine whether the reserves are updated regularly and are appropriately updated when new information is received and are evidenced by the appropriate approval. Obtain copies of the reserve reports, noting management approval.</td>
<td>Select a sample of paid claims and compare the final overall claims settlement with the case reserve to determine whether the reserves are adequate and/or updated accurately.* Verify that the information contained in management reserve reports is accurate and complete and determine whether the appropriate analysis is being used to evaluate the reserves.</td>
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<td>Identified Risk</td>
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<tr>
<td>The insurer is not properly recording case reserves (assumed or ceded) for contracts subject to reinsurance.</td>
<td>RV CR LG</td>
<td>CO VA AC</td>
<td>RA</td>
<td>The insurer has policies in place to verify that case reserves subject to reinsurance are valid and accurate (within contract time frame, covered under the contract, etc.).</td>
<td>Review the insurer’s policies to determine appropriateness, noting management approval.</td>
<td>Perform procedures to determine whether case reserves recorded by the insurer agree with the case reserves of the assuming (ceding) insurer.</td>
</tr>
<tr>
<td>Actuarial analyses relied upon by the insurer’s management in determining carried reserves are not based on appropriate methods and/or reasonable assumptions.</td>
<td>RV VA AC PD</td>
<td>RA</td>
<td>RV VA AC PD</td>
<td>The insurer’s actuarial analyses use appropriate methods and reasonable assumptions that have been based on historical results (to the extent appropriate), adequately documented, approved by senior management (where appropriate) and in accordance with statutory accounting principles and applicable state statutes and/or regulations.</td>
<td>Gain an understanding of the methods and assumptions used in the analyses compared with prior periods.</td>
<td>Review the actuarial analyses’ methodologies for appropriateness and assumptions for reasonableness, with assistance from the insurance department actuary or an independent actuary.</td>
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<td>Actuarial analyses relied upon by management in determining carried reserves are subject to a peer review process. Management receives regular reports on loss/LAE adjustment expense (LAE) reserve levels, loss/LAE ratios (including incurred but not reported (IBNR)) by</td>
<td>If performed in-house, review and test the actuarial peer review process and related sign-offs.</td>
<td>Verify that reserving methodologies and assumptions are in accordance with the relevant SSAPs related to P&amp;C reserving, as well as applicable statutes, regulations, pronouncements and/or bulletins.</td>
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</table>
|                                                                                  |              |           |               |                   | Verify management review of loss/LAE reserve reporting and test the operating effectiveness of procedures in place. | Review prior history of loss development, as well as subsequent loss development data to analyze the appropriateness of methodologies and reasonableness of.
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<th>Identified Risk</th>
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<th>Critical Risk</th>
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<td>line or class of business grouped by accident year and calendar year, as well as other key ratios, and reviews unusual fluctuations on a timely basis to review reserves for adequacy.</td>
<td>Request and review the insurer’s organizational chart and job descriptions to determine whether the functions are separate and distinct.</td>
<td>assumptions.</td>
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<td>The insurer utilizes a fully staffed, well-qualified actuarial function that is under the direction of an actuary that has an Accepted Actuarial Designation, as defined in the NAIC Statement of Actuarial Opinion Instructions, and is experienced in the lines of business written by the insurer.</td>
<td>Interview the Appointed Actuary during the planning phase of the examination to ascertain the degree of influence the insurer’s management has on the Appointed Actuary’s work.</td>
<td>Determine whether the appropriate disclosures have been made in the Notes to the Financial Statements for the changes in the insurer’s reserve methodologies.</td>
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<td>The reserving actuarial unit’s responsibilities are segregated from the pricing actuarial unit, but there is regular communication between the two units.</td>
<td>Request and review the insurer’s organizational chart and job descriptions to determine whether the functions are separate and distinct.</td>
<td>Review actuarial reports and compare reports to prior periods. Investigate significant variations.</td>
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<td>The insurer’s management does not inappropriately influence the methods, assumptions or conclusions of the Appointed Actuary.</td>
<td>Request and review the insurer’s organizational chart and job descriptions to determine whether the functions are separate and distinct.</td>
<td>Utilize the insurance department actuary or an independent actuary to perform an independent calculation/estimate of the loss/LAE reserves for significant reserve segments with volatility, if necessary.</td>
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<td>Review the external auditor’s reserve level calculations, when available, and the Appointed Actuary’s report; independent tests should only be conducted if other tests are not conclusive.</td>
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<td>Review correspondence related to peer review for appropriate depth of review.</td>
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<td>Compare the Appointed Actuary’s assumptions and estimates with those in other available actuarial analyses.</td>
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<td>Identified Risk</td>
<td>Branded Risk</td>
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<td>Catastrophe-type (CAT) claims or large or significant exposure type claims data are not separately identified and evaluated from other claims.</td>
<td>OP RV</td>
<td>AC VA</td>
<td>RD RA</td>
<td>The insurer has established procedures to prepare the claims data for actuarial review by extracting CAT claims or large or significant exposure type claims, for a separate reserve analysis.</td>
<td>Test the operating effectiveness of the insurer's established procedures to prepare the claims data for actuarial review. Review the insurer's actuarial reserve analysis for incorporation of a separate review of CAT claims or large or significant exposure type claims.</td>
<td>Obtain a detailed download of all claim transactions during the examination period. Utilize audit software to verify that claims data appropriately distinguishes CAT claims or large or significant exposure type claims and that these claims have been extracted from the general claims data and presented separately to the actuary.</td>
</tr>
<tr>
<td>Changes in the legal environment or changes in the insurer's underwriting, case reserving or claims-handling processes are not appropriately considered within the insurer's reserving assumptions and methodologies.</td>
<td>OP RV ST</td>
<td>VA PD AC</td>
<td>RA</td>
<td>The insurer has procedures in place to monitor and communicate changes in the legal environment (e.g., changes in case law, award amounts, trends in the number of claims being litigated) are being taken into consideration by management in a timely manner. The insurer has procedures in place for the underwriting, case reserving and claims-handling units to communicate changes in their processes to the reserving unit in a timely manner.</td>
<td>Review the insurer's process to monitor changes in the legal environment that may affect the reserving process and reflect changes appropriately in management's determination of carried reserves. Review evidence of communication between the reserving unit and other relevant insurer units.</td>
<td>Through a review of documentation supporting management's carried reserves, determine whether changes in the legal environment or changes in the insurer's internal processes have been properly incorporated.</td>
</tr>
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<td>Identified Risk</td>
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<tr>
<td>The loss and loss adjustment expense (LAE) reserve computations are not performed correctly or the selected estimates are unreasonable.</td>
<td>OP RV</td>
<td>AC VA</td>
<td>RA</td>
<td>The insurer has an established process (although assumptions and methodologies may change) to estimate the loss reserves on an annual basis. The insurer has established processes to estimate the defense and cost containment (DCC) and the adjusting and other (AO) loss adjustment expense reserves on an annual basis. The insurer maintains a fully staffed, well-qualified actuarial department that is under the direction of a fellow (or associate) of the Casualty Actuary Society (FCAS) and is experienced in the lines of business written by the insurer. Senior management uses either internal or independent actuaries to conduct reserve analyses of all major lines on an annual basis.</td>
<td>Review the process in place (which may include performance of a walkthrough) to estimate the loss reserves. Review the processes (which may include a walkthrough) in place to estimate both the DCC and AO loss adjustment expense reserves. Review the credentials, background and responsibilities of the insurer’s actuarial department staff for appropriateness.</td>
<td>Utilize the insurance department actuary or an independent actuary to perform an independent estimate of the loss reserves. Utilize the insurance department actuary or an independent actuary to prepare an independent estimate of LAE. Perform analytical procedures to review the reasonableness of loss reserve estimates.</td>
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<tr>
<td>The actuarial calculations are subject to a peer review process.</td>
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**Attachment Two**
P&C Reserves Repository

**Attachment Three-B**
Examination Oversight (E) Task Force

12/1/21

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NAIC Proceedings – Fall 2021
<table>
<thead>
<tr>
<th>Identified Risk</th>
<th>Branded Risk</th>
<th>Exam Asrt.</th>
<th>Critical Risk</th>
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<th>Possible Test of Controls</th>
<th>Possible Detail Tests</th>
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<tr>
<td>Management does not have reasonable support for its carried reserves.</td>
<td>OP ST LG VA PD RA</td>
<td>The insurer has a process in place for determining carried reserves, and management is able to explain its selection.</td>
<td>The insurer’s board of directors (or committee thereof) receives an annual presentation on the actuarial analysis process. Management receives regular reports on loss ratios (including IBNR) by line or class of business for accident year and calendar year, as well as other key ratios, and reviews unusual fluctuations on a timely basis to review reserves for adequacy.</td>
<td>Review meeting minutes of the board of directors (or committee thereof) to verify that a presentation was given on the actuarial analysis process. Verify management review of loss reserve reporting and test the operating effectiveness of procedures in place.</td>
<td>Review management’s guidelines regarding the determination of carried reserves. Verify that any material changes from the prior year’s reserves and any material differences between carried reserves and the Appointed Actuary’s point estimate are properly documented. Review the documentation supporting management’s carried reserves, including management’s analysis of the reasonableness of the reserve estimates.</td>
<td>Review meeting minutes of the board of directors (or committee thereof) minutes for evidence of a presentation and review of information supporting management’s best estimate of the booked reserves (e.g., the actuarial report).</td>
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<td>The insurer does not maintain an adequate premium deficiency reserve.</td>
<td>RV RQ OP</td>
<td>VA CO CM</td>
<td>RA</td>
<td>The insurer has a process in place to review for premium deficiencies on an annual basis in accordance with SSAP No. 53. Qualified personnel perform, review, and sign off on premium deficiency reserve calculations.</td>
<td>Review the process in place and verify key controls surrounding the calculation of premium deficiency reserves. Obtain the premium deficiency reserve calculations, and verify approval and sign-off.</td>
<td>Perform an analytical review of loss ratios. If necessary, utilize the insurance department actuary or an independent actuary to perform a detailed review or an independent calculation/estimate of the premium deficiency reserves.</td>
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</table>
Annual Statement Blank Line Items

There are no Annual Statement line items directly related to the underwriting process; however, policies underwritten and rate calculations may impact line items associated with areas such as premiums and reserves.

Relevant Statements of Statutory Accounting Principles (SSAPs)

All of the relevant SSAPs related to the underwriting process, regardless of whether or not the corresponding risks are included within this exam repository, are listed below:

No. 6   Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due from Agents and Brokers (All Lines)
No. 51R  Life Contracts (Life Companies)
No. 53   Property Casualty Contracts – Premiums (P&C Companies)
No. 54R  Individual and Group Accident and Health Contracts (Health Companies)
No. 65   Property and Casualty Contracts (P&C Companies)
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<td><strong>Other Than Financial Reporting Risks</strong></td>
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<td>The insurer has not developed and followed its overall underwriting strategy.</td>
<td>ST PR/UW OP</td>
<td>Other</td>
<td>UPSQ</td>
<td>The underwriting strategy indicates the types and lines of business (coverages), geographical areas and other rating classes the organization seeks to write in.</td>
<td>Review documentation demonstrating that the insurer has developed a formal underwriting strategy.</td>
<td>Review the insurer’s underwriting strategy for appropriateness.</td>
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<td>The overall underwriting strategy is reviewed, monitored and approved by the board of directors on a regular basis.</td>
<td>Review board minutes and/or packets for evidence that the board actively reviews and/or approves the insurer’s underwriting strategy on a regular basis.</td>
<td>Review the information provided within underwriting reports reviewed by management and the board for accuracy and appropriateness.</td>
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<td>The underwriting department has established and documented goals in accordance with the insurer’s overall underwriting strategy.</td>
<td>Review the underwriting department’s goals for compatibility with the insurer’s overall underwriting strategy.</td>
<td>Review historical premium written detail as well as underwriting and profitability results and determine whether the underwriting strategy is being followed.</td>
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<td>The insurer reviews its underwriting performance to identify non-compliance with its underwriting strategy.</td>
<td>Review the insurer’s process to monitor compliance with underwriting strategy and determine if non-compliance is appropriately remediated.</td>
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<td>The insurer has not established and maintained appropriate risk exposure limits (including catastrophe coverage) that are consistent with risk</td>
<td>ST PR/UW</td>
<td>Other</td>
<td>UPSQ</td>
<td>The insurer has established and documented risk exposure limits by geography, other rating classes and line of business (coverages) that have been reviewed and approved by senior management.</td>
<td>Review documentation of risk exposure limits and evidence of senior management review/approval. Consider if the risk limits are consistent with the risk appetite and risk tolerance</td>
<td>Utilize audit software to review the insurer’s risk exposures for compliance with insurer limits. (For P&amp;C companies, summarize policies by ZIP code, industry code, policy size, etc.; for life and health insurance, consider relevant factors that may impact risk exposure.)</td>
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<td>appetite.</td>
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<td>Risk exposure limits established by the insurer consider the direct and indirect impacts of climate change risk.</td>
<td>levels articulated in the company’s ERM process and consider alignment with the company’s reinsurance program.</td>
<td>companies, summarize by risk class, age, medical codes, etc.) for compliance with insurer limits. If the insurer has not identified risk exposure limits, test the risk exposures for appropriateness by considering applicable industry standards and comparison to peer groups.</td>
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</table>

The insurer utilizes a fully staffed, well-qualified underwriting function that has experience in all lines of business (coverages) and geographic locations (rating classes) served by the insurer.

The insurer utilizes risk models to track compliance with exposure limits established by the insurer.

Test the operating effectiveness of the insurer’s controls to track compliance with the exposure limits by reviewing modeling data.

The insurer has not established sufficient pricing practices, resulting in inadequate or excessive premium rates in relation to its assumed risks and expense structure. Consider utilizing an ST PR/UW Other UPSQ The insurer has developed comprehensive pricing practices that have been approved by senior management. Pricing practices include consideration of future changes in loss. Review documentation of pricing practices and evidence of senior management review/approval. Perform a walkthrough of the pricing process and observe how the impact of

Review the underwriting and pricing guidelines established by the insurer for appropriateness.

Perform analytical procedures to review the insurer’s profitability and history of indicated rates vs.
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<td>actuarial specialist to assist with test procedures related to this risk.</td>
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<td>development including the impact of climate change risk.</td>
<td>claim trends including climate change risk and weather variability is considered when establishing rates/prices.</td>
<td>selected/filed rates to evaluate the sufficiency of premium rates.</td>
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<td>The insurer utilizes a fully staffed, well-qualified pricing actuarial function that has experience in all lines of business (coverages) and geographic locations (rating classes) served by the insurer.</td>
<td>Review the credentials, background and responsibilities of the insurer’s pricing actuarial department for appropriateness.</td>
<td>If rates have been subject to insurance department approval, consider whether reliance can be placed on this work.</td>
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<td>The pricing actuarial function has an established process to calculate base premium rates based on historical loss results, trends, principal advisory organizations (ISO, LIMRA, etc.) and/or other appropriate factors (e.g., costs of reinsurance, expense structure, commission rates) and the calculation is subject to a peer-review process.</td>
<td>Perform a walkthrough to gain an understanding of the rate calculation process, and obtain evidence of a peer review of base premium rate calculations and possibly get input from line personnel.</td>
<td>If deemed necessary, utilize the insurance department actuary or an independent actuary to perform a review or independent calculation of base premium rates.</td>
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<td>Regulatory changes are factored into pricing decisions.</td>
<td>Perform a walkthrough of the company’s pricing process and observe how regulatory changes are factored into pricing decisions.</td>
<td>Compare base premium rates utilized by the insurer to industry averages and advisory organization recommendations for reasonableness.</td>
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<tr>
<td>Policies are issued that do not comply with</td>
<td>OP PR/UW</td>
<td>Other</td>
<td>UPSQ</td>
<td>The insurer utilizes a fully staffed, well-qualified pricing actuarial function</td>
<td>Review the credentials, background and responsibilities of the insurer’s pricing actuarial department.</td>
<td>Test a sample of new policies underwritten to</td>
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<td>underwriting and pricing guidelines.</td>
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<td>underwriting function that has experience in all lines of business (coverages),</td>
<td>responsibilities of the insurer’s underwriting function (internal and/or external).</td>
<td>determine whether the final underwriting decision (including any deviations from</td>
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<td>geographic locations and other rating classes served by the insurer.</td>
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<td>accepted guidelines) was made by someone at an appropriate authority level.*</td>
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<td>The insurer provides initial and ongoing training programs to qualify its</td>
<td>Review documentation outlining the insurer’s training of underwriting staff.</td>
<td>Test a sample of new policies underwritten for compliance with appropriate</td>
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<td>underwriting staff to follow the insurer guidelines established.</td>
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<td>underwriting guidelines.*</td>
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<td>Underwriters are restricted in the type and amount of policies that they</td>
<td>Test the operating effectiveness of automated controls (i.e., authority levels)</td>
<td>Test a sample of new policies underwritten for appropriate pricing.</td>
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<td>underwrite by authority levels built into the system.</td>
<td>through reperformance and observation.</td>
<td>Review certificates of authority for the states and jurisdictions where the insurer is</td>
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<td>The insurer has established a QA process to review new policies underwritten for</td>
<td>Re-perform, on a sample basis, testing of policies reviewed by the QA function for</td>
<td>licensed to write business as of the examination date.</td>
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<td>compliance with underwriting guidelines on a sample basis.</td>
<td>proper implementation of the insurer’s underwriting guidelines.</td>
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<td>The insurer designates an individual to be responsible for tracking and</td>
<td>Review the insurer’s process for tracking and maintaining licenses to write business.</td>
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<td>maintaining licenses for all jurisdictions in which it transacts business.</td>
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<td>The insurer has a process in place that requires deviations from pricing or</td>
<td>Review the insurer’s process for reviewing deviations from pricing or acceptability</td>
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<td>acceptability guidelines to</td>
<td>guidelines.</td>
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<td>Underwriting results are not monitored and updated in order to measure success or failure of business written.</td>
<td>PR/UW ST</td>
<td>Other</td>
<td>UPSQ</td>
<td>be pre-approved, reviewed, and/or spot-checked.</td>
<td>Review company reports to determine sufficient oversight of the company's portfolio.</td>
<td>Review underwriting results for profitability. Consider profitability from a variety of perspectives, including product lines, geographic areas and distribution channels. Discuss any significant variances or discrepancies between planned strategies/budgets/pricing assumptions and actual results with senior management.</td>
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<td>A portfolio manager analyzes key portfolio indicators—such as policies in force, new policy count and policy retention—on a monthly, quarterly and annual basis. Actual policy in force counts are compared to the annual policy in force goals to assess the growth or decline in portfolio size. The company measures underwriting results and key policy characteristics at specific frequencies to uncover unexpected relationships between policy characteristics, variances from pricing assumptions or other factors that may affect portfolio performance. The company has a process in place to take corrective actions to address product and underwriting problems identified in the portfolio.</td>
<td>Verify management oversight and approval of the measures used to assess underwriting results and variances from pricing assumptions and of the periodic reports used for monitoring portfolio performance.</td>
<td>Verify the company has implemented changes to underwriting guidelines to address policies with</td>
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<td>The insurer has developed or implemented marketing or distribution plans that</td>
<td>OP PR/UW</td>
<td>Other</td>
<td>The insurer has established and maintains clear and reasonable goals and objectives</td>
<td>Review the marketing and distribution plans and obtain evidence of management approval.</td>
<td>Review marketing and distribution plans and compare with underwriting strategy to determine if there are inconsistencies. Consider if there are inconsistencies with other information filed with the department (e.g. business plan, ORSA, risk registers, etc.).</td>
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<td>are not feasible or consistent with its business and underwriting strategy.</td>
<td></td>
<td>UPSQ</td>
<td>regarding marketing and distribution plans (i.e., direct, online, agency network, app, etc.) to achieve its underwriting strategy.</td>
<td>Determine if the insurer periodically evaluates its marketing and distribution plans and updates the plans, if necessary, to address changes in the marketplace and effectively execute the underwriting strategy.</td>
<td>Review the company’s marketing and distribution plans for feasibility and appropriateness in light of market conditions and competition.</td>
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<td>Marketing and distribution plans are reviewed and updated on a regular basis to account for changes in the marketplace and consumer preferences.</td>
<td>Review evidence of cross-unit communication and consider the frequency/depth of communication in evaluation of the company’s control.</td>
<td>Review company’s ongoing performance against projections to evaluate the effectiveness of the company’s marketing and distribution efforts.</td>
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<td>The insurer has cross-unit meetings prior to product roll out and periodically thereafter on all product lines to ensure business decisions are aligned across units/departments and changes are communicated in a timely manner</td>
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<td>The insurer does not effectively oversee its producers, including managing</td>
<td>OP PR/UW</td>
<td>Other</td>
<td>The insurer has developed comprehensive underwriting, pricing and premium processing guidelines and practices that have been approved by senior management and communicated to the MGAs and TPAs.</td>
<td>Review documentation of underwriting, pricing and premium processing guidelines and practices for evidence of senior management review/approval, as well as evidence of communication and training provided to the MGAs and TPAs.</td>
<td>Perform analytical procedures to review the underwriting and premium processing results of significant MGAs and TPAs.</td>
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<td>general agents (MGAs) and third-party administrators (TPAs), to ensure that</td>
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<td>UPSQ</td>
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<td>If deemed necessary, perform a site visit to examine the underwriting process.</td>
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<td>appropriate underwriting and</td>
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<td>premium processing standards are practiced.</td>
<td>ST PR/UW</td>
<td>Other</td>
<td>UPSQ</td>
<td>The insurer monitors the underwriting and premium processing results of its MGAs/TPAs through a regular review of relevant ratios.</td>
<td>Review documentation that provides evidence of regular review of MGA/TPA underwriting and premium processing results by the insurer.</td>
<td>and premium processing functions at the MGA/TPA.</td>
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<td>The insurer requires a Type II SOC 1 report be issued for the service provider and reviews annually.</td>
<td>Review the service provider’s audited financial statements and Type II SOC 1 report to determine the service provider appears to have a solid financial position and appropriate internal controls.</td>
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<td>The insurer performs regular reviews of its MGAs/TPAs to determine whether insurer underwriting standards are being consistently followed and whether premiums are processed and remitted in accordance with company standards.</td>
<td>Review any audit reports and other documentation to determine whether the insurer provides sufficient oversight of its MGAs/TPAs.</td>
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<td>The company has not established appropriate rates for its long-term care insurance (LTCI) policies</td>
<td>ST PR/UW</td>
<td>Other</td>
<td>UPSQ</td>
<td>The insurer utilizes a fully staffed, well-qualified actuarial pricing function that has significant experience and expertise in LTCI.</td>
<td>Review the credentials, background and responsibilities of the insurer’s actuarial pricing function for appropriateness.</td>
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<td>The company conducts experience studies and utilizes credible data as the basis for its rate assumptions.</td>
<td>Select a sample from experience studies to verify support for and consistency with rate assumptions used by the company.</td>
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<td>The company files accurate records.</td>
<td>Communicate with</td>
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<td>and complete rate increase requests with all departments in a timely manner.</td>
<td>department staff in charge of LTCI rate review requests (in multiple states if appropriate) to assess the quality and timeliness of the insurer’s rate requests.</td>
<td>If rates have been subject to insurance department approval, consider whether reliance can be placed on this work. If deemed necessary, utilize the insurance department actuary or an independent actuary to perform a review or independent calculation of premium rates. Compare rate increase assumptions to reserve assumptions, (e.g., review the rate requests and compare against <em>Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves</em> (AG 51) filings) to ensure that assumptions used for pricing and reserving do not materially conflict. Track the progress of the company in achieving its rate increase goals by comparing rate increases received against those requested. If necessary, evaluate the potential impact of rate request denials on the future solvency position of the insurer.</td>
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<td>Financial Reporting Risks¹</td>
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<td>Policy data are not properly and completely entered into the system (See also Examination Repository – Reserves – Claims (Life)).</td>
<td>OP PR/UW</td>
<td>AC CO</td>
<td>UPSQ RA</td>
<td>The insurer’s system contains edit checks that require policy data to be complete and reasonable before being entered into the system.</td>
<td>Test the operating effectiveness of edit checks through reperformance and observation.¹</td>
<td>Trace a sample of records from the policy data to the database and from the database to the policy data to verify and validate key data elements used in the database. Utilize an actuary to determine the most significant lines of business and data points used in the estimate and focus accuracy testing on those.</td>
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<td>The insurer has a QA process in place that tests policy data entered into the system on a sample basis.</td>
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<td>Policies are underwritten with high deductibles that expose the company to significant collectibility/credit risk.</td>
<td>ST PR/UW CR</td>
<td>Other</td>
<td>UPSQ</td>
<td>The insurer reviews the credit quality of potential policyholders before underwriting high-deductible policies.</td>
<td>Review evidence of credit assessment prior to the approval of high-deductible policies.</td>
<td>Consider reviewing a sample of high deductible policies and evaluate sufficiency of collateral based on ongoing claims activity and credit risk of the insured.</td>
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<td>The insurer requires collateral to be posted and maintained to ensure that deductibles on significant</td>
<td>Obtain evidence of the insurer’s process to require and maintain collateral at a sufficient level for high-</td>
<td>Perform an analytic to review and assess historical</td>
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¹ For Life companies, consider performing this test in conjunction with testing performed in the Examination Repository Reserves (Life) which often include similar data elements.
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<th>Identified Risk</th>
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<th>Exam Asrt.</th>
<th>Critical Risk</th>
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<td>claims can be collected.</td>
<td>deductible policies.</td>
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<td>Collateral levels and associated claims activity are reviewed on a regular basis to ensure collectibility.</td>
<td></td>
<td>Review the quality/liquidity/availability of collateral held for high deductible policies.</td>
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Date: November 3, 2021

To: Susan Benard, Chair, NAIC Financial Examiners Handbook (E) Technical Group
    Bailey Henning, NAIC Financial Examination Manager

Re: Comment on the Life Reserve Repository Exposure

Connecticut would like to thank the technical group for exposing the proposed revisions to the Life Reserves Repository. We request the members to consider the following suggestion:

For the identified risk of “In-force data is not complete or accurate nor consistent with accounting records” a new Possible Detail Test was recommended as follows - “send confirmations to policyholder to verify accuracy of significant attributes” (page 34).

We would suggest to remove this new possible detail test for the following reasons:

- Timing of when the confirmations will be returned could be well after the completion of Phase 5 for this key activity.
- A small percentage return rate is highly likely.

If the external auditors sent confirmations these can be obviously utilized for a possible detail test.

We appreciate your consideration of our comments and look forward to the next technical group discussion.

Thank you,

William Arfanis

William Arfanis
Examination Manager
Connecticut Insurance Department
D. Coordination of Holding Company Group Exams

A coordinated group examination should attempt to be a comprehensive and simultaneous examination of insurance entities in a holding company group, which may be domiciled in multiple states. The phrases “holding company group” and “group” are used interchangeably throughout this section and are meant to include insurers that meet the definition for inclusion in an “insurance holding company system” as defined in the Insurance Holding Company System Regulatory Act (§440), as well as entities that do not belong to the same group code, but may share common systems, are tied together through large transactions or could otherwise benefit from being examined together by a group under common control that does not meet this definition but would benefit from coordinated examination efforts. Coordination among the states should include the timing, scope and extent of examination procedures, utilization of specialists (e.g., information systems and actuarial) and their work products, and allocation of work among examiners. This coordination promotes communication among the states and the efficient use of resources, provides an avenue for multiple perspectives to be shared, and minimizes the duplication of work.

Exam coordination among insurers of a group or holding company system is critical for effective solvency regulation. When examinations are conducted on a group of insurers, the goal is to gain efficiencies and prevent duplication of testing wherever possible. Group examinations not only provide information on each insurer individually, but also provide an avenue for regulators to understand and evaluate the risks of the holding company group as a whole. Under Model §440, regulators have the authority to examine “any insurer registered under Section 4 and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.” Therefore, in conducting a coordinated group exam, the lead state or exam facilitator should work with the assigned financial analyst to identify and address any significant concerns at the group level with the potential to threaten the solvency of the insurers being examined. In this situation, a group examination report may be issued by the lead state, but does not reduce the need to obtain evidence about the solvency of each insurer or eliminate requirements for individual examination reports.

States should coordinate examinations of all types of insurers operating in holding company groups when possible, including health insurers that operate primarily as health maintenance organizations (HMOs). Even though these organizations are often composed of single-state entities, they could still share processes, controls and decision-making that might be more efficiently reviewed through a coordinated group examination.

When conducting a coordinated examination, states participating in the examination will often have access to information that is considered sensitive and/or confidential. The NAIC Financial Regulation Standards and Accreditation Program requires that the states allow for the sharing of otherwise confidential information and administrative or judicial orders to other state regulatory officials, providing that those officials are required, under their law, to maintain its confidentiality. The NAIC Master Information Sharing and Confidentiality Agreement allows for signatory states to share confidential information with another signatory state that can demonstrate that its laws will protect the confidentiality of the shared information. This agreement is designed to eliminate the need for states to sign numerous multi-state agreements on a myriad of regulatory subjects.

Before, during and after a group examination, the Lead State, Exam Facilitator and any other regulators that have domiciles in the group—whether participating in the group exam or not—should be prepared to discuss relevant information with the NAIC Financial Examiners Coordination (E) Working Group. This information could include, but is not limited to, scheduling a group exam, the progress of a group exam, and why coordination did or did not occur between states for a particular group.

Determining the Lead State and Subgroups of Companies

Every insurance holding company system has individual characteristics that make it unique. Therefore, an evaluation of these traits is required to determine how examinations for the group should be coordinated and which individual state is known as the Lead State, should assume the leadership role in coordinating group examinations. The Lead State assumed this responsibility will be known as the Lead State and is charged with the coordination of all financial exams for the holding company group, as well as other regulatory solvency monitoring activities, such as group supervision, including holding surplus.
company analysis, group profile summary (GPS), assessments of the group’s corporate governance and ERM functions, etc.) as defined within the Financial Analysis Handbook.

In most situations to date, the Lead State has emerged by mutual agreement (i.e., self-initiative on its part and recognition by other states), generally as a result of the organizational structure of the group or as a result of the domicile of primary corporate and operational offices. The input of domestic regulators within the group also plays critical role in determining which state should be chosen to fulfill the role of the Lead State. Other factors that may be considered when determining the Lead State are:

- State with the largest number of domestic insurance companies in the group.
- State of large or largest premium volume or exposure.
- Domiciliary state of top-tiered insurance company in an insurance holding company system.
- Physical location of the main corporate offices or largest operational offices of the group.
- Expertise in the area of concern and experience of staff in like situations.
- State whose regulatory requirements have driven the design of the organization’s infrastructure.

Input from domestic regulators in the group, as well as holding company personnel, should be considered when determining how the companies in the group might be broken up into subgroups for financial exam purposes, if necessary. Because each group has its own unique characteristics, as do the companies within each group, it might be appropriate to separate the group into smaller factions and identify an Exam Facilitator for each subgroup examination. In order to gather information to make this decision and to assist in planning the coordinated examination, the Lead State might review group information contained in the Lead State Summary Report on iSite+, as well as request that holding company group personnel provide information to be considered in grouping companies within the holding company group for financial examinations. At a minimum, the information provided should include the topics of corporate governance of the group, risk management and decision-making, key functional activities and processes, lines of business, and computer systems. This information request is also included in Exhibit Z, Part One.

Responsibilities of the Lead State

The primary purpose of the Lead State is to promote the coordination of exams for all entities within the group. In achieving this goal, the Lead State should fulfill the following responsibilities:

1. Develop, maintain and communicate group coordination plan:
   
   The Lead State should actively encourage all states within the group to participate in coordinated group examinations when possible. To help facilitate participation by all states, the Lead State should develop, maintain and communicate a global group coordination plan, using Exhibit Z, Part Two-A, or a similar document. The group coordination plan may include, but is not limited to, information about potential subgroups, anticipated examination schedule, primary location of fieldwork, etc. The Lead State should also consider whether other entities that do not share a group code should be involved in the coordinated examination. For example, there may be entities that share services or other financial relationships with the entities in the group but are not under common control or do not have an assigned NAIC code (i.e., captive insurance companies or other risk-bearing entities, warranties, etc.). Consideration of whether these entities may benefit from involvement and/or awareness of the coordinated examination should be documented in the coordination plan, when appropriate. Such a plan would allow ample time for the states to make the necessary arrangements to participate in future coordinated efforts.

   The frequency at which the coordination plan is updated and communicated to domestic regulators within the group may vary based on the size and complexity of the group. At minimum, the group coordination plan should be updated and communicated at least 4 months prior to the as-of date of an expected examination. However, updates should be made and appropriately communicated based on relevant changes to the group and/or examination schedule.
The Lead State should be prepared to discuss relevant information pertaining to the global coordination plan and the status of coordination efforts with the NAIC Financial Examiners Coordination (E) Working Group as requested. If selected, the Lead State would be required to present such information to the Financial Examiners Coordination (E) Working Group at an NAIC national meeting.

2. Monitor the status of existing examinations activities performed on all entities within the group.

This requires the Lead State to have an understanding of the progress of all ongoing exams performed on all entities within the group. The Lead State should also be aware of the significant results of all recently completed exams. If consistent problems are identified during examination efforts, the Lead State may need to become involved in addressing the issues at the group level.

3. Identify subgroups when appropriate that may be appropriate for performing coordinated examinations.

In situations where it is not feasible for all legal entities within a group to be examined at one time, it is the Lead State’s responsibility to determine subgroups for ongoing examination purposes. The Lead State should consider company use input from the company, including responses to (i.e., Exhibit Z, Part One), as well as input from other domestic regulators within the group when making this determination. In addition, the Lead State should receive input from other domestic regulators within the group when making this decision. The use of subgroups should be reflected in the group coordination plan (i.e., Exhibit Z, Part Two-A). However, it is the Lead State’s responsibility to determine subgroups for ongoing examination coordination purposes.

4. Schedule the coordinated examination:

For each holding company group, consideration should be given to the priority of each entity within the group when determining the frequency at which group examinations should be performed. The Lead State should obtain input from all of the key domestic regulators within a group (or subset of companies) before determining the “as-of” date for the next examination. This input may be obtained through the use of a supervisory college, conference calls conducted through the financial analysis process, or other meetings to discuss the financial regulation of a particular group.

In addition to basing the frequency of full-scope group examinations on the financial strength of the group, regulators should consider performing limited-scope exams when specific concerns arise with the holding company group. Whenever conclusions are reached regarding the scheduling of full or limited-scope group examinations, prompt notification...
should be provided to all states with domestics in the group (or subset of companies) to enable all domestic states the opportunity to participate in the group examination.

The group examination schedule should not preempt consideration of a state’s prioritization schedule or postpone examinations of troubled companies, nor should it interfere with the state’s obligation to conduct a full scope examination of its domestic insurance companies in accordance with state statutes. However, states should remain flexible and attempt to coordinate, when appropriate, to ensure an effective and efficient examination. In some circumstances, this may necessitate accelerating the examination schedule of one or multiple legal entities in the group in order to synchronize the examination schedule.

5. Notify others regulators and the companies in the group of an upcoming examination (informal notification):–

The Lead State should notify other states that have domestics in the group of the exam well in advance of significant planning work to allow them the opportunity to participate on the examination. Advance notification should also be extended to the companies that will be examined as part of the group examination to allow them to prepare. An informal notification to the other state regulators and the companies should occur as early as possible and is recommended at least six months prior to the “as-of” date (e.g., 12/31/20xx) of the examination. In most circumstances, the formal calling of the group examination in FEETS should occur at least 90 days before the anticipated start date of the group examination by the Lead State. The timing difference between the informal notification and the calling in FEETS allows the Lead State time to determine specific attributes of the group exam, such as the primary contact person and the anticipated start date of the exam that may not be known six months before the “as-of” date. If an exam is scheduled due to specific concerns with a group of companies that do not allow the exam to be called in FEETS at least 90 days before the anticipated start date, the Lead State should document an explanation for inclusion in the group exam workpapers and notify other state insurance regulators as soon as possible.

The Lead State or Exam Facilitator (if known at the time) should also notify the companies that will be examined as part of the group examination to allow them and their respective external auditors time to prepare. This notification should occur at least six months before the “as-of” date of the group examination.

6. Call group examination(s) in FEETS (formal notification): and determine the Exam Facilitator for each group examination called—

The chief examiner of the Lead State or designee is responsible for placing the group examination call in FEETS to simultaneously examine the entire group (or subset) of insurance companies involved in an insurance holding company group. When calling the group examination(s), the Lead State should indicate (by “inviting”) which legal entities in the group will be examined together.

- **Timing of the group exam call:**
  In most circumstances, the formal calling of the group examination in FEETS should occur at least 90 days before the anticipated start date of the group examination by the Lead State. The timing difference between the informal notification and the calling in FEETS allows the Lead State time to determine specific attributes of the group exam, such as the primary contact person and the anticipated start date of the exam that may not be known six months before the “as-of” date.

  If an exam is scheduled due to specific concerns with a group of companies that do not allow the exam to be called in FEETS at least 90 days before the anticipated start date, the Lead State should document an explanation for inclusion in the group exam workpapers and notify other state insurance regulators as soon as possible.

- **Assign Exam Facilitator (if applicable):**
  One of the first responsibilities of the Lead State when a group exam is planned is to call the group examination in FEETS and to determine who will perform the role of Exam Facilitator. In many situations, it is expected that the Lead State will assume the Exam Facilitator role itself to conduct and lead the group examination. However, in situations where subgroups have been formed that don’t involve
the Lead State, it is anticipated that the Exam Facilitator role will be delegated to an accredited state within the group. If the responsibility is delegated, the accepting state would then assume the responsibilities associated with conducting that group examination. The role of Exam Facilitator is typically temporary in nature because it pertains only to a specific group examination being performed; once that exam has been closed, the need for an Exam Facilitator is no longer present and any assumed responsibilities remit back to the Lead State (if they were delegated). For some groups that maintain clear long-term subgroups, the Exam Facilitator role may be more permanent.

The selection of the Exam Facilitator can be accomplished through a review of the documentation provided by the holding company group personnel and through discussions with the impacted states. The regulated entities should also be allowed to provide input on the Exam Facilitator determination process where appropriate. The designated contact person should be the chief examiner, or equivalent, for the Exam Facilitator of each group exam.

**Please Note:** Due to the design of FEETS, the Lead State will always call the exam in FEETS, regardless of whether there is a different state designated to facilitate the group exam. If a different state has been delegated the responsibilities of the Exam Facilitator, the Lead State must designate the Exam Facilitator in the FEETS group exam call. Once the Exam Facilitator has been assigned in FEETS, that state will be able to make changes to the assigned group exam, including close the group exam upon completion.

- **Other Considerations:**
  It is recommended that all group examinations be called in FEETS regardless of what type(s) of insurers are being examined. For example, if a group exam is being conducted for a group of HMOs that are all single-state entities, the group exam should still be called in FEETS for informational and tracking purposes. Specific requirements regarding calling an exam in FEETS can be found in the “Responsibilities of the Lead State” section above.

  Additionally, when calling a group exam in FEETS, only entities that share an NAIC group code are pre-populated. However, there may be other entities that should be considered for inclusion in the group exam. This may include affiliated companies that do not have an NAIC code (i.e., captive insurance companies, other risk-bearing entities, warranties, etc.). It may also include Unaffiliated companies that have significant influence or could materially impact insurers in the group should also be considered for inclusion in the group examination (e.g., a company that has a significant reinsurance relationship with a company belonging to the holding company group). The examination of companies that are members of a holding company system having only a reinsurance relationship with the company under the examination may be conducted on a limited basis to verify the complete nature of transactions (obligations, liabilities and assets transferred between parties). Consideration of inclusion should also be extended to affiliated companies that may share services or other financial relationships with companies in the group but do not belong to the same group or that do not have an NAIC code (i.e., captive insurance companies or other risk-bearing entities, warranties, etc.).

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1. Act as the Exam Facilitator for all group examinations as deemed appropriate—The responsibilities associated with this role are outlined later in this section.

7. Maintain communication with the group personnel—The Lead State should serve as the primary regulatory contact with top management of the group on an ongoing basis regarding overall coordination activities for companies within the group. Additionally, the Lead State is responsible for elevating significant solvency concerns to top management of the group when issues are unable to be resolved at lower levels within the group.
8. Act as the Exam Facilitator, as deemed appropriate:
   As noted above, unless otherwise assigned, the Lead State will also act as the Exam Facilitator for coordinated examinations of companies within the group, for all group examinations, as deemed appropriate. The responsibilities associated with this role are outlined later in this section.

Additional Considerations for Scheduling a Coordinated Group Exam

For each holding company group, consideration should be given to the priority of each entity within the group when determining the frequency at which group examinations should be performed. The Lead State should obtain input from all of the key domestic regulators within a group (or subset of companies) before determining the "as of" date for the next examination. This input may be obtained through the use of a supervisory college, conference calls conducted through the financial analysis process, or other meetings to discuss the financial regulation of a particular group. In addition to basing the frequency of full-scope group examinations on the financial strength of the group, regulators should consider performing limited-scope exams when specific concerns arise with the holding company group. Whenever conclusions are reached regarding the scheduling of full or limited-scope group examinations, prompt notification should be provided to all states with domestics in the group (or subset of companies) to enable all domestic states the opportunity to participate in the group examination.

The chief examiner of the Lead State or designee is responsible for placing the group examination call to simultaneously examine the entire group (or subset) of insurance companies involved in an insurance holding company group. It is recommended that all group examinations be called in FEETS regardless of what type(s) of insurers are being examined. For example, if a group exam is being conducted for a group of HMOs that are all single-state entities, the group exam should still be called in FEETS for informational and tracking purposes. Specific requirements regarding calling an exam in FEETS can be found in the “Responsibilities of the Lead State” section above.

Unaffiliated entities that have significant influence or could materially impact insurers in the group should also be considered for inclusion in the group examination. The examination of companies that are members of a holding company system having only a reinsurance relationship with the company under the examination may be conducted on a limited basis to verify the complete nature of transactions (obligations, liabilities and assets transferred between parties).

Responsibilities of the Exam Facilitator

The role of Exam Facilitator may vary from exam to exam; however, certain responsibilities assigned to this role are shown below. As discussed in the “Review and Reliance on Another State’s Workpapers” section following this section, the Exam Facilitator is responsible for the overall quality of work performed in completion of a fully-coordinated group examination. Additionally, the Exam Facilitator for all examinations must be an accredited state.

1. Develop an examination team:
   Once it has been determined that a coordinated group exam will be conducted, a determination should be made of all of the states that will have a direct role in the examination. The Exam Facilitator should work with the states in the group to determine the necessary staffing requirements for the specific examination at hand, including which states within the group plan to have a direct role in the examination and whether additional specialists are needed.

   The Exam Facilitator should contact the participating states to establish points of contact by name/role, determine the amount of interest in participating in the coordinated examination, and establish lines of communication with participating states. Preferably, the Exam Facilitator should designate a primary and a back-up point of contact for communications with the organization under review and with other state regulators, and with other stakeholders, federal Reserve, federal and state banking agencies, functional regulators and the public. At a minimum, information for the primary contact person should be provided for the group exam in FEETS.
While developing the exam team for a group examination, the Exam Facilitator should coordinate and utilize any available resources (within the group or contracted) that are necessary and appropriate to complete an effective and efficient examination. These may include, but are not limited to, financial analysts, financial or market conduct examiners, IT examiners, actuaries, legal counsel, rate and form experts, or valuation experts. Consideration should be given to the areas of expertise needed to complete the examination. If possible, states participating in the group exam should consider utilizing the same staffing resources when efficient to do so. For example, it may be efficient to utilize the work of one actuary who could become familiar with the general processes utilized by the group of insurers instead of contracting several different actuaries who would all have to familiarize themselves with the same processes.

The Exam Facilitator should contact the participating states to establish points of contact by name/role, determine the amount of interest in participating in the coordinated examination, and establish lines of communication with participating states. Preferably, the Exam Facilitator should designate a primary and a back-up point of contact for communications with the organization under review and with other state regulators, Federal Reserve, federal and state banking agencies, functional regulators and the public. At a minimum, information for the primary contact person must be provided for the group exam in FEETS.

2. Seek input from other regulators:
   During the planning stages of an exam, the Exam Facilitator should request input from other regulators regarding any areas of concern that should be addressed during the group exam. Input should be requested from any states with domestics in the group or subgroup, as applicable, even if a state is unable to participate in the fully coordinated exam. This responsibility includes obtaining input from each state regarding the key activities and inherent risks it anticipates for each of its domestic companies. Consistent with the guidance in Phase 1, identification of key activities and risks should primarily be determined by areas that represent significant solvency concerns. The Exam Facilitator should also contact regulators of holding company groups that include an entity or entities that are at least in part regulated outside the state insurance regulatory structure for items to consider or address during the examination.

Once the Exam Facilitator has accumulated information from each regulator, in addition to information related to its own domestics, it should determine which key activities/inherent risks will and will not be addressed as part of the group examination and notify the other state insurance regulators. Testing performed by participating states in areas deemed insignificant to the overall group examination are considered state-specific procedures and, therefore, the oversight of such work is outside of the Exam Facilitator’s responsibility.

3. Delegate responsibilities among the examination team:
   Once the multi-state examination “team” has been established, the Exam Facilitator should clearly delegate responsibilities between itself and any participating examiners with input from participating states. The Exam Facilitator should develop a process to manage information requests going to holding company group personnel to prevent redundancy. The Exam Facilitator should also attempt to coordinate the timing of work that will be performed by all states participating on the group exam to the extent possible. This includes organizing a review of shared processes and controls and determining which state(s) are responsible for which key activities and processes. When delegating responsibilities, the Exam Facilitator should consider the resources needed and available for the task among the participating states as well as the expertise and ability to supervise personnel as necessary. Although certain tasks may be delegated among participating states, the Exam Facilitator remains responsible for the overall quality of work performed in completion of a coordinated group examination and should review such work accordingly.

One of those responsibilities includes meeting with internal and external auditors. The Exam Facilitator should ensure completion of Exhibit E – Audit Review Procedures for the group examination. The Exam Facilitator should also coordinate the communication of obtaining and reviewing any relevant auditor workpapers to prevent redundancy between states.

In Phase 5, detail testing may be necessary to obtain additional exam evidence for any particular identified risk. With input from the participating states, the Exam Facilitator should determine whether detail testing will be
performed as part of the group examination or if the testing will be performed separately by each domestic regulator. Regardless of which method is used, if detail testing will involve substantive testing of individual account balances, the testing should be applied at an individual company level based on the residual risks determined during the group exam (assuming the identified risk was one that was assessed during the group exam). In other words, the materiality levels for each individual company should be utilized.

When selecting what substantive testing should be performed, the materiality levels for each individual company should be utilized so that exam evidence will be obtained for each insurer based on its dollar value. However, if detail testing will consist of testing the attributes (or accept/reject testing) of underlying data utilized in other calculations (e.g., loss reserves, unearned premiums), the testing may be performed at the group level because the examiner is testing the occurrence of a particular attribute in a population subject to the same control processes. For pooling arrangements, see the “Exceptions to Consider Related to Coordinating Group Exams” section below.

4. Establish lines of communication with top management in the group:
   related to the group exam being performed — The Exam Facilitator should ensure that there are regular and candid discussions occur with top management of the insurance companies regarding the results of the ongoing group examination. A structure for obtaining updated information from company management regarding the ongoing exam should also be established. If significant solvency concerns arise that are unable to be resolved by the Exam Facilitator, the issue should be raised to the Lead State, if different, to address with top management of the group.

5. Obtain a thorough understanding of the companies being examined: as part of the group exam as they relate to the organization as a whole — The Exam Facilitator should obtain as much insight as possible into about the organization as a whole group/subgroup when leading a coordinated group exam effort. To gain this understanding, the Exam Facilitator should focus on the holding company, or ultimate controlling entity, and subsequently on its underlying subsidiaries that will be included in the group exam. The Exam Facilitator should also take the predominant primary role in obtaining and reviewing analysis work pertaining to the organization as a whole-group/subgroup in preparation for the group exams by working with the individual domestic states and foreign regulators to complete a collective understanding of the holding company group.

6. Coordinate and conduct C-level interviews: Interview management and board members at the holding company level — The Exam Facilitator should perform interviews of the upper-level management and members of the board, and its committees, at the level at which oversight and management of the group’s primary insurance activities are performed. Participating states may provide questions to the Exam Facilitator that they would like asked during interviews. These states may also participate in the interviews in limited situations when deemed appropriate. These interviews should be conducted in-person if possible, and it may be beneficial to schedule them during regularly scheduled board committee meetings if convenient for scheduling purposes. When these interviews are completed, the information should be distributed and shared among regulators as necessary to prevent unnecessary duplication of efforts. When subgroups are utilized, the Exam Facilitator of the subgroup should consult with the Lead State to determine whether a corporate governance assessment has been performed at the holding company level and if it would be appropriate to leverage at the subgroup level.

7. Share information with participating states during the group exam — Procedures should be established regarding how information will be shared, including ensuring that all participating states have real-time access to the information. This step is critical to establish the Exam Facilitator as a true “facilitator” by supplying the states and other functional regulators with the appropriate information. This can be accomplished through periodic status meetings (i.e., monthly) among the participating states and/or verbal or written updates from the Exam Facilitator to the broader group of state insurance regulators.

Real-time access of workpapers could also be accomplished through the use of a shared hosting environment like NAIC Citrix server or other tools available to individual states. When possible, the examination team should conduct work within the same examination file to allow for enhanced collaboration among exam participants.
Utilizing the same examination file may also reduce the possibility of duplicative documentation and enable other participants to observe and review work in real time. Insurance departments should develop methods to receive, as well as to communicate, pertinent information regarding holding companies and insurance groups to other affected states and other functional regulators.

8. Review the work performed by participating states:—

As noted previously, the Exam Facilitator is responsible for the overall quality of work performed in completion of a fully coordinated examination. Therefore, the Exam Facilitator should perform a sufficient level of review of work completed by participating states on behalf of the coordinated exam effort to gain comfort that the quality of work meets the examination objectives and the Exam Facilitator’s expectations. When determining the extent of review, the Exam Facilitator should consider its comfort and experience with the quality of work performed by each participating state. The accreditation status of participating states may also be considered in determining the level of review necessary to gain comfort in the quality of the work performed. As discussed in the “Review and Reliance on Another State’s Workpapers” section following this section, the Exam Facilitator is responsible for the overall quality of work performed in completion of a fully coordinated group examination.

9. Promote consistency in examination deliverables:—

The Exam Facilitator should communicate with all states involved in the coordinated effort to promote consistency of information shared in management letters and examination reports. If the Exam Facilitator determines that examination deliverables will include reporting at the group level (i.e., a group management letter), in addition to the legal entity examination deliverables, the Exam Facilitator should consult with the Lead State (if different) and other states participating in the examination to determine which results and observations will be included. Additional guidance for preparing management letters, including considerations for determining the significance and severity of findings or comments to be communicated as well as the level at which corrective measures can be taken can be found in Section 2-7.

10. Distribute information to participating states and other functional regulators, when applicable:—

In limited situations, participating states may opt to work in a standalone examination file that is separate from the coordinated group examination file. If this happens, once the work of the group is completed, the Exam Facilitator is required to provide all participating state(s) an electronic copy of the corresponding workpapers related to the group examination for inclusion in the workpapers for their respective individual company exams. The Exam Facilitator should also communicate the completion of the group exam procedures to the holding company group personnel and to indicate that any work after that point is being performed by individual states for their individual domestics.

The NAIC Financial Regulation Standards and Accreditation Program requires that the states allow for the sharing of otherwise confidential information and administrative or judicial orders to other state regulatory officials, providing that those officials are required, under their law, to maintain its confidentiality. The NAIC Master Information Sharing and Confidentiality Agreement allows for signatory states to share confidential information with another signatory state that can demonstrate that its laws will protect the confidentiality of the shared information. This agreement is designed to eliminate the need for states to sign numerous multi-state agreements on a myriad of regulatory subjects.

11. Resolve any disputes or disagreements regarding the group examination:—

The Exam Facilitator should settle any disagreements among participating states prior to finalizing the coordinated examination. If the Exam Facilitator is unable to resolve the issue at hand, it should defer the issue to the Lead State (if different than the Exam Facilitator). If the issue is not able to be resolved at that level, the Financial Examiners Coordination (E) Working Group can be consulted for timely resolution.

12. Hold an exit conference with the participating states:—

Once the group exam work is completed, the Exam Facilitator should host an exit conference to discuss the overall results of the group exam and possible steps for regulating the holding company group in the future. The Lead State should be invited to participate in the exit conference if they were not already participating in
the examination. During this meeting, the Lead State and the Exam Facilitator should discuss with the participating states when the next group exam should be scheduled and update the group coordination plan accordingly, based on the topics included in the “Additional Considerations for Scheduling a Coordinated Group Exam” section above. If the regulators have difficulty coming to an agreement regarding the next group exam date, they should reach out to consult the Financial Examiners Coordination (E) Working Group for input and assistance.

13. Close the group examination in the NAIC-FEETS

Upon the completion of the group examination, the Exam Facilitator should ensure that each participating state has linked its individual examination(s) to the group examination in FEETS. Once work in support of the coordinated group exam has been completed and each participating state has linked its individual examination(s) to the group exam, the Exam Facilitator should close the group examination. Each domestic state is responsible for closing its individual examination(s) upon completion, as noted within the “Responsibilities of States Participating in a Coordinated Exam” section below.

Responsibilities of States Participating in a Fully Coordinated Exam

In general, the role of each participating state that is not the Exam Facilitator is to pledge some level of cooperation and coordination with other states and to give support and recognition to the Exam Facilitator. In order to be considered a participating state, a state must demonstrate active involvement throughout the duration of the coordinated examination. This can be accomplished in a number of specific ways as described below:

Indicate willingness to participate in the coordinated examination

1. Respond to informal and formal notifications of anticipated coordinated exam:
   When planning a coordinated examination, the Lead State (or Exam Facilitator, if different) will typically issue an informal notification of an upcoming examination several months in advance of the planned examination as-of date. Participating states are encouraged to respond to the informal notification in a timely manner to allow the Lead State/Exam Facilitator to adequately plan for the coordinated examination. Each participating state is encouraged to be flexible when attempting to coordinate and should consider the long-term benefits of coordination regarding participation on the group exam.

   The Lead State (or Exam Facilitator, if different) will also issue a formal notification (sent via email by FEETS) of an upcoming coordinated examination at least 90 days prior to the examination as-of date. The participating state(s) should respond to the Exam Facilitator within 30 days of receiving the email notification regarding the calling of a group examination. Each participating state is encouraged to be flexible when attempting to coordinate and should consider the long-term benefits of coordination.

   Note: If a state plans to examine a legal entity that belongs to a holding company group, it should first contact the Lead State to determine whether a coordinated examination is planned or should be considered.

2. Call individual exam(s) in FEETS and link to the group exam:
   If the state(s) plan to participate in the coordinated examination, it should call an individual exam in FEETS for each domestic legal entity that will be examined as part of the coordinated examination. Each applicable individual examination should also be linked to the group examination in FEETS.

Participation in exam planning

3. Actively participate in the planning phases of the group exam—Provide input to the Exam Facilitator:
   During the planning phases, the participating state(s) should communicate key activities, inherent risks or other areas of concern for each domestic company that the participating state(s) would like to be addressed during the
group exam, as well as The participating state(s) should also provide an overview of any state-required specific procedures (i.e., required compliance testing) the participating state plans to perform.

Consistent with the guidance in Phase 1, identification of key activities and risks should primarily be determined by areas that represent significant solvency concerns. The states should be notified by work with the Exam Facilitator to determine which risks will and will not be addressed as part of the group examination. This information should help the state in determining whether additional risks will need to be addressed outside of the group examination efforts.

Testing performed by participating state(s) in areas deemed insignificant to the overall group examination are considered state-specific procedures and, therefore, the quality of such work is the responsibility of the participating state.

Active involvement in the planning phases of the exam may include documenting correspondence with the Exam Facilitator and other participating states, reviewing and signing off on the planning memo, participating in the discussion of risk identification, etc.

4. Coordinate the use of any-examination resources, including contracted examiners and specialists, with the Exam Facilitator:
The participating state(s) should provide specific expertise and resources to assist the Exam Facilitator and other states throughout the group examination process as requested. The participating state(s) should coordinate the use of contracted examiners and specialists, when possible.

5. Coordinate information requests with the Exam Facilitator:
Offer constructive suggestions for information requests, interview questions, coordinated actions and timeliness of information. Any general communication on behalf of the group exam should be discussed with the Exam Facilitator prior to contacting company personnel to prevent duplication, if possible. This includes any information requests being sent as part of the group examination.

6. Consider interviewing individuals at the legal-entity level:
who are unique to the participating state’s particular insurer, if necessary. The participating state(s) should also provide the Exam Facilitator with interview questions to cover during C-Level interviews performed for the coordinated group exam, if any. The participating state(s) may also consider conducting interviews with individuals at the legal-entity level, if deemed necessary (e.g., to address matters specific to the legal entity that were not addressed through the group C-Level interviews).

Completion of testwork and other responsibilities

7. Complete delegated group responsibilities:
The participating state(s) are expected to complete group responsibilities delegated by the Exam Facilitator to the satisfaction of the Exam Facilitator, which may include:
• completing assigned testing, such responsibilities may also include clearing review points
• addressing feedback provided by the Exam Facilitator,
• performing detail reviews of testwork completed by its own staff’s testwork and
• other responsibilities as communicated by the Exam Facilitator.

8. Leverage work performed in fulfillment of the coordinated effort:
The participating state(s) should leverage work performed in fulfillment of the coordinated effort, even when completed by other states within the group. Participating state(s) should avoid creating duplicative documentation and instead include a limited number of hyperlinks and/or key workpapers that are necessary to understand where coordinated work is located.
9. Provide adequate oversight of the work of its own staff, contract examiners, specialists and consultants:—

It is not the responsibility of the Exam Facilitator to supervise personnel from other states on a day-to-day basis. Each state must provide adequate oversight of its examiners, regardless of whether they are state employees or contract examiners, and should consider the allotted time that has been budgeted for the work of that state’s resources. Each state will be held accountable for the performance of personnel it has scheduled on any group examination.

10. Be engaged throughout the examination:

The participating state(s) should be informed and prepared to share information and perspectives pertinent to the group examination and the respective domestic insurers, —This includes actively participating in conference calls and meetings arranged by the Exam Facilitator.

Participation at the conclusion of the exam

11. Participate in the exit conference:

Demonstrate participation in the exit conference hosted by the Exam Facilitator by providing any relevant information, input and conclusions on the group exam as well as input on exam deliverables (i.e., exam report, management letter). As discussed in the “Responsibilities of Exam Facilitator” section above, when preparing examination deliverables, guidance at Section 2-7 should be considered.

12. Close individual examination(s) in FEETS:

At the conclusion of the examination(s), issue report(s) of domestic(s) by uploading the report(s) to FEETS and closing the exam(s) in FEETS. Upon the completion of the individual examination(s), the participating state should ensure that the individual examination(s) for its domestic(s) being examined as part of the group examination are linked to the group exam call in FEETS (if not already done). The participating state must distribute the report(s) of its domestic(s) to the states in which the insurer(s) are licensed and/or transacting business by uploading the exam report(s) to FEETS and closing the exam. This shall occur no more than 30 days beyond the adoption date of the exam report(s). When closing the examination(s) in FEETS, include the next planned “as-of” date for each domestic that should be consistent with what was discussed during the exit conference.

Exceptions to Special Considerations Related to Coordinating Group Exams

Differing exam cycles:
The Lead State should take state statutes into consideration because they may differ regarding how often a financial examination is required (e.g., three to five years). Several insurers within a holding company system with different states of domicile may be on varying cycles when their exams are performed. If it is deemed beneficial for states to participate on a group exam even though their legal entities are not yet due for an examination, those states, after discussions with the Lead State, may consider accelerating their next exam “as-of” date in order to match the “as-of” date of the group examination.

Use of subgroups:
In striving toward examination coordination, it is important to note that complete coordination may not improve the examination efficiencies for some groups. In some circumstances, different Exam Facilitators are required to separate the companies within a group on different examination coordination schedules. Regulators will be able to utilize the NAIC Group Exam Report in FEETS to assist with determining how companies within the group may have been separated into subgroups based on previous group exams performed. The use of subgroups should also be described in the coordination plan for the group. This is in accordance with examination coordination efforts illustrating that coordination efficiencies have been achieved for those companies with similar systems, management, and/or control processes across legal entities, business units or lines of business within a group.

Responding to a specific issue/concern not relevant to the entire group:
A situation may arise where a domestic regulator has concerns about a particular insurer within a group that is not determined to be significant to the group overall. In these situations, in order to attempt to keep domestic insurers coordinated as part of a group examination, the domestic regulator should consider performing a limited-scope exam on that entity, if possible. However, if a limited-scope exam is insufficient and a full-scope examination of the domestic entity is warranted outside the normal group exam schedule, the Lead State should be notified and the examination should be performed by the domestic regulator utilizing work previously completed by the group as appropriate. After the examination is performed, the domestic regulator should attempt to coordinate future examinations with the group if at all possible.

Non-participating states utilizing group examination work:

Although a state may be unable to participate on a group examination at a certain point in time, that state may benefit from receiving group exam workpapers completed at any time during the exam period for its individual domestic exam(s). In these cases, the non-participating state should contact the Lead State and Exam Facilitator directly to obtain access to those workpapers and they should be made available. The non-participating state should give adequate time for the request to be fulfilled and for the requested workpapers to be adequately reviewed before the work is provided to the non-participating state. This does not require a review of all the exam work, but only the specific work requested so the work can be received timely.

Similar to utilizing the work from external/internal auditors, if an examiner plans to utilize documentation that was performed on a group exam from a year prior to the current examination “as-of” date, the examiner should obtain evidence that the item documented (e.g., internal controls) has not changed subsequent to the prior period testing. The more reliance that is placed on the prior period documentation received from the group exam, the more examination evidence should be obtained. Verification that the item documented has not changed should be obtained by a combination of inquiry, observation, reperformance and examination of documents, and should be clearly documented in the examination workpapers. If it has significantly changed since the prior period, the examiner should not utilize the prior period workpapers for that area as examination evidence.

Pooling arrangements and the use of group materiality:

When conducting an examination of a group that pools 100% of its business through the use of a pooling arrangement, it may be acceptable to calculate materiality at the group level. Group materiality may be beneficial for these situations because the risks are consistently shared throughout the group, and any detail testing that is based on materiality will take all the transactions of the group into consideration. With the Exam Facilitator leading the discussion, the regulators within the group should determine if this is appropriate for the group of insurers in a pooling arrangement and if exam evidence is being obtained for all insurers under examination.

E. Review and Reliance on Another State’s Workpapers

For a number of reasons, state insurance regulators have recognized that a growing need to more fully coordinating their regulatory efforts. One such reason is the realization that the analysis helps ensure a more complete understanding of an individual company may not be complete without understanding, within the context of the insurance holding company group of which the individual company is a part. Insurers within an insurance holding company group may have common management and similar information systems and/or control processes. Therefore, if the insurer under examination is part of an insurance holding company group, the domestic state could benefit from the work of another state if that other state’s examination procedures address the domestic insurer’s financial statements or internal control procedures.

Depending on how the examination is coordinated, the extent of documentation required to explain the reliance of a domestic state on the work of another state varies. There are three general scenarios that may affect the extent of documentation.

1. Lead State/Exam Facilitator, conducting a fully coordinated group examination.

   -When a coordinated group examination is conducted in this manner, the Lead State/Exam Facilitator is responsible for the overall quality of the work performed in support of the coordinated exam conclusions. Any work performed that is solely related to an individual domestic is excluded from the Lead State/Exam Facilitator’s work.
responsibility. For a discussion of specific responsibilities of the Lead State/Exam Facilitator, refer to the “Responsibilities of the Lead State” and the “Responsibilities of the Exam Facilitator” sections above. Additionally, Exhibit Z, Part Two – Section A and/or Exhibit Z, Part Two – Section B should be completed in this scenario.

2. Participating State in a fully-coordinated group examination.

To demonstrate adequate participation, the participating state should complete Exhibit Z, Part Two – Section C to assist in documenting compliance with the responsibilities outlined in the “Responsibilities of States Participating in a Fully-Coordinated Exam” section above. Such documentation may be supplemented by a separate memo, if deemed necessary, to demonstrate compliance. In addition, the participating state assumes ownership of any state-specific procedures that are performed and is responsible for the quality of such work.

3. States not participating in a fully-coordinated group examination.

States in this category conducted a standalone examination separate from the fully-coordinated group examination. States in this category are responsible for all work contained in the examination file. If a state is utilizing existing work but was not directly involved in the planning, oversight and review of the examination work, this state takes ownership of the project and is responsible for the overall quality of work performed in support of examination conclusions.

This state should perform a review of the testing state’s work program and conclusions to ensure the work being relied upon is sufficient to meet the needs of its examination. When determining the extent of review, the state utilizing the work of another state should consider its comfort and experience with the quality of work performed by that state. In addition, the accreditation status of other states may also be considered in determining the level of review to be performed by the relying state. Exhibit Z, Part Two – Section D should be completed in this scenario.
November 5, 2021

Susan Bernard, Chair
Financial Examiners Handbook (E) Technical Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

By e-mail to Bailey Henning at BHenning@NAIC.org

Re: Proposed Handbook Revisions, October 5, 2021

Dear Ms. Bernard:

This submission is in response to the Financial Examiners Handbook (E) Technical Group’s October 5, 2021 exposure of proposed revisions to the Financial Examiners Handbook. Our concerns with the proposed revisions are few, and most of our comments are intended only to clarify areas which may be confusing.

On page 2, in the first paragraph, there is this language: “…other groups under common control that do not meet this definition for [inclusion in an “insurance holding company system” as defined in the Insurance Holding Company System Regulatory Act (#440)] but would benefit from coordinated examination efforts.”

- It is not clear to AHIP what examples of such “other groups” there may be, and it may not be clear to examiners either. Therefore, we suggest providing some indicative examples of such “other groups.”

On page 6, under “other considerations” there is this phrase: “Unaffiliated entities that have significant influence or could materially impact insurers in the group should also be considered for inclusion in the group examination.” An example is provided, i.e., of an unaffiliated entity that has a reinsurance relationship with the entity/group under examination.

- Again, if there are other indicative examples (in this instance, of such “unaffiliated entities”) it would be helpful to cite them in the text.

On page 9, item 7 contains this phrase: “Real-time access of workpapers could also be accomplished through the use of a shared hosting environment.”

- As worded, this seems to invite any number of possible tools for the Exam Coordinator to utilize, some of which may not be adequately secure, and all of which would require appropriate use and protocols to assure confidentiality of the insurer/group’s information. AHIP suggests that additional guidance in those
respects be provided, or reference be made elsewhere to existing applicable NAIC guidance which addresses such concerns regarding confidentiality and security of company information.

On page 10, item 9 has this language: “If the Exam Facilitator determines that examination deliverables will include reporting at the group level (i.e., a group management letter), in addition to the legal entity examination deliverables, the Exam Facilitator should consult with the Lead State (if different) and other states participating in the examination to determine which results and observations will be included. Additional guidance for preparing management letters can be found in Section 2-7.”

- While we agree that the Lead State should determine which results and observations should be included in a group management letter, such a determination should consider that, due to materiality or other factors, some results and observations are more appropriately the responsibility of management or the Board only at the legal entity level. Examination findings and recommendations at the legal entity level that may also be appropriate for inclusion in a group management letter should be limited to those that are, or which could become, material at the group level, or which relate, or could relate, to multiple entities within the group and which could thus have a broader impact across the group.

We appreciate the opportunity to review and comment, as well as for your consideration of our views. We look forward to discussing them with you and the Working Group members.

Sincerely,

Bob Ridgeway
Bridgeway@ahip.org
501-333-2621

Cc: Tom Finnell
The IT Examination (E) Working Group of the Examination Oversight (E) Task Force met Nov. 18, 2021. The following Working Group members participated: Jerry Ehlers, Chair (IN); Ber Vang, Vice Chair (CA); Blasé Abreo (AL); Mel Anderson (AR); William Arfanis and Ken Roulier (CT); Ginny Godek (IL); Shane Mead (KS); Dmitriy Valekha (MD); Kim Dobbs and Cynthia Amann (MO); Justin Schrader (NE); Eileen Fox (NY); Metty Nyangoro (OH); Eli Snowbarger (OK); Melissa Greiner and Matt Milford (PA); and Eleanor Lu (WI).

1. **adopted the Cybersecurity Vulnerability Response Plan**

Mr. Ehlers said the first item to consider for adoption is the **Cybersecurity Vulnerability Response Plan**, a sound practices document which was developed in response to a referral received from the Chief Financial Regulator Forum (Attachment Four-A). This referral asked that additional guidance be developed to assist state insurance regulators in evaluating emerging cybersecurity vulnerabilities and determining whether additional investigation is needed. Mr. Ehlers asked Jacob Steilen (NAIC) to summarize the comments received during the exposure period (Attachment Four-B). There were several editorial comments incorporated as friendly amendments. Mr. Steilen said that one comment was received from the American Property Casualty Insurance Association (APCIA) regarding the introduction of the concept of significance or materiality when evaluating which cybersecurity vulnerabilities to investigate. Mr. Mead explained that incorporating such wording would conflict with the National Institute of Standards and Technology (NIST) definitions outlined in the document and referenced at SP 800-53 Rev. 5, Page 421. Ms. Dobbs agreed and said introducing the concept of materiality also introduces semantics in debating what is meant by “material” with the company. The Working Group decided to reject the addition of materiality into the document.

Jeff Martin (UnitedHealthcare—UHC) asked if each state’s adoption status of the **Insurance Data Security Model Law** would affect any of the procedures recommended in this document. Bruce Jenson (NAIC) said that Model #668 has notification requirements in the event a breach has occurred, whereas this document is concerned with vulnerabilities that may or may not lead to a breach situation. Therefore, it is unlikely that the adoption status will affect the recommended procedures within this document.

Angela Gleason (APCIA) stated that her organization is concerned that this document may lead to an increase in inquiries that could result in companies having less time available to monitor and protect policyholders. Mr. Jenson explained that the existing process for making inquiries about emerging vulnerabilities varies by state. He said this document is intended to create a more consistent and streamlined approach to such inquiries, as well as to help guide state insurance regulators in evaluating whether additional investigation is warranted as a result of the inquiry. Furthermore, the document emphasizes the lead state taking a primary role in these efforts, which should mitigate the concerns regarding a potential increase in the volume of inquiries. Mr. Ehlers stated that the procedures in this document are not required to be performed but are useful in guiding state insurance regulators in these circumstances.

Ms. Amann made a motion, seconded by Mr. Arfanis, to post the **Cybersecurity Vulnerability Response Plan**, as amended, to the group’s web page (Attachment Four-C). The motion passed.

2. **adopted Guidance for Inclusion in the Handbook**

   a. **Guidance for Evaluating Accessibility and Transferability of Policyholder Data**

Mr. Ehlers said the next set of revisions to consider for adoption were developed in response to a referral from the Receivership Financial Analysis (E) Working Group (Attachment Four-D) and are intended to provide IT examiners additional guidance for evaluating the accessibility and transferability of policyholder data, if warranted, during the IT review of a financial condition examination. Mr. Ehlers asked Mr. Steilen to summarize the comments received on the exposed **Financial Condition Examiners Handbook** revisions in this area during the exposure period. A comment was received from the National Conference of Insurance Guaranty Funds (NCIGF) recommending adding language specifying that these proposed procedures should only be invoked for insurers in hazardous financial condition.
Ms. Gleason said industry has some concern that the proposed procedures imply that legacy systems will be required to be updated to a format consistent with Uniform Data Standards (UDS). Mr. Steilen indicated that is not the intention of these revisions. He said that the proposed guidance is subject to the risk assessment, as is consistent with the overall risk-focused approach to financial condition examinations. Therefore, the proposed procedures are subject to the IT examiner’s discretion and are not required to be performed on each examination.

Barbara Cox (NCIGF) said that the intent of the request by the NCIGF is to strike a balance between companies in good financial condition conducting business as usual, while avoiding challenges that can occur in the event of receivership due to companies using antiquated systems, data being maintained by third parties, etc. She said the intention is not to create a burden for companies and that she believes the proposed guidance appropriately reflects this goal. Ms. Dobbs commented that the proposed language already states that the financial condition of the insurer can be a factor considered when applying these procedures. She also explained that vulnerabilities can happen in healthy insurers and eventually lead to financial troubles, so waiting for a financial trigger could delay valuable investigation time. The Working Group agreed that the financial condition of the insurer should remain as an item that could be considered during investigation but is not a requirement for deploying these procedures.

Tom Finnell (America’s Health Insurance Plans—AHIP) asked a question regarding the transferability of data and if it needs to be clarified, the places to which data might be transferred. Mr. Steilen said the proposed revisions to the Exhibit C, Part Two – IT Work Program Instructional Notes include examples of possible scenarios in which data may need to be transferred beyond a receivership event.

Mr. Roulier made a motion, seconded by Mr. Vang, to adopt the guidance for evaluating the accessibility and transferability of policyholder data for incorporation into the following sections of the Handbook: 1) Section 1-3 narrative guidance; 2) Exhibit C, Part One - IT Planning Questionnaire (ITPQ); and 3) Exhibit C, Part Two – IT Work Program and Instructional Notes (Attachment Four-E). The motion passed.

b. Ransomware Guidance

Mr. Ehlers said the final set of revisions to consider for adoption were developed in response to the growing prevalence of ransomware attacks and the effect of such attacks on an insurer’s operations. Mr. Ehlers asked Mr. Steilen to summarize the comments received during the exposure period. Mr. Vang suggested broadening the proposed procedure related to employee training from email phishing training to information security training. Mr. Meade suggested the language of information security awareness training. The Working Group agreed. A comment was received from the National Association of Mutual Insurance Companies (NAMIC) regarding the definition of “offline.” The Working Group agreed to change this word to “immutable” to convey the concepts that the backups should be unable to be edited.

Ms. Amann made a motion, seconded by Mr. Valekha, to adopt the ransomware guidance, as amended, for incorporation into the following sections of the Handbook: 1) Section 1-3 narrative guidance and 2) Exhibit C, Part Two – IT Work Program (Attachment Four-F). The motion passed.

Having no further business, the IT Examination (E) Working Group adjourned.
MEMORANDUM

TO: Jerry Ehlers (IN), Chair of the IT Examination (E) Working Group

FROM: Judy Weaver (MI), Facilitator of the Chief Financial Regulator Forum

DATE: March 16, 2021

RE: Referral on Cyber Vulnerability Guidance

On its March 16, 2021 call, the Chief Financial Regulator Forum discussed the recent cyber vulnerabilities and exposures that may have impacted various insurance companies, including the Solar Winds cyberattack and the Microsoft Exchange Server zero-day vulnerabilities. In discussing these potential exposures, financial regulators indicated a need for additional guidance on how to address significant vulnerabilities with the potential to impact domestic insurers in a timely manner as they emerge.

While existing IT Examination guidance in the *Financial Condition Examiners Handbook* includes procedures for evaluating cybersecurity controls in place at an insurer, including patch maintenance and intrusion detection processes, those procedures are typically only conducted during a scheduled full-scope examination. As such, the Chief Financial Regulator community is requesting that the Working Group consider the development of additional guidance and procedures for regulator use in evaluating an insurer’s response to significant emerging vulnerabilities and exposures, outside of a full-scope financial examination. Such procedures should be flexible enough to be incorporated into limited scope/interim examination efforts, the ongoing financial analysis process, or even into ad-hoc inquiries/requests for information.

In developing such guidance, the Working Group is encouraged to consider whether it would be more appropriate for such guidance to be included in NAIC handbooks, or as a separate best-practice tool maintained elsewhere. In addition, the Working Group is encouraged to consider coordinating efforts in this area with the Market Conduct Examinations Guidelines (D) Working Group, given its role in maintaining a post-breach checklist and related guidance in the *Market Regulation Handbook*.

If there are any questions regarding the proposed recommendation, please contact either me or NAIC staff (Bruce Jenson at bjenson@naic.org) for clarification.

Thank you for your consideration of this referral.
November 15, 2021

Jacob Steilen, Financial Examination and Accreditation Specialist
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

VIA Electronic Mail: jsteilen@naic.org

RE:  IT Exam Referral – Cyber Vulnerability Best Practices and Ransomware Updates

Dear Mr. Steilen:

The American Property Casualty Insurance Association (APCIA)\(^1\) appreciates the opportunity to comment on the recent draft Cyber Vulnerabilities Best Practice document (Vulnerability Best Practices) and Ransomware updates.

**Referral on Cyber Vulnerability Guidance**

Industry shares the same resiliency goals and objectives as regulators and we believe the current framework of regulation and examination is robust and provides visibility into the processes and procedures that are critical to maintaining a secure environment. Nevertheless, we do appreciate that additional balanced guidance for high-risk incidents could be helpful. APCIA is concerned that as drafted this additional layer of guidance could become overly burdensome, particularly during a time when organizations are focused on assessing and hardening their systems.

For instance, the draft Vulnerability Best Practices loosely defines the triggers for an interim exam. Given the nature and purpose of this document it is important to elaborate on when an additional review may be necessary. To carefully balance the need of the regulator and the organization’s need to focus resources on protecting information and systems, the guidance should be narrowly tailored on significant vulnerabilities – those that are high risk and externally facing or are prominent supplier vulnerabilities.

Additionally, the guidance may consider taking an approach that is less akin to an examination and instead view this as an opportunity to enable information sharing and alerting companies to the real-world threats that are out there. The New York Department of Financial Services took this approach after SolarWinds. DFS issued an alert and simply asked those impacted to assess their risk and assure DFS that they were on top of the matter. In many circumstances, this threshold inquiry will be sufficient.

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\(^1\) Representing nearly 60 percent of the U.S. property casualty insurance market, the American Property Casualty Insurance Association (APCIA) promotes and protects the viability of private competition for the benefit of consumers and insurers. APCIA represents the broadest cross-section of home, auto, and business insurers of any national trade association. APCIA members represent all sizes, structures, and regions, protecting families, communities, and businesses in the U.S. and across the globe.
The draft Vulnerability Best Practices also includes definitions. We suggest that the definition of “Vulnerability” be amended to state, “Material weakness in an information system . . .” Also, rather than add another definition for a breach, which creates an additional standard, the guidance should simply indicate that each state has defined this term in its breach notification laws.

Respectfully, recognizing the creation of the new Cybersecurity Working Group and that the draft Vulnerability Best Practices is not part of the Handbook, we would welcome additional time and opportunity to collaborate on this document.

**Ransomware Updates**
Consistent with the risk-based and flexible approach critical to any information security program, APCIA urges the group to avoid a requirement that all back-ups be air gapped. Some platforms are much easier than others to air gap based upon the backup technology. For instance, modern technology solutions may offer different controls that may be just as effective as an air gap. Further, even if it was possible to air gap the newer technologies, it could have potential operational impacts. As such, the group may consider a statement that acknowledges air gaps as well as other “isolated and appropriate protection mechanisms” that a company may utilize.

**Referral on Data Transfer Guidance**
APCIA wants to confirm that the data transfer guidance being proposed in the Handbook is limited to the original intended scope of receivership and insolvency situations. The draft is unclear as to the scope and seems to suggest it would look at all companies and their structures for ease of data transfer. If that is the case, is this creating a Uniform Data Standard (UDS) without specifically stating such? As noted in our March comment letter, APCIA would oppose Uniform Data Standards (UDS) for all companies. Receivership/insolvency of carriers affects a small percentage of the insurance companies and the current language in the Financial Condition Examiners Handbook (Handbook) seems appropriate. The cost and burden to ensure all systems follow UDS would be overly burdensome and costly for financially sound companies with little benefit realized, since most companies will never go into receivership. If the Handbook needs amended, we urge clarity that the language does not create a UDS for all companies and it is limited only to high priority companies such as those in receivership or in a troubled condition.

Thank you again for the opportunity to provide feedback and we welcome additional dialogue and are happy to answer any questions that you may have.

Respectfully submitted,

Angela Gleason
November 12, 2021

Mr. Jerry Ehlers, Chair
Information Technology (IT) Examination (E) Working Group
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

Attn: Mr. Jacob Steiien, NAIC Financial Examination Specialist via electronic mail filing


Dear Mr. Ehlers:

We appreciate the opportunity to provide comments to the Information Technology (IT) Examination (E) Working Group in response to the documents that were exposed during the conference call held on October 13, 2021. Our comments are related to the Ransomware Updates portion of the exposures.

On the first page of the exposed document, an added bullet indicates the examiners should “Require strong passwords and multi-factor authentication.” Generally, and broadly “requiring” MFA may present challenges to organizations. We would recommend language such as “where appropriate” or similar caveat for MFA.

On the second page of the exposure, two new test procedures have been added to the Exhibit C Table. We understand these to be aimed at containing ransomware after it has entered a network. If an organization is impacted by a ransomware attack, restoring from backups is one solution. Having air gapped backups helps ensure your backups are not also impacted by the ransomware and are available to restore the environment. The internal firewalls would help prevent machines impacted by ransomware from spreading it to other machines.

While we believe neither control is necessarily bad, perhaps focus should be more on preventative controls to keep ransomware from entering our network to begin with. Training employees to spot phishing emails which may contain links to ransomware and then periodically testing them on this through phishing campaigns. Companies should not allow employees to have the administrative right necessary for ransomware to install itself. It could run anti-malware software which can identify and block ransomware.
In summary, we suggest changing focus to front-end controls rather than back-end controls. Testing for air gapped backups and internal firewalls may not be necessary if the Company has the appropriate front-end preventative controls in place.

Thank you for your consideration of these suggested revisions. Should you or members of the Technical Group have questions or comments, I would be glad to address them.

Sincerely,

Jeff Martin
Director, NAIC Policy
UnitedHealthcare
Regulatory Financial Operations
Office: (813) 890-4569
Jeffrey_K_Martin@uhc.com
November 11, 2021

To: Bailey Henning, Financial Examination Manager
   Jacob Steilen, Financial Examination and Accreditation Specialist

RE: RFAWG Referral Exposure Draft – Information Technology (IT) Examination (E) Working Group

Dear Ms. Henning and Mr. Steilen:

NCIGF is the national coordinating body for the property casualty guaranty funds. We worked closely with the RFAWG on their referral dated March 22, 2021, and we applaud your efforts to respond with the exposure draft relating to this referral.

We have two minor changes to suggest. With regard to Section 1-3, we suggest that a clarification be made to make the discussion relating to data migration be limited to companies at a company control level or lower as prescribed by the Risk-Based Capital (RBC) for Insurers Model Act. Our suggestion appears on p. 10 of Section 1-3 and we excerpt the relevant text below: (our change is marked in underline text.)

The solvency outlook of the company may be considered when discussing if data migration to a more uniform format is necessary—it is recommended that this be considered only when the company is at a “company control” level or lower.

We feel this change will recognize our common goal of ensuring troubled companies that may be placed into liquidation at some point can be smoothly transitioned to the guaranty funds. At the same time this modification avoids creating undue burdens on going concerns in sound financial status.

As a purely technical matter, we suggest the reference on this same page to Uniform Data Standards be changed to NAIC Uniform Data Standards.

Thank you for considering our comments.

Roger Schmelzer
President & CEO
From: Jonathan Rodgers
To: Henning, Bailey; Steilen, Jacob
Cc: Cate Paolino; Erin Collins
Subject: Ransomware Guidance
Date: Friday, November 12, 2021 7:48:12 AM
Attachments: image001.png
Att. 14 – Ransomware updates.pdf

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Bailey and Jacob,

Thank you for giving attention to these important IT considerations, particularly on the emerging issue of ransomware. Our members are very much interested in these issues and find a lot of value in the changes made to the IT section of the Exam HB in recent years. As we continue to receive feedback on these important issues, it is worth noting that our members are continuously evolving to update their IT systems; therefore, as I’m sure you are both aware, the problems and issues continue to evolve as well. Having said that, we did receive feedback on the ransomware updates added to Section 1-3; however, we didn’t include them in a formal comment letter, as we weren’t sure how others are interpreting the guidance. We share the following feedback/questions for the working group to consider. And for what it is worth, we have made one suggested edit to the first point raised, but I’m not sure if that addresses all the concerns.

Ransomware Financial Examination Guidance: Received member feedback that terms used in the proposed IT exam guidance, such as “offline,” “inaccessible from the internet” and “Inaccessible remotely” need to be clarified.

A. Addition to “General Information Technology Review: Ransomware Updates to Consider” – Ransomware: Have system backups that are stored in an air gapped, offline environment that is inaccessible from the internet; this backup can be quickly deployed in the event the production environment is infected. Companies should test backup deployment regularly.

1. They are interpreting the term “inaccessible from the internet” to mean that it’s not accessible without a VPN. Their system is like many systems in that their backup is the cloud, which is accessible from the internet through VPN; however, not everyone has access (need credentials and device).
   - It appears to be common to have backups accessible through the internet (VPN). Companies generally locate backup facilities 25+ miles away and only a handful of personnel can access them via a VPN site to site connection.

2. They have questions about the term “offline environment”
   - Does this mean online briefly for the backup and then unplugged subsequently?

NAMIC Suggestion: Would this capture issue 1 and 2? Are there concerns with this approach?

Have system backups that are stored in an air gapped, offline environment that is inaccessible from the internet, or stored at an offsite location accessible via a secure (i.e., VPN) internet connection with limited access to only credentialled personnel; this backup can be quickly deployed in the event the production environment is infected. Companies should test backup deployment regularly.

B. Common Controls

3. DSS 04:08: Common Control: The backup environment should be isolated, air gapped,
and inaccessible from the internet so that information cannot be accessed remotely.

Preliminary Information Request: Provide evidence that backup and storage environments are properly isolated and inaccessible remotely.

- What does “remotely” mean? “inaccessible remotely.”
- “inaccessible remotely” could be interpreted to mean that a physical visit to the backup site would be required to do the work.
- VPN is not the same as “remotely”
- Does that mean you cannot access the backup via a secure (VPN) internet connection?

Thank you for all the work you do. Have a good weekend.

-Jon

Given the potential impact on company operations, the working group is currently developing guidance to help IT examiners address this issue. A new subsection is being proposed to be added to Section 1-3 to reflect recent research on the topic and to tighten up the guidance related to the protection of system backups in the event of a ransomware attack.

**Jon Rodgers**
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Cybersecurity Vulnerability Response Plan

OVERVIEW

Cyber vulnerabilities have become increasingly prevalent and significant as cybercriminals seek to exploit vulnerabilities to breach a company’s information technology (IT) security defenses. Conducting a preliminary investigation of possible exposure to these vulnerabilities as they arise can help financial regulators evaluate the operational resiliency of their groups/domestic insurance companies and determine whether a cyber event has occurred that would require further investigation.

However, it is important to note that reported vulnerabilities do not necessarily indicate a cybersecurity breach that would trigger formal notifications and consumer protection requirements, as companies should be addressing vulnerabilities before they can be exploited. As such, many states assign the responsibility for investigation of significant reported vulnerabilities to financial regulators either as a follow-up to ongoing financial exam work in assessing and monitoring IT security controls or as part of an ad-hoc financial analysis inquiry where appropriate. Recent examples of such vulnerabilities include the Microsoft Exchange Server weaknesses, the SolarWinds remote code execution vulnerability, and the Qualys cloud storage vulnerability. Vulnerabilities include threats to the company’s internal systems, as well as breaches at third parties that host, or have easy access to, company confidential data.

The primary purpose of this document is to guide examiners and/or analysts through the ad-hoc inquiry that may be necessary when a cybersecurity exposure or vulnerability has been identified or alleged in the period between full-scope examinations. It is, however, up to those examiners or analysts to use sound professional judgement when deciding to undertake such inquiries.

The results of the ad-hoc inquiry may warrant additional investigation, which could include calling a targeted examination, performing interim work, and/or follow-up on recommendations by the department analyst. If additional investigation is warranted, examiners should consult Exhibit C – IT Work Program in the Financial Condition Examiners Handbook to identify relevant procedures.

If, after investigating potential vulnerabilities, the domestic/lead state determines that a cybersecurity breach has occurred, information on the breach should be promptly shared with market conduct regulators and other affected states in accordance with existing regulatory guidance. Protocols in the Market Regulation Handbook can then be used in situations where a breach has occurred, specifically the post-breach checklist in Addendum A to Operations/Management Standard 17 Chapter 20 – General Examination Standards.
Terms & Definitions

- **Vulnerability** – Weakness in an information system, system security procedures, internal controls, or implementation that could be exploited or triggered by a threat source.

- **Incident** – An occurrence that actually or imminently jeopardizes, without lawful authority, the confidentiality, integrity, or availability of information or an information system, or constitutes a violation or imminent threat of violation of law, security policies, security procedures, or acceptable use policies.

- **Breach** – The loss of control, compromise, unauthorized disclosure, unauthorized acquisition, or any similar occurrence where: a person other than an authorized user accesses or potentially accesses personal identifiable information (PII), or an authorized user accesses PII for an other than authorized purpose.

*Definitions provided by the National Institute of Standards and Technology (NIST) glossary linked [here](NIST SP 800-53 rev. 5, Page 421)*

**ACTION ITEMS FOR REGULATORS AFTER A VULNERABILITY HAS BEEN IDENTIFIED**

The following section provides common questions and answers to help regulators determine an appropriate course of action in responding to identification of an emerging vulnerability.

1. **Which insurers should regulators contact regarding an identified vulnerability?**
   Professional judgment should be used by the department in determining which insurers to contact based on previous examination and analysis work, as well as the size and severity of the vulnerability identified.

2. **Which state(s) should lead the effort of responding to notification of an emerging vulnerability?**
   In recognition of the lead state approach to financial regulation and deference to a domestic regulator, as well as to reduce the number of overlapping requests and to create efficiencies for both insurers and regulators, the lead state (for groups) and/or domestic regulator should lead the effort of investigating significant vulnerabilities.

3. **What area of the department should take responsibility for investigating cyber vulnerabilities and breaches?**
   It is up to each department to determine which area should take responsibility for investigating vulnerabilities, which could be affected by subject matter expertise and availability, the NAIC has primarily classified follow-up procedures for known breaches as a market regulation activity and has included such procedures in the *Market Regulation Handbook*. This is primarily due to the importance of ensuring adequate consumer protection post breach. However, given that a breach can also affect an insurer’s solvency position, coordination with financial regulators in post-breach follow-up activities is encouraged.
Investigations related to significant vulnerabilities are typically viewed as following up on financial exam work to assess IT security controls. As such, it is recommended that financial regulators take the lead in addressing significant identified vulnerabilities. However, given the potential for a vulnerability exposure to turn into a breach, early coordination with market regulation is encouraged.

4. **Does the adoption status of the NAIC’s Insurance Data Security Model Law (#668) (or other relevant state law) affect a state’s response?**
   
   As this guidance focuses primarily on addressing an identified vulnerability, as opposed to an incident or breach, it is not clear whether information on the vulnerability and how it has been addressed would be reported to the department unless or until an actual incident or breach has occurred. As a result, it may be appropriate to proactively address an identified vulnerability even if your department has reporting requirements already in place. Proactive investigation of identified vulnerabilities with insurers may help prevent breaches from occurring that the department would otherwise have to address down the line. However, before taking steps to address an identified vulnerability, the regulator should ensure that the department has not yet received a notice from the insurer on this exposure.

   Those states that have passed Model #668 may find themselves at an advantage as they will be informed of breaches in a timely manner and will have greater opportunity to speak and coordinate with their licensees, as well as with other states.

5. **If the investigation of cyber vulnerabilities identifies a need to take additional steps in addressing IT control processes, how can this work be performed so that it can be used on the next full scope exam?**

   The most effective way to conduct this investigation in a manner that would allow the results to be integrated into an upcoming full-scope exam would be to use the interim work concept as defined by the [Financial Condition Examiners Handbook](#) (see Section 1-1, Part I). Interim work is intended to provide examiners the opportunity to conduct exam procedures in areas that are considered inherently risky but are not known to present an immediate concern. A separate examination report is not required in the interim period as information deemed appropriate for report purposes will be included within the full-scope examination report. However, results of interim work are expected to be documented in Exhibit AA—Summary Review Memorandum.

   **Example Scenario:**
   
   Let us assume a software vulnerability was identified. If after having received what the team has determined to be adequate information, and having thoroughly reviewed all of this information, the team should then conclude whether the insurer has taken
appropriate steps to mitigate concerns related to this vulnerability or whether additional actions are warranted. In this example, the exam team concludes it is necessary to check the insurer’s patch management protocols. To investigate the vulnerability, the team performs interim work and learns that the company has an updated patch negating the vulnerability. Additionally, the team selects a sample of insurer servers to verify they are at the right version/patch level. From here, the team would inquire about the vulnerability and how the insurer handled it. The team, having received adequate responses, concludes that the insurer has taken appropriate steps to mitigate concerns related to this vulnerability.

At the time of the full-scope exam, this work could be used to help address the DSS 05.01 procedure on Exhibit C. However, before leveraging interim work, the exam team should perform roll-forward procedures to determine whether the processes tested in the interim period are still in place and substantially the same, as changes may affect the conclusions that were reached in the interim period. For additional guidance about rolling forward interim work procedures for use in the full-scope exam, see Section 1-1 in the Financial Condition Examiners Handbook.

POSSIBLE QUESTIONS IN DETERMINING AN INSURER’S EXPOSURE TO A KNOWN VULNERABILITY

The following questions can be used to help a regulator determine an insurer’s exposure to a known vulnerability, as well as any steps taken to mitigate and address the vulnerability (if exposed). These questions should be customized to the specific situation identified. As the topics addressed and questions raised are largely in line with topics covered during an examination IT review, regulators are encouraged to work with their IT specialists, if necessary, to customize the inquiries, evaluate the appropriateness of responses received, and determine if any additional follow-up is necessary. If specialist resources are not available to a state in this area, NAIC IT security staff may be available to assist in this regard. Where appropriate, corresponding topics from Exhibit C – Evaluation of Controls in Information Technology from the Financial Condition Examiners Handbook have been included to assist in evaluating an insurer’s response to a specific question.

1. Does the insurance company have any exposure to the discovered vulnerability?

2. If applicable, has the insurance company deployed updates to affected [application] servers?
   a. What are the insurance company’s patch management protocols?
   b. Was the recommended patch applied?
   c. What steps were taken between when the vulnerability was discovered and when the patch was applied to mitigate the risk?
   d. If the insurance company has not been able to patch, has it followed [application vendor/developer] instructions for how to mitigate through reconfiguration?

See Exhibit C ITPQ question #5
e. Has the insurance company taken steps to investigate its systems and logs for exploitation, persistence, or evidence of lateral movement? If so, has the insurance company remediated any identified exploitation or persistence and investigated its environment for indications of lateral movement?

*See Exhibit C DSS 05.07*

3. For vulnerabilities derived from breaches at insurer third parties:
   a. Was company data exposed, or does the third party have easy access to your data?
   b. Has access been restricted?
   c. What steps have been taken to mitigate the risk that your data was exposed?
   d. What communication has taken place?
   e. Has the insurance company addressed this issue with its third-party service providers, if applicable?

*See Exhibit C ITPQ Question #3*
Conclusions & Next Steps

<table>
<thead>
<tr>
<th>Conclusions Reached</th>
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<tbody>
<tr>
<td>No breach or control issues discovered.</td>
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<tr>
<td>Mitigating factors were strong and/or further procedures proved there was no additional material risk.</td>
</tr>
<tr>
<td>No breach discovered, but concerns noted on adequacy of controls.</td>
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<tr>
<td>No signs of a breach occurring, but during inquiry and investigation concerns were noted regarding the adequacy of controls.</td>
</tr>
<tr>
<td>Further information still required.</td>
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<tr>
<td>Still not certain whether a breach occurred and/or information was extracted by an unauthorized party.</td>
</tr>
<tr>
<td>Breach discovered.</td>
</tr>
<tr>
<td>Information was accessed and extracted by an unauthorized party.</td>
</tr>
<tr>
<td>No further action required. Findings can be incorporated into the next scheduled exam.</td>
</tr>
<tr>
<td>Document the risk identified and the control processes surrounding that risk. Communicate with analyst for ongoing monitoring. Schedule a targeted exam or interim work to look into the issue further.</td>
</tr>
<tr>
<td>Consider calling a targeted exam regarding the issue. Perform additional interim work. Analyst provides ongoing monitoring.</td>
</tr>
<tr>
<td>Contact Market Conduct department (or similar department) and begin hand-off of the investigation to them.</td>
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Additional Resources

Cyber Alerts & Bulletins:
https://us-cert.cisa.gov/ncas

Publicly disclosed cyber vulnerabilities:
https://cve.mitre.org/

National vulnerability database:
https://nvd.nist.gov/

Reported breach tracker for health information:
https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf
To: Jerry Ehlers (IN), Chair of Information Technology (IT) Examination (E) Working Group (ITEWG)

From: Toma Wilkerson (FL) and Donna Wilson (OK), Co-Chairs of the Receivership Financial Analysis (E) Working Group (RFAWG)

Date: March 22, 2021

RE: Data Transfer Guidance in the IT Work Program of the Financial Condition Examiners Handbook

The RFAWG has discussed concerns noted in recent receiverships of insurance companies whereby receivers and guaranty funds continue to face challenges, including technical challenges, related to the timely and efficient transfer of data (e.g., claims data and policyholder records) from the insurance company in receivership to the receiver and/or guaranty funds. This generally occurs when data is not stored in a usable format or data is stored in information technology (IT) systems that are not easily extractable or transferable. Challenges with data and records may arise when insolvent insurance companies have used third-party administrator(s) (TPA) or have multiple IT platforms and legacy systems. In the case of a TPA, it is not uncommon for data to be comingled between clients. Understanding an insurance company’s IT systems and data in advance of any future insolvency helps to minimize costs and delays in claims payments at the onset of the receivership process.

The RFAWG recognizes that the Financial Condition Examiners Handbook contains some existing guidance regarding receivership considerations, including the following language that was added to the Considerations for Potentially Troubled Insurance Companies section of the Handbook in 2019:

If receivership or liquidation is triggered, and assets are transferred to the receiver or guaranty fund to settle obligations, it is important that the company’s data be maintained in such a format to ensure that policies can continue to be maintained and claims can continue to be paid. For example, the company should have the ability to export its claims data through a defined format (Uniform Data Standards [UDS]) that would allow the data to be received and utilized by a third-party guaranty fund. Therefore, the examination may include additional procedures as part of the IT review to identify and locate data storage and processes, understand the format of the data, and ensure that proper functionality exists for timely and efficient export of policy and claims data in the event of a receivership.

However, given the continued issues noted in this area, RFAWG feels it would be beneficial for ITEWG to consider additional guidance specific to the IT review conducted during a financial condition examination, including the incorporation of specific procedures into Exhibit C – Evaluation of Controls in Information Technology. This is particularly relevant when insurers are considered by the domestic state insurance regulator to be financially troubled or high priority; however, given that correcting data format and system issues may take time for insurers to resolve, claims data formatting and storage considerations may be relevant for all examinations.

The RFAWG recommends that such guidance address the following:

- Gain and document an understanding of the insurance company’s IT systems, data storage, data formats and any legacy systems.
- Based on the appropriate RBC level, review and test whether claims data, reserve information and policyholder records held by the insurer and by any TPAs are capable of being easily and timely accessible and extracted, and if necessary, translated into a format used by receivers and guaranty funds in the event of insolvency.
  - Property and Casualty Guaranty Funds utilize the Uniform Data Standards (UDS) reporting system for the timely and efficient transfer of claims data and policyholder records.
Life and Health Guaranty Associations do not utilize UDS; however, they require easy and timely advance access to data to establish agreements and infrastructures to either transfer or continue administration of the insolvent company’s policyholders.

Information often needed in receivership includes for example: in force; policyholder information (policy master files), policy values; policy forms; claims files & history; rate files & history; reserves; information by line of business, provider/vendor agreements.

- Encourage mitigation by the insurance company or its TPA of any data or IT system format, storage and transferability issues found during examination.
- Consideration of utilizing receivers and guaranty funds as resources at any point in the data evaluation and mitigation process.

If you have questions, please contact Jane Koenigsman, NAIC Staff, at jkoenigs@naic.org.
General Considerations

- Elements of a training that are tailored to the employee’s specific roles, responsibilities, and access rights.

Since cybersecurity threats are constantly evolving, it is important to have a strong and up-to-date training regimen. Additionally, in a strong cybersecurity program trainings should be performed on a consistent and periodic (e.g. annually) basis to ensure the information reaching the employees is commensurate with the modern-day threats facing the company. As regulators evaluate the appropriateness of the program, they should consider whether the training is mandatory for all employees and whether it includes procedures and instructions for employees to follow in the event that the employee has a good faith, fact-based belief that a breach or cybersecurity event may have occurred.

Vulnerability Management

In the most robust information security programs, companies understand that not all vulnerabilities can be eliminated, typically due to business needs or time and resources. However, companies should have an understanding and should inventory their identified vulnerabilities as well as have a plan to ensure vulnerabilities that can’t be eliminated are mitigated as much as possible. For instance, if the insurer is unable to confirm that a third-party service provider is able to secure their own access to the company’s information system, the company should ensure they monitor the service provider’s access to determine if improper activity occurs on the company’s network. As many vulnerabilities originate with a company’s patching practice, it is important that regulators obtain an understanding of the company’s patch management. Research suggests that in any given year, the majority of breaches have a root in a Common Vulnerability and Exposure (CVE) that often has been known and identified for several years. An insurer should maintain a strong practice of patch management, or at least a practice of understanding and mitigating existing vulnerabilities as an important part of a robust security program. For vulnerabilities discovered between exam periods, the NAIC maintains a Cyber Vulnerabilities document on the IT Examination (E) Working Group webpage with company questions and follow-up procedures to learn more about the extent of the vulnerability, how that information can be used going forward, and possible actions to be taken, if warranted (e.g., targeted exam procedures, additional interim procedures, etc.).

Ransomware

Ransomware is one of the more common manifestations of a cybersecurity risk. Ransomware attacks pose a significant risk to confidentiality and availability on company data. It is difficult to predict when and where a ransomware attack will strike, so it is important for a company to maintain strong cyber hygiene habits to stay ready for ransomware attacks. At a minimum, insurers with good cyber hygiene do the following:

- Patch their systems/networks regularly, timely, and in accordance with application updates
- Require strong passwords, and multi-factor authentication, where appropriate
- Have information security awareness training, including email filtering and anti-phishing training for employees, with periodic phishing test campaigns
- Monitor and react to suspicious activity on their network
- Have system backups that are stored in an air gapped, immutable environment that is inaccessible from the internet, this backup can be quickly deployed in the event the production environment is infected. Companies should test backup deployment regularly.
- Have firewalls, or other mechanisms within the network so someone with unauthorized access cannot move laterally
- Limit user access rights to the minimum necessary to perform their job
- Have and test a robust incident response plan

Company Acquisitions

Finally, in situations where a company has recently acquired/integrated another company, the IT examiner should also pay special attention to the procedures performed in integrating company systems. This is often when companies are most vulnerable to cybersecurity threats as controls are often in flux and mistakes in integration may create vulnerabilities that are not easily identified or remedied.

Exhibit C, Part Two (Instruction Note 3) includes specific mention of risk statements and sections of the exhibit that can be applied to ensure the examination has an appropriate response to identified cybersecurity risks.
SECTION 1 – GENERAL EXAMINATION GUIDANCE

General Considerations

Note that the findings identified through the review of the company’s cybersecurity control environment should be communicated to the financial examiner via the IT Summary Memo.

Uniformity of Data for Timely & Efficient Transfer

Legacy systems with uncommon and difficult-to-access data structures should be flagged for further investigation as part of the IT review. Companies with multiple IT platforms, multiple cloud storage providers, or that rely on MGAs or TPAs may be at a higher risk, especially if its data is stored in a commingled environment. The ability to migrate and transfer data may be relevant in a number of scenarios including switching service providers, merging with or acquiring another company, company insolvency necessitating the transfer of policyholder data to the guarantee fund, etc. If the data is found to be in a format that is not conducive with timely and efficient data transfer, the IT examination team is encouraged to notify the insurer to discuss data migration and the possible need for a more uniform data standard (for example, NAIC Uniform Data Standards—UDS—for property and casualty companies). The IT exam team may also review contracts with third-party data storage providers for clauses on data transfer rights. The solvency outlook of the company may be considered when discussing if data migration to a more uniform format is necessary. See DSS 01.01 in Exhibit C for common controls, information requests, and possible procedures regarding the quality, timeliness, and availability of data. In summary, the data should be stored in a format which allows it to be accessed, utilized, and efficiently transferred, if necessary.

Note: While NAIC Uniform Data Standards apply specifically to property and casualty companies, all companies should have the ability to export claims data through a defined format that would allow the data to be received and utilized by a third-party guaranty fund, if necessary. See the NAIC UDS Operations Manual for more information. This manual is maintained by the National Conference of Insurance Guaranty Funds. The following sections would be most applicable to examiners:

- A Record Extended Table Appendix: IX
- B Record Extended Table Appendix: XIX
- G Record Extended Table Appendix: LVIII
- F Record Extended Table Appendix: LIV
- I Record Extended Table Appendix: LXV
- Coverage Codes: 15-1
- Transaction Codes: 14-1
- Other Code Tables: 16-1

Customization for Small Companies

When conducting an IT review of a small company or a company with a non-complex IT environment, it is acceptable to limit the extent of test procedures performed. However, the examination must adhere to the six-step process outlined above. This includes obtaining the ITPQ responses from the insurer, completing a basic work program, and preparing a summary memo concluding on the results of the IT review and its impact on the rest of the examination.

The most significant area to be customized for small insurers is the IT work program. Regardless of size or complexity, some level of testing is required to be performed to verify the design and operating effectiveness of the insurer’s IT environment; however, the presentation of such work may vary. It is recommended that IT examiners perform some level of review for IT general controls in place within each domain of the COBIT Framework. This may be shown using a customized version of Exhibit C – Part Two, where a limited number of controls applicable to the insurer are populated and reviewed. In limited circumstances, as described below, IT examiners may bypass the utilization of Exhibit C – Part Two:

1. If the CPAs or the company’s internal audit function (if deemed independent) have performed a review of ITGCs that sufficiently cover risks within each of the COBIT domains, the IT examiner may rely on such work without mapping or linking the work to a separate work program. However, the IT examiner must document their comfort with and planned reliance on the work performed.
PART ONE – INFORMATION TECHNOLOGY PLANNING QUESTIONNAIRE (ITPQ)

For the questions below, provide the requested documentation and the name, title, telephone number and e-mail address of the individual who will be most able to discuss and clarify the information presented.

If a particular section does not apply to your company, give a brief explanation of why it does not apply. All responses should be in the form of a separate summary memorandum, headed with the corresponding section label. Where possible, electronic responses are preferred.

1. Use of Information Technology
   If the company does not process its business electronically, provide a narrative description explaining how the company’s business is processed. The remainder of this section does not need to be completed.

   If the company only processes business electronically on a stand-alone personal computer and does not use networking technology, provide a narrative description explaining how business is processed, including the type of application software being used. The remainder of this section does not need to be completed.

2. Information Technology Governance
   a. Provide the name, telephone number and e-mail address of the chief information officer (or equivalent).
   b. Provide specific detailed organizational charts for the company’s IT department, and/or any affiliates providing IT services, that show its various functional divisions (i.e., operations, programming, support services, etc.). Show reporting relationships of the IT department within the organization.
   c. Provide an executive overview of your company’s IT strategic plans, including plans for e-commerce.
   d. Provide an executive overview of your IT steering committee, or other group that establishes and directs IT policies and strategies, indicating the membership of the group and the frequency of their meetings.
   e. Provide an overview of ERM program, if not already provided, and associated touchpoints in relation to IT risks.
   f. Describe the frequency, type, and content of interaction with the company’s board of directors regarding key IT risks, such as cybersecurity.

3. Information Technology Infrastructure
   a. Provide the name, telephone number and e-mail address of the chief technology officer (or equivalent).
   b. Provide a listing of the locations of all data-processing centers used by your company, whether owned by the company or by a third-party administrator that processes data for the company.
   c. Provide a system-wide map or topography, showing all hardware platforms and network connections, indicating all internal and external access points. In addition, complete a separate Systems Summary Grid for each platform (see Attachment 1). A sample Systems Summary Grid is provided with this questionnaire (see Attachment 2).
   d. Provide a narrative explanation of the application-level interfaces (manual and automated) among the various programs/platforms (e.g., claims system feeds into the accounting system).
   e. Provide a list of any business or data-processing services provided by the company to any other entities, including affiliates, indicating the type of service provided and a summary of the terms of the agreements (e.g., named parties, effective date, period and services covered). Also indicate if a service level agreement (SLA) exists for each of these services.
   f. Provide a list of any business or data-processing services performed by any other entities on behalf of the company, such as a third-party administrator (TPA, MGA, GA, etc.) or an affiliate, indicating the type of service provided and a summary of the terms of the agreements (e.g., named parties, effective date, period,
location and services covered). Also indicate if an SLA exists for each of these services and if data stored at
the TPA is comingled with other data sets or clearly segregated.

g. Describe any business the company is conducting through electronic channels, indicating the type and volume
of business and the date when it was implemented. Note: E-commerce methods of transmission might include
voice recognition units (VRUs), the Internet, third-party extranets, and wireless and broadband
communications media.

4. Information Technology Audits, Reviews and Risk Assessments

a. Provide the name, telephone number and e-mail address for the partner of your company’s independent
external audit team and the internal audit director (or equivalent), if they exist.

b. Provide a list of any IT audits/reviews performed within the past two years, including e-commerce areas,
cybersecurity assessments and any IT related reviews of financial significant 3rd party vendors Include the
dates, review subjects and who performed the audits/reviews (e.g., internal audit, external audit, SOC 1 Type
II Reports, SOC for Cybersecurity reports, cyber self-assessment tools, Sarbanes-Oxley, state insurance
departments, governmental agencies, and/or any other contractor or affiliate that might have performed an
audit/review).

c. Arrange for a copy of the IT work included in the most recent audit workpapers to be provided from the
company’s external audit firm. The workpapers should be provided no later than the response date identified
for the IT Planning Questionnaire.

d. Please provide all current assessments of the company’s IT risks, whether internally or externally conducted.

5. Information Technology Security

a. Provide the name, telephone number and e-mail address for the chief security officer (or equivalent).

b. Provide a copy of all IT security related policies.

If not explicitly described in the policies or if formal, written policies exists, please provide a detailed
description of:

- Data Confidentiality – Discuss how data elements are classified and who determines which
  individuals/roles have access to data elements.

- Data Encryption – Discuss if confidential data is encrypted both at rest and in transit, including the
  process and methods of encryption.

- System and Network Access Controls – Discuss how access is controlled (network-level, server-level,
  application-level, or a combination), which directory services are used for network access, whether
  authentication servers are used, etc.

- Multi-Factor Authentication – Discuss the current use of multi-factor authentication including where
  it’s used, the type being used, and any plans for expanding its’ usage.

- Anti-virus/Anti-malware – Discuss the anti-virus/anti-malware software, and patch management
  program in place including the systems used and the strategy for keeping these products current.

- Security Logging & Monitoring – Discuss the process and tools used for logging and monitoring
  security events across network devices, servers, endpoints, systems and applications. Also discuss
  how the company aggregates and correlates this information across the breadth of monitoring points.

- Intrusion Detection & Prevention – Discuss the program in place to detect and prevent intrusion into
  the company’s network and systems including the types of tools and technology being used.

- Vulnerability Management – Discuss the company’s vulnerability management program including the
  scope of coverage, tools and techniques, frequency of scanning, reporting of known vulnerabilities,
  remediation, etc.
• Penetration Testing – Discuss the types and frequency of penetration testing and whether it’s conducted by internal employees or external firms. Also discuss whether the company uses advanced techniques such as red and blue team exercises.

• Security Awareness Training – Discuss the security awareness training program required for all employees including how often it’s required and how participation is tracked. Also discuss the contents of the training program and whether advanced techniques such as anti-phishing campaigns are conducted to reinforce the program.

• IT Asset Inventories – Discuss the inventory management program in place for physical devices, software and applications.

• Third–Party Vendor Management – Discuss the program to assess and address security risks posed by third-party service providers including the group(s) responsible risk ranking or tiering.

• Data Loss Prevention – Discuss the program in place to detect and prevent protected information from leaving the company.

c. Provide a description of the types of sensitive information that is maintained or accessed by the company (e.g. Social Security numbers, protected health information, personally identifiable information, etc.) and the approximate amount of records containing each type of information. For each type of sensitive information, provide the number of outside vendors who have access to or maintain sensitive information.

d. If applicable, provide a description of updates to the company’s controls and/or processes to ensure compliance with the General Data Protection Regulation (GDPR) or other applicable data protection requirements.

6. Information Technology (IT) Security – Incident Response

a. Provide documentation of the response plan in place for cybersecurity incidents. (Note that this may be covered by the disaster recovery plan, but the plan provided should include consideration of IT-specific events.)

b. Provide a listing of any instances in which confidential company or policyholder information was or was likely to have been breached. Include the following information in the response provided:

   • How the event was detected.
   • Correlation of events and evaluation of threat/incident.
   • Resolution of threat, or creation and escalation of an appropriate work order.
   • Post-remediation analysis, including any resulting change in controls/operations to mitigate threat of event reoccurrence.
   • Extent of involvement of senior levels of management.
   • Extent of expenses (including legal claims to be incurred) as a result of the incident.
   • Details on the information that was compromised (both in quantity of information breached and type of information that was breached).

7. System Development/Change Management

a. Provide the name, telephone number and e-mail address for the system architect/chief software engineer (or equivalent).

b. Provide an executive overview of the company’s system development life cycle (SDLC) and change-management methodologies and indicate whether the company uses internal personnel and/or external vendors to develop and/or change its systems or programs. Include discussion of the process used when purchasing application solutions.
c. Provide the name, vendor, version number and platform for all change management/system development software, if utilized.

8. Business Continuity
   a. Provide the name, telephone number and e-mail address of the individual responsible for maintaining, updating and testing the company’s business continuity and disaster recovery plans.
   b. Provide a copy of your IT business continuity and disaster recovery plans (if not already provided in response to the above questions), including information on any contracts for alternate sites (i.e., named parties, site location, type of site, effective date and period covered). Also, provide evidence of the last test results for the plans and management’s resolutions of any test discrepancies.
   c. Provide a description of your company’s data and systems backup strategy, including your records retention policy.
   d. Provide a copy of the most current business impact analysis.

9. Financially Significant Systems
   a. If the company uses multiple platforms/systems to process financial transactions — including premium, claim, reinsurance and investment transactions — include a reconciliation of amounts processed on each separate system to total dollar amount processed during the prior year. Indicate whether the company anticipates any change in processing volumes during the current year. Note: The Technology Summary tool provided on iSite+ or a comparable substitute that provides the same information should be used to accomplish this purpose.
   b. Identify and discuss other significant critical management reporting/operational systems, such as data warehouses, sales and marketing systems, communication systems, management dashboards and any other management information systems.
   c. Discuss the accessibility and transferability of significant datasets (i.e., policy admin data, claims data, etc.). Indicate whether data is able to be queried and transferred in the event of an audit, new storage service provider, or other event that would require data to be relocated.
**Systems Summary Grid**

For each primary hardware platform, list the application software products used in each of the insurance business cycles.

<table>
<thead>
<tr>
<th>Hardware Platform (manufacturer/model)</th>
<th>Operating System*</th>
<th>Access Control Software**</th>
<th>Program Management Software</th>
<th>Database Management Software</th>
<th>Hardware Location</th>
<th>Business User Location(s)</th>
<th>Individual Responsible</th>
<th>Product Name and Version</th>
<th>Software Source:</th>
<th>Application Support:</th>
<th>Date of Last Significant Update</th>
<th>Date of Initial Implementation</th>
<th>Developer/Vendor</th>
<th>Application Support Vendor</th>
<th>Date of Initial Implementation</th>
<th>Date of Last Significant Update</th>
<th>Developer/Vendor</th>
<th>Application Support Vendor</th>
<th>Date of Initial Implementation</th>
<th>Date of Last Significant Update</th>
<th>Developer/Vendor</th>
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</table>

**NOTE:** Make as many copies as necessary to represent every primary hardware platform being used. These might include mainframe, microcomputer and/or network server systems. Additional financially significant applications should be inserted as needed.

* e.g., z/OS, z/VM, Clearpath, OS/400, i5/OS, Windows Server 20XX, Open Enterprise Server, Linux, Unix, AIX, Open Solaris, etc.

**e.g., RACF, Top Secret, ACF2, BSafe, Active Directory, eDirectory, Solaris, etc.

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INSTRUCTION NOTE 1: After the examiner has identified controls over the company’s IT environment, based on the company’s responses to the ITPQ and other information provided to the examiner, the examiner may determine that these controls over the company’s IT environment should be tested for operating effectiveness. Section 1, Part III of this Handbook provides specific guidance on sampling for tests of controls and should be utilized by the examiner when testing the company’s identified controls. In some cases, the examiner may be asked to assist in the financial examination, as outlined in the “General Information Technology Review” in Section 1, Part III of this Handbook. If it is determined that some of this work includes substantive testing, the examiner should utilize the substantive sampling guidance provided in Section 1, Part III of this Handbook.

INSTRUCTION NOTE 2: The following issues are addressed in Part One (ITPQ) and Part Two (Evaluation of Controls in IT Work Program). If the ITPQ is utilized and subsequently it is determined that all sections and risks included in the IT work program should be addressed, the responses received in the ITPQ should be considered when requesting information on the corresponding sections of the IT work program listed below.

<table>
<thead>
<tr>
<th>Information Technology Planning Questionnaire (ITPQ)</th>
<th>Evaluation of Controls in Information Technology (IT) Work Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>2b</td>
<td>APO 01.01-01.02, MEA 02</td>
</tr>
<tr>
<td>2c</td>
<td>APO 02</td>
</tr>
<tr>
<td>2d</td>
<td>APO 02, APO 04</td>
</tr>
<tr>
<td>3c</td>
<td>APO 09</td>
</tr>
<tr>
<td>3f</td>
<td>APO 10</td>
</tr>
<tr>
<td>4a – 4d</td>
<td>MEA 02</td>
</tr>
<tr>
<td>5b</td>
<td>DSS 05.01 – 05.04</td>
</tr>
<tr>
<td>7a</td>
<td>APO 03</td>
</tr>
<tr>
<td>7b</td>
<td>DSS 03.05, BAI 02.04, BAI 03.05, BAI 06</td>
</tr>
<tr>
<td>8b – 8d</td>
<td>BAI 03.02, BAI 04.02, DSS 04</td>
</tr>
<tr>
<td>9a – 9c</td>
<td>DSS 04.04, DSS 04.07, DSS 05.01, APO 03, APO 04</td>
</tr>
</tbody>
</table>

INSTRUCTION NOTE 3: Examiners may determine that cybersecurity risks are significant for the insurer under examination. This may be based on responses provided to the ITPQ, results of planning and examiner’s judgment. To ensure that the examination procedures performed include an adequate response to the insurer’s cybersecurity risk, which can affect multiple facets of the IT environment, examiners may consider performing procedures in relation to risk statements APO 1, APO 10, APO 12, DSS 02 and DSS 05. Note these risk statements and associated procedures may or may not explicitly mention the threat of cybersecurity in the language presented, but examiners should customize the procedures provided to respond to this risk as appropriate. Examiners may determine that additional risks are relevant when considering cybersecurity exposure, and should tailor their work program based on information available on the exam. Additional considerations for cybersecurity concerns are located in Section 1-III (A) of the Examination Handbook guidance, entitled “General Information Technology Review.”

INSTRUCTION NOTE 4: Examiners should consider the overall accessibility and transferability of the company’s claims and policyholder data. Holistically, the exam team should determine whether the company would be able to transfer its data efficiently and effectively to another location should that need occur (e.g., when switching service providers, in the event of an audit or receivership, etc.). Companies that rely heavily on legacy systems, MGAs, multiple cloud platforms, TPAs, or that commingle claims data may be at a higher risk. Risk statements APO 03, APO 04, DSS 04, and DSS 05 can be referenced for procedures surrounding data quality, infrastructure, security, and portability.
<table>
<thead>
<tr>
<th>Risk Stmt #</th>
<th>Risk Statement</th>
<th>Ctrl #</th>
<th>Common Controls</th>
<th>Preliminary Information Request</th>
<th>Possible Test Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSS 01</td>
<td>The quality, timeliness and availability of business data is reduced due to an ineffective data-management process.</td>
<td>DSS 01.01</td>
<td>All data expected for processing is received and processed completely, accurately and in a timely manner, and all output is delivered in accordance with business requirements.</td>
<td>Provide evidence of the controls that ensure all data expected for processing is available and processed completely and in a timely manner.</td>
<td>Interview company personnel to verify the process controls over data management to determine whether there is responsibility over the availability and completeness of data and the timeliness and accuracy of data processing.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Procedures are defined, implemented and maintained for IT operations.</td>
<td>Provide a copy of the policy and procedures for IT operations.</td>
<td>Review the standard IT operational procedures and verify the propriety and effectiveness of the procedures for abnormal operating system termination, the inclusion of a callout list in the case of emergency, etc.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Claims and policy admin data is stored in a format that allows it to be transferred and utilized, if necessary (for example, in the event of a receivership or audit, changing vendors, etc.).</td>
<td>Provide documentation regarding the accessibility and transferability of company claims and policy admin data.</td>
<td>Review the claims and policy admin data and determine if there would be any accessibility or transferability issues if the company needed to move its policy admin data.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The scheduling and completion of jobs is organized into a sequence, maximizing</td>
<td>Provide a copy of the job run log showing batch job execution.</td>
<td>Verify that the log is reviewed on a routine basis and on a timely manner.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Provide a copy of</td>
<td>Verify that procedures include points of contact.</td>
</tr>
</tbody>
</table>
Section 1-3: Letter A: General Information Technology Review

Ransomware

Ransomware is one of the more common manifestations of a cybersecurity risk. Ransomware attacks pose a significant risk to confidentiality and availability on company data. It is difficult to predict when and where a ransomware attack will strike, so it is important for a company to maintain strong cyber hygiene habits to stay ready for ransomware attacks. At a minimum, insurers with good cyber hygiene do the following:

- Patch their systems/networks regularly, timely, and in accordance with application updates
- Require strong passwords, and multi-factor authentication, where appropriate
- Have information security awareness training, including email filtering and anti-phishing training for employees, with periodic phishing test campaigns
- Monitor and react to suspicious activity on their network
- Have system backups that are stored in an air gapped, immutable environment that is inaccessible from the internet, this backup can be quickly deployed in the event the production environment is infected. Companies should test backup deployment regularly.
- Have firewalls, or other mechanisms within the network so someone with unauthorized access cannot move laterally
- Limit user access rights to the minimum necessary to perform their job
- Have and test a robust incident response plan

Exhibit C – Part 2 Narrative guidance – Instructional Notes

Adding areas of focus in the Exhibit C table in a similar format as the procedures related to cybersecurity.

INSTRUCTION NOTE 3: Examiners may determine that cybersecurity risks are significant for the insurer under examination. This may be based on responses provided to the ITPQ, results of planning and examiner’s judgment. To ensure that the examination procedures performed include an adequate response to the insurer’s cybersecurity risk, which can affect multiple facets of the IT environment, examiners may consider performing procedures in relation to risk statements APO 1, APO 10, APO 12, DSS 02 and DSS 05. Note these risk statements and associated procedures may or may not explicitly mention the threat of cybersecurity in the language presented, but examiners should customize the procedures provided to respond to this risk as appropriate. DSS 04 covers the protection of system backups in the event of a ransomware attack. Examiners may determine that additional risks are relevant when considering cybersecurity and ransomware exposure, and should tailor their work program based on information available on the exam. Additional considerations for cybersecurity concerns are located in Section 1-III (A) of the Examination Handbook guidance, entitled “General Information Technology Review.”
### Exhibit C – Part 2 Table

**DSS 04 Risk Statement** - Inadequate continuity management may result in the inability to ensure critical business functions.

**DSS 04.07:**

<table>
<thead>
<tr>
<th>Common Controls</th>
<th>Preliminary Information Request</th>
<th>Possible Test Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>All critical backup media, documentation and other IT resources necessary for IT recovery and continuity plans are stored off-site in a secure location.</td>
<td>Provide a copy of policies and procedures relating to the backup of systems and data, including copies of recovery procedures for off-site backups and information about off-site backup locations and/or service providers.</td>
<td>Inquire and verify that data is protected and secured when taken off-site and while in transit to the storage location. Inquire and verify that the backup facilities are not subject to the same risks as the primary site. Inquire and verify that there is an air gap, or other protection mechanisms, between the company's production environment and backup systems. The air gap (whether logical or physical) should be designed in a manner that if a ransomware attack infects the company's main production systems, the immutable, offline backups could be deployed to replace the infected systems.</td>
</tr>
</tbody>
</table>

**DSS 04.08:**

| The company has procedures in place for backup and restoration of systems, applications, data and documentation that are consistent with its business requirements and continuity plan. The backup environment should be isolated, air gapped, and inaccessible from the internet so that information cannot be accessed or changed remotely. | Provide evidence that backup and storage requirements for critical systems, applications, data and related documents are periodically reviewed and aligned with risks and the continuity plan. Provide evidence that backup and storage environments are properly isolated. | Verify that critical systems, applications, data and related documents that affect business operations are periodically reviewed for alignment with the risk management model and IT service continuity plan. Verify that adequate policies and procedures for backup of systems, applications, data and documentation exist and consider factors including: 1) Frequency and age of backups. Older backups can be used in the event a newer backup copy is infected. 2) Type of backups (e.g., disk mirroring, external media, full, incremental, air gapped, immutable, offline copy, etc.). 3) Automated online backups. 4) Data types (e.g., voice, optical). 5) Creation of logs. 6) Critical end-user computing data (e.g., spreadsheets). 7) Physical and logical location of data sources. 8) Security and access rights. 9) Encryption. |
FINANCIAL STABILITY (E) TASK FORCE

Financial Stability (E) Task Force Dec. 7, 2021, Minutes ................................................................. 10-1047
Financial Stability (E) Task Force Sept. 30, 2021, Minutes (Attachment One) ......................................... 10-1051
Exposed List of Macroprudential (E) Working Group Considerations – Private Equity (PE) Related and Other
(Attachment Two) ................................................................................................................................. 10-1054
Draft: 12/14/21

Financial Stability (E) Task Force
Virtual Meeting (in lieu of meeting at the 2021 Fall National Meeting)
December 7, 2021

The Financial Stability (E) Task Force met Dec. 7, 2021. The following Task Force members participated: Marlene Caride, Chair (NJ); Eric A. Cioppa, Vice Chair (ME); Alan McClain (AR); Ricardo Lara represented by Kim Hudson (CA); Andrew N. Mais represented by Wanchin Chou (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmaier represented by Ray Spudeck (FL); Doug Ommen (IA); Gary D. Anderson represented by Christopher Joyce (MA); Kathleen A. Birrane represented by Lynn Beckner (MD); Chlora Lindley-Myers represented by John Rehagen (MO); Eric Dunning represented by Justin Schrader (NE); Adrienne A. Harris represented by Bill Carmello (NY); Jessica K. Altman represented by Melissa Greiner (PA); Raymond G. Farmer represented by Michael Shull (SC); Carter Lawrence represented by Bill Huddleston (TN); Cassie Brown represented by Mike Boerner (TX); and Scott A. White represented by Thomas J. Sanford (VA).

1. **Heard Opening Remarks**

Commissioner Caride said materials for consideration and discussion for this meeting are available on the NAIC website in the Committees section under the Financial Condition (E) Committee.

2. **Adopted its Sept. 30 and Summer National Meeting Minutes**

The Task Force met Sept. 30 and took the following action: 1) adopted its 2022 proposed charges; 2) received an update on private equity; and 3) received a macroprudential risk update.

Mr. Rehagen made a motion, seconded by Superintendent Cioppa, to adopt the Task Force’s Sept. 30 (Attachment One) and July 27 (see NAIC Proceedings – Summer 2021, Financial Stability (E) Task Force) minutes. The motion passed unanimously.

3. **Heard an Update on FSOC Developments**

Superintendent Cioppa reported that President Joe Biden signed an executive order on climate-related financial risk on May 20. He summarized the Financial Stability Oversight Council’s (FSOC) responsibilities from the executive order as focusing on:

- Assessing the climate-related financial risk, including both physical and transition risks, to the financial stability of the federal government and the U.S. financial system.
- Facilitating the sharing of climate-related financial risk data and information among FSOC member agencies and other agencies.
- Including discussion of climate risk in the FSOC’s annual report to the U.S. Congress.

Superintendent Cioppa said the effort receiving the most attention is a request for FSOC to issue a special report on FSOC member agencies’ efforts to integrate consideration of climate-related financial risk in their policies and programs, including a discussion of:

- The necessity of any actions to enhance climate-related disclosures by regulated entities to mitigate climate-related financial risk to the financial system and a recommended implementation plan for those actions;
- Any current approaches to incorporating the consideration of climate-related financial risk into their respective regulatory and supervisory activities and any impediments in adopting those approaches;
- Recommended processes to identify climate-related financial risk to the financial stability of the U.S.; and
- Any other recommendations on how identified climate-related financial risk can be mitigated, including through new or revised regulatory standards.

Superintendent Cioppa added that the FSOC made some key recommendations to its member agencies with the release of this requested report on Oct. 21, including in broad terms:

- Update existing regulations to address climate risk, particularly for vulnerable populations;
- Build out staff and data resources to assess climate risk on both sides of the balance sheet;
• Develop mechanisms to share data and information between FSOC members; and
• Refine public disclosures on climate risk.

To close the report on climate activities, Superintendent Cioppa stated the FSOC is creating two internal climate-related committees to facilitate cooperation and information sharing among FSOC members and to review their collective efforts to respond to the report recommendations.

Superintendent Cioppa also reported on the increased investment in, and ownership of, life insurers by private equity firms. He noted that the Federal Insurance Office (FIO) and others have raised questions about the business model, affiliated transactions, investment transparency, fee structures, and other aspects of these enterprises, which are often driven by the low interest rate environment. He said the NAIC has focused on this area in the past but indicated renewed interest at the state and federal level. He stated that while the interest is often framed as a private equity phenomenon, the types of investments and structures are often driven by the low interest rate environment and thus are not limited to private equity ownership structures. Superintendent Cioppa supports the Macroprudential (E) Working Group’s active consideration of some oversight enhancements.

4. Received the Report of the Macroprudential (E) Working Group

Mr. Schrader reported that the Macroprudential (E) Working Group met Nov. 30 and Oct. 18 in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities or individuals) and paragraph 4 (internal or administrative matters of the NAIC or any NAIC staff) of the NAIC Statement on Open Meetings. He added that the Working Group primarily discussed private equity (PE)-owned insurers and the liquidity stress test (LST) project.

Mr. Schrader said that historically there were relatively few PE-owned insurers, so most of the state insurance regulatory response centered on relevant questions state insurance regulators should ask during the analysis and examination processes. He noted that recently, PE acquisitions of insurers have increased and, therefore, state insurance regulators’ interest in PE-owned insurers has been increasing. He said that state insurance regulators have been tracking PE concerns. However, he cautioned that complex group structures and agreements are occurring even with more traditional holding companies and that investment-related considerations may exist for any legal entity involved in specific transactions, even when affiliates and related parties are not involved.

Mr. Schrader emphasized the importance of having a single point of contact for all NAIC matters related to PE-owned insurers, which could be the Working Group since the work is addressed by its charges. He added that in this role, the Working Group would also need to monitor and maintain status information on work occurring at other committees. Mr. Schrader reported that the Working Group constructed a list of regulatory considerations related to PE-owned insurers, but he noted that the considerations are not limited to the PE ownership model, and some may even be present in stand-alone legal entity insurers.

Mr. Schrader requested that the Task Force affirm the role of the Working Group as the coordinator of considerations related to PE-owned insurers and expose an initial draft of considerations for a 30-day public comment period. He added that the Working Group will finalize the initial list of considerations and then assess each consideration to determine if further work is deemed necessary, and if so, by which NAIC committee. He suggested that if work is not already underway at other NAIC committees, a referral will be developed and sent. He said that for all such work at other committees, the Working Group’s staff support will maintain status information.

Mr. Schrader reported the Working Group reviewed the results from the recently filed 2020 LST and started discussing plans for next year’s filings. He added that the Working Group plans to reconvene the LST Study Group to begin planning the 2021 LST framework, with filings due in 2022. He said the Working Group has scheduled a regulator-to-regulator meeting in December and will schedule a meeting with industry participants in early January 2022. Mr. Schrader summarized the LST filings generally showed state insurance regulators what they expected, as follows, but with data to support those expectations:

• The insurance industry has a strong liquidity position, which helps to avert significant asset sales even in worst case scenario models.
• Insurers’ own worst-case scenarios resulted in the largest amount of modeled assets sales.
• Modeled asset sales compared to average daily trading volumes of those assets suggest minimal, if any, impact to capital markets under the most stressful scenarios, which was the primary macroprudential consideration of the LST.

Mr. Schrader noted that state insurance regulators will want to further consider these results since this was the initial LST. Mr. Schrader then made a motion, seconded by Commissioner Ommen, for the Task Force to receive the Macroprudential (E) Working Group’s report. The motion passed unanimously.
Mr. Boerner made a motion, seconded by Commissioner Ommen, for the Task Force to affirm the Macroprudential (E) Working Group as the coordinator of considerations related to private equity owners of insurers and to expose its initial draft list of considerations for a 30-day public comment period (Attachment Two). The motion passed unanimously. Subsequent to the Task Force meeting, the Chair, Commissioner Caride extended the comment period to end on Jan. 18, 2022.

5. Received the Report of the Valuation Analysis (E) Working Group

Mr. Boerner reported that in 2019, the Task Force made a request to the Valuation Analysis (E) Working Group to assess a potential concern related to economic scenario generators (ESG) developed by the American Academy of Actuaries (Academy). He stated the concern is that the ESG may be deficient by not adequately considering a very low interest rate environment, which could raise a material risk at the macroprudential level in the U.S., particularly for variable annuities. Mr. Boerner said that in the interim period until a new ESG is in place, the Task Force asked the Working Group to assess this concern and provide assurance that any issues either have been addressed or will be addressed. He summarized that an initial response by the Working Group to the Task Force was provided in November 2019 based on the Working Group’s monitoring and review of insurers representing 90% of the U.S. variable annuity (VA) business in force. He added that the Working Group’s most recent effort involved a request for insurers to perform two VA stress tests, which had the purpose to assess, at an industry level, the impact of a continuation of persistently low interest rates on VA reserves and risk-based capital (RBC). He summarized the details of the VA stress tests:

- Twenty-three insurers provided data for year-end 2020.
- For the first stress test, insurers were asked to produce the same results but replace stochastic interest rate scenarios with a prescribed deterministic interest rate scenario.
- For the second stress test, insurers were asked to repeat the calculation but replace the prescribed interest rate scenario with one defined by the insurer as being the worst moderately adverse low interest rate condition.
- The first stress test showed an increase of $6.3 billion or 13%, and the second stress test showed an increase of $5.6 billion or 12% for a base of $48.2 billion of pre-reinsurance ceded reserves for guaranteed benefits.
- The first stress test showed an increase of $1.8 billion or 24%, and the second stress test showed an increase of $1 billion or 13% for a base of $7.5 billion of RBC.

Jennifer Frasier (NAIC) said that most insurers reported that they have taken actions or are planning future actions to address interest rate risk to calculate their RBC and variable annuity reserves, such as:

- Repricing.
- Redesigning or discontinuing products.
- Changing hedging or adjusting investment strategies.
- Using a more conservative proprietary ESG.

Commissioner Caride asked if the Working Group will continue to monitor this issue until the revised ESG is in effect and provide the Task Force with updates regarding any concerns. Mr. Boerner confirmed that the Working Group will do so.

Mr. Boerner made a motion, seconded by Mr. Chou, for the Task Force to receive the report of the Valuation Analysis (E) Working Group (Attachment Three). The motion passed unanimously.

6. Heard an International Update

Tim Nauheimer (NAIC) reported that the International Association of Insurance Supervisors (IAIS) has completed the global monitoring exercise (GME) for 2021, which included analysis of data received in connection with the individual insurer monitoring (IIM) and the sector wide monitoring (SWM) exercises. He added that the IAIS has issued the summary confidential report to the Financial Stability Board (FSB). Mr. Nauheimer said for the next cycle of the GME, the IAIS may not only include additional data requests on climate and cyber-risks, but also credit risk, low interest rate environment, and PE ownership, which emerged as part of the three themes from the last GME. He stressed that the IAIS recognizes the need to strike a balance with respect to burden for insurers and supervisors by optimizing the data requested to perform the analysis. Mr. Nauheimer added the IAIS is also considering data row deletions, which the NAIC hopes will result in no additional rows on a net basis after considering all the additions and deletions as prescribed in the technical specifications. He also said the next publication of the Global Insurance Market Report (GIMAR) will focus on cyber-risk.

Mr. Nauheimer reported that the IAIS launched its second consultation on the development of liquidity metrics with comments due Jan. 23, 2022. He summarized that the latest IAIS consultation focuses on developing the Phase II approach, which uses a
company’s cash-flow projections which aligns with the NAIC’s adopted domestic approach to assessing liquidity risk. He said interested parties should provide comments prior to the Jan. 23, 2022, deadline.

Having no further business, the Financial Stability (E) Task Force adjourned.
The Financial Stability (E) Task Force met Sept. 30, 2021. The following Task Force members participated: Marlene Caride, Chair (NJ); Eric A. Cioppa, Vice Chair, represented by Vanessa Sullivan (ME); Alan McClain represented by Mel Anderson (AR); Ricardo Lara represented by Susan Bernard (CA); Andrew N. Mais represented by Kathy Belfi (CT); Karima M. Woods represented by Philip Barlow (DC); David Altmaier represented by Carolyn Morgan (FL); Doug Ommen represented by Carrie Mears (IA); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Lynn Beckner (MD); Eric Dunning represented by Justin Schrader (NE); Adrienne A. Harris represented by Bill Carmello (NY); Jessica K. Altman represented by Kimberly Rankin (PA); Raymond G. Farmer represented by Michael Shull (SC); Carter Lawrence represented by Trey Hancock (TN); and Cassie Brown represented by Jamie Walker (TX). Also participating were: Robert Wake (ME); and Cameron Piatt (OH).

1. **Heard Opening Remarks**

Commissioner Caride said materials for consideration and discussion for this meeting were sent by email to the member, interested state insurance regulator, and interested party distribution lists for the Task Force, but they are also available on the NAIC website in the Committees section under the Financial Condition (E) Committee.

2. **Considered Adoption of its Charges**

Mr. Carmello made a motion, seconded by Mr. Barlow, to adopt the Task Force’s charges (see NAIC Proceedings – Fall 2021, Financial Condition (E) Committee, Attachment One-D). The motion passed unanimously.

3. **Heard an Update on Private Equity**

Eric Kolchinsky (NAIC) reported that private equity (PE) firms have increasingly been intertwined with insurance companies because of low interest rates and the changing PE business model. He added that the NAIC’s Capital Markets Bureau (CMB) maintains a manually researched and constantly updated list of 177 companies owned or controlled by PE. He concluded that PE-owned companies focus far more on investing in asset-backed securities (ABS) than the insurance industry as a whole: 25% vs 10% of total bonds in 2020.

Mr. Kolchinsky summarized that concern about PE ownership of insurance companies has been broadly expressed but to be actionable, these concerns need to be translated into a specific characteristic or behavior that differentiates the PE ownership structure from other insurance companies. He suggested using a “first principles” approach to zero in on the concern and list potential next steps.

Mr. Kolchinsky said transactions of affiliates have been a key regulatory concern, but the current regulatory framework was developed in the context of stock companies and mutuals. He added that insurers may use dividends, salaries, or benefits to extract excessive value so regulations focus on the oversight of value extraction by, for example, gating dividends and salaries. He explained that unlike stock companies and mutuals, PE-owned insurance companies look to extract value via fees rather than primarily dividends or salaries. He noted that state insurance regulators review and approve affiliated transactions but cautioned that it is not clear if all appropriate PE transactions are captured.

Mr. Kolchinsky elaborated that PE-owned insurance companies seeking to generate fees are the ultimate risk taker, but the relationships between PE and the insurer are not always clear:

- 1st degree affiliates are structured vehicles, which are managed by the PE-owned company’s asset management affiliate, but it is common for PE-owned companies to report affiliate-managed collateral loan obligations (CLOs) and other structured finance products as unaffiliated.
- 2nd degree affiliates are the debt and equity of PE-owned companies held by CLOs or collateral funding obligations that are either affiliated or unaffiliated and are held by the insurer. For example, the CMB found that for one large insurer, about 70% of its CLOs hold some exposure to the PE’s portfolio companies.
In terms of next steps, Mr. Kolchinsky suggested a new definition for PE-owned insurer:

“Financial Entity Owned Insurer is a regulated insurer, which is controlled by or has a long-term investment management agreement with an entity, which:

1) Derives the majority of its revenue through the management of or investment in financial assets.
2) Is not itself a regulated insurer.
3) Has some minimum amount of assets under management.”

Mr. Kolchinsky also suggested enhanced disclosures that bolster the definition of affiliate to include entities managed by an affiliate of the Financial Entity Owned Insurer:

- Fees paid or accrued to 1st and 2nd degree affiliates.
- Assets under management of all affiliates.
- Investments where there are other relationships with 1st and 2nd degree affiliates.

Ms. Belfi said considerable work goes into approving affiliate and investment manager agreements because it is an affiliate relationship. She asked if creating an investment or charging a fee is what is not currently being captured. Mr. Kolchinsky agreed and noted that, for example, for a CLO, there is no disclosure of a contract of the asset manager’s part of the trustee as the investor, but an affiliate may be receiving fees where an insurance company is an investor in the trust.

Mr. Barlow suggested that at least a 1st degree affiliate should be captured under the Insurance Holding Company System Regulatory Act (#440), but he asked if the new definition of a PE-owned insurer should be included. Mr. Kolchinsky responded that the company studied had good reporting, but Model #440 may not capture the new definition of a PE-owned insurer.

Ms. Mears asked if there are recommendations for the Task Force. Mr. Kolchinsky responded that he is looking for feedback and then further work would be referred to the appropriate committees. Ms. Mears asked if traditional insurers that own an asset management firm would be included. Mr. Kolchinsky responded that if the insurer owns an asset management firm, that is excluded from the definition because the insurer is already regulated. Ms. Mears asked if the presentation covers the scope of the work to be done. Mr. Kolchinsky said he views the presentation as a starting point, but there needs to be an understanding of the relationships between affiliates to determine what the solutions are and if the relationships are de minimis, then maybe nothing needs to be done. Ms. Mears asked if enhanced reporting would capture the traditional insurer that owns the asset manager who sponsors a CLO. Mr. Kolchinsky responded he would be open to that if the Task Force agrees on broader disclosures.

Mr. Wake said definitions would be clearer if 1st and 2nd degree affiliates are called 2nd and 3rd degree affiliates with the understanding that 1st degree affiliate is what Model #440 already defines. He added that consideration should be given to sorting out traditional insurers from these PE-owned insurer business models by defining the kind of transactions in an officially neutral way to determine the activities of asset management that are problematic and those that are not, rather than just looking if the controlling entity happens to be a financial entity. He suggested screening out traditional insurance activities that are not problematic through careful definitions and de minimis standards. He concluded that a traditional insurer that adopts some of those problematic practices could be included, but a PE-owned insurer that behaves like a traditional insurer could be excluded. Mr. Kolchinsky agreed.

Mr. Piatt said some state insurance regulators may have been on the Sept. 29 call regarding referral of the multistate NAIC Uniform Certificate of Authority Application (UCAA), known as Form A, when a PE-owned insurer wants to acquire an insurer. He added that the definition of a PE-owned insurer in that context is different. He asked for clarification of the definition. Mr. Kolchinsky responded that defining is a difficult task, but the focus is on fee generation.

Commissioner Caride said Todd Sells (NAIC) will receive all emails with respect to feedback to Mr. Kolchinsky’s presentation from members and interested parties.

4. **Heard a Macroprudential Risk Assessment Update**

Tim Nauheimer (NAIC) reported that the International Association of Insurance Supervisors (IAIS) has completed a large component of the global monitoring exercise (GME), which included analysis of data received in connection with the individual
insurer monitoring (IIM) and the sector wide monitoring (SWM) exercises. He added that several firms were identified for follow-up action, which included a questionnaire sent to the group wide supervisor. He said the IAIS plans to release the next draft of the public consultation on liquidity metrics in mid-November, which utilizes a company’s cash flow projections and more aligns with the NAIC’s approach to assessing liquidity risk.

Mr. Nauheimer reported that reminders were sent to lead states of the insurers in scope of the NAIC’s liquidity stress test in the event lead states wanted to follow up with their insurers’ filings due Sept. 30. He added that NAIC staff will compile submitted data from lead states and present them to the Macroprudential (E) Working Group. He said the Working Group will continue to develop the risk assessment framework, and a small drafting group of NAIC staff has been established to address the risk assessment details and finalize a proof of concept of the risk dashboard. The Working Group plans to use existing aggregated company data filed with the NAIC and public sources to conduct a risk assessment. The Working Group will have a call on Oct. 18 to receive the first version of the risk dashboard, and it hopes to have a first draft submitted for input by the Task Force later this year.

Stephen Broadie (American Property Casualty Insurance Association—APCIA) asked if the Oct. 18 Working Group call will be open or closed. Mr. Nauheimer responded that the initial call will be closed to get the framework for the risk dashboard in place, but some subsequent calls at the Task Force will be open.

Martin Mair (MetLife) asked what role the chief risk officer (CRO) council will play with respect to the development of the risk dashboard. Mr. Nauheimer responded that NAIC staff reached out to the CRO council for initial feedback on the risk dashboard, but he expects that NAIC staff will reach out again to collaborate.

Having no further business, the Financial Stability (E) Task Force adjourned.
Regulatory Considerations Applicable (But Not Exclusive) to Private Equity (PE) Owned Insurers

A summary of currently identified regulatory considerations follows with no consideration of priority or importance (green underlined font indicates current or completed work by another NAIC committee group). Most of these considerations are not limited to PE owned insurers and are applicable to any insurers demonstrating the respective activities.

1. Regulators may not be obtaining clear pictures of risk due to holding companies structuring contractual agreements in a manner to avoid regulatory disclosures and requirements. Additionally, affiliated/related party agreements impacting the insurer’s risks may be structured to avoid disclosure (for example, by not including the insurer as a party to the agreement).

2. Control is presumed to exist where ownership is >=10%, but control considerations may exist with less than 10% ownership. For example, a party may exercise a controlling influence over an insurer through Board and management representation or contractual arrangements, including non-customary minority shareholder rights or covenants, investment management agreement (IMA) provisions such as onerous or costly IMA termination provisions, or excessive control or discretion given over the investment strategy and its implementation.

3. The material terms of the IMA and whether they are arm’s length—including the amount and types of investment management fees paid by the insurer, the termination provisions (how difficult or costly it would be for the insurer to terminate the IMA) and the degree of discretion or control of the investment manager over investment guidelines, allocation, and decisions.

4. Owners of insurers may be focused on short-term results which may not be in alignment with the long-term nature of liabilities in life products. For example, excessive investment management fees paid to an affiliate of the owner of an insurer may effectively act as a form of unauthorized dividend in addition to reducing the insurer’s overall investment returns. Similarly, owners of insurers may not be willing to transfer capital to a troubled insurer.

5. Operational, governance and market conduct practices being impacted by the different priorities and level of insurance experience possessed by entrants into the insurance market without prior insurance experience, including, but not limited to, PE owners. For example, a reliance on TPAs due to the acquiring firm’s lack of expertise may not be sufficient to administer the business. Such practices could lead to lapse, early surrender, and/or exchanges of contracts with in-the-money guarantees and other important policyholder coverage and benefits.

6. No uniform or widely accepted definition of PE and challenges in maintaining a complete list of insurers’ material relationships with PE firms. (UCAA [National Treatment WG] dealt with some items related to PE.) This definition may not be required as the considerations included in this document are applicable across insurance ownership types.

7. The lack of identification of related party-originated investments (including structured securities). For example, this may create potential conflicts of interests and excessive and/or hidden fees in the portfolio structure. Assets created and managed by affiliates may include fees at different levels of the value chain. Regulatory disclosures may be required to identify underlying related party/affiliated investments and/or collateral within structured security investments. (An agenda item and blanks proposal are being developed by SAPWG.)

8. Though the blanks include affiliated investment disclosures, it is not easy to identify underlying affiliated investments and/or collateral within structured security investments.

9. Broader considerations exist around asset manager affiliates (not just PE owners) and disclaimers of affiliation avoiding current affiliate investment disclosures. (A new Sc Y, Pt 3, has been adopted and will be in effect for year-end 2021. This schedule will identify all entities with greater than 10%...
ownership – regardless of any disclaimer of affiliation - and whether there is a disclaimer of control/disclaimer of affiliation. It will also identify the ultimate controlling party. Additionally, SAPWG is developing a proposal to revamp Schedule D reporting, with primary concepts to determine what reflects a qualifying bond and to identify different types of investments more clearly, including asset-backed securities.)

10. The material increases in privately structured securities (both by affiliated and non-affiliated asset managers), which introduce other sources of risk or increase traditional credit risk, such as complexity risk and illiquidity risk, and involve a lack of transparency. (The NAIC Capital Markets Bureau continues to monitor this and issue regular reports, but much of the work is complex and time-intensive with a lot of manual research required. The NAIC Securities Valuation Office will begin receiving private rating rationale reports in 2022; these will offer some transparency into these private securities.)

11. The level of reliance on rating agency ratings and their appropriateness for regulatory purposes (e.g., accuracy, consistency, comparability, applicability, interchangeability, and transparency). (VOSTF has previously addressed and will continue to address this issue.)

12. The trend of life insurers in pension risk transfer (PRT) business and supporting such business with the more complex investments outlined above (LATF has exposed questions aimed at determining if an Actuarial Guideline is needed to achieve a primary goal of ensuring claims-paying ability even if the complex assets (often private equity-related) did not perform as the company expects, and a secondary goal to require stress testing and best practices related to valuation of non-publicly traded assets. Additionally, enhanced reporting in 2021 Separate Accounts blank will specifically identify assets backing PRT liabilities.) Considerations have also been raised regarding the RBC treatment of PRT business.
   a. Review applicability of Department of Labor protections resulting for pension beneficiaries in a PRT transaction.
   b. Review state guaranty associations’ coverage for group annuity certificate holders (pension beneficiaries) in receivership compared to Pension Benefit Guaranty Corporation (PBGC) protection.

13. Insurers’ use of offshore reinsurers (including captives) and complex affiliated sidecar vehicles to maximize capital efficiency and introduce complexities into the group structure.
To: Commissioner Marlene Caride, Chair of the Financial Stability (E) Task Force  
From: Mike Boerner, Chair of the Valuation Analysis (E) Working Group  
Date: December 7, 2021  
Re: Response to Request from the Financial Stability (E) Task Force

I. Executive Summary

In 2019, the Financial Stability (E) Task Force (FSTF) made a request to the Valuation Analysis (E) Working Group (VAWG) to assess a potential concern related to Economic Scenario Generators (ESGs) developed by the American Academy of Actuaries (Academy). It was suggested that there is a deficiency in the current ESG in that it doesn’t adequately consider a very low or negative interest rate environment, and more specifically that this raises a material risk at the macro prudential level in the U.S., particularly for variable annuities. To allay any concerns during the interim period until a new ESG is in place, the FSTF asked the VAWG to assess this concern and provide assurance that any issues either have been addressed, or will be able to be addressed.

An initial response was provided to the FSTF on November 27, 2019 (see Appendix A) based on the VAWG’s monitoring and review of companies representing over 90% of the U.S. variable annuity (VA) business inforce. Since then, the VAWG has continued to assess the materiality of variable annuity interest rate risk and the approaches companies have taken to measure and manage it. The most recent effort involved a request for the companies to perform two stress tests for disclosure (VA Stress Tests). The purpose was to assess, at an industry level, the impact of a continuation of persistently low interest rates on VA reserves and risk-based capital. This report provides details and key findings from the VA Stress Tests as well as an update on the development of the new ESG.

For both of the VA Stress Tests, the company’s actual reserves and risk-based capital as of 12/31/2020 were used as a baseline for comparison. For Stress Test #1, companies were asked to produce the same results, but replace the stochastic interest rate scenarios with a prescribed deterministic interest rate scenario. For Stress Test #2, companies were asked to repeat the calculation, but replace the prescribed deterministic scenario with one defined by the company as being the worst moderately adverse low interest rate condition.

For 23 companies combined, the baseline for pre-reinsurance ceded guaranteed benefit reserves plus risk-based capital was $55.7 billion. Stress Test #1 produced a total of $63.8 billion, an increase of $8.1 billion (15%). The result was similar for Stress Test #2, which produced an increase of $6.6 billion (12%). For additional context, this compares to the entire life and annuity sector’s capital and surplus of $451 billion as of 12/31/20.

Separating out the reserve and risk-based capital impacts, the results are as follows. In total, the baseline for the pre-reinsurance ceded reserves for guaranteed benefits was $48.2 billion, with Stress Test #1 showing an increase of $6.3 billion (13%) and Stress Test #2 showing an increase of $5.6 billion (12%). The total baseline for risk-based capital was $7.5 billion, with Stress Test #1 showing an increase of $1.8 billion (24%) and Stress Test #2 showing an increase of $1.0 billion (13%).

Most companies have taken actions or are planning future actions to address interest rate risk, such as: repricing, redesigning, or discontinuing products; changing hedging or adjusting investment strategies; or using a more conservative proprietary ESG. These actions provide a level of assurance that companies are addressing the impact of persistently low interest rates. The VAWG plans to continue to track this concern and, as appropriate, will provide referrals to domestic state regulators for additional review and follow-up of individual companies.

The implementation of a new ESG is in progress. An ESG Drafting Group is developing recommendations for ESG objectives and resulting ESG scenarios for the Life Actuarial (A) Task Force (LATF) to consider.
II. VA Stress Tests

A. Background

Variable Annuity writers that represent over 90% of the U.S. variable annuity business inforce were contacted in December 2020 and asked to perform two stress tests for disclosure by 3/31/2021. The purpose of the tests was for VAWG to assess, at an industry level, the impact of a continuation of persistently low interest rates on variable annuity reserves and risk-based capital.

B. Stress Test Instructions

Companies were asked to perform two stress tests according to the following instructions:

After calculating 12/31/2020 variable annuity reserves and risk-based capital as normal, repeat the calculations, replacing the stochastic interest rate scenarios with a single deterministic interest rate scenario.

Interest rate dependent scenarios under the VM-21 framework (e.g., bond fund returns, money market returns) should be adjusted to align with this deterministic interest rate scenario, but all other components of the modeling should remain the same (e.g., the same stochastic equity scenarios, investment strategy, clearly defined hedging strategy modeling, etc. should be used for the stress test).

Stress Test #1 (Regulator defined):
Start with the U.S. Treasury yield curve as of 12/31/20. Assume this Treasury curve remains level for the first 5 years of the projection period, and then has annual parallel shifts by the amount of max [0, (1.5% - T0)/5] in years 6-10 where T0 denotes the 10-year Treasury rate as of 12/31/20. Assume that the yield curve remains level thereafter.

<table>
<thead>
<tr>
<th>BOY</th>
<th>1-5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10+</th>
</tr>
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<tbody>
<tr>
<td>T0*</td>
<td>0.93%</td>
<td>1.044%</td>
<td>1.158%</td>
<td>1.272%</td>
<td>1.386%</td>
<td>1.5%</td>
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Stress Test #2 (Company defined):
The deterministic scenario should represent the worst moderately adverse low interest rate condition the company believes it would need to pass, starting with the U.S. Treasury yield curve as of 12/31/20 and developing afterwards in a way the company feels is appropriate. This may include either parallel or non-parallel shifts of the yield curve. Companies were asked to provide a complete description of the stress test used.

C. Summary of Results for Stress Test #1

Results for Stress Test #1 were calculated in comparison to a baseline of actual reserves and risk-based capital at year-end 2020. Shown below, for all surveyed companies combined, is the increase in total reserves for guaranteed benefits (which excludes the cash surrender value) plus risk-based capital over the baseline.

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Increase over Baseline</th>
<th>% Increase over Baseline</th>
</tr>
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<tbody>
<tr>
<td>Pre-Reinsurance Ceded Reserve for Guaranteed Benefits</td>
<td>$48.2 B</td>
<td>$6.3 B</td>
<td>13%</td>
</tr>
<tr>
<td>Risk-Based Capital</td>
<td>$7.5 B</td>
<td>$1.8 B</td>
<td>24%</td>
</tr>
<tr>
<td>Total</td>
<td>$55.7 B</td>
<td>$8.1 B</td>
<td>15%</td>
</tr>
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</table>
Looking at the Reserve for Guaranteed Benefits at the company level, the results ranged from a 500% increase to a 20% decrease.
- Approximately 35% of the companies showed more than a 20% increase over baseline
- Approximately 40% of the companies showed an increase over baseline of 0% to 20%
- Approximately 25% of the companies showed a decrease from the baseline

Many companies provided comments to explain the stress test results. Companies that reported reserve increases gave reasons such as increased hedge costs, decreased investment yields, and higher claims. Companies that reported reserve decreases gave reasons such as using a proprietary ESG for baseline/actual that produced a more conservative result than the stress test, reflecting an increased hedge benefit, and producing improvements based on asset/liability management strategies.

At the company level, changes to Risk-Based Capital ranged from a 120% increase to a 20% decrease.
- Approximately 30% of the companies showed no change
- Approximately 50% of the companies showed an increase
- Approximately 20% of the companies showed a decrease

D. Summary of Results for Stress Test #2

Results for Stress Test #2 were calculated in comparison to a baseline of actual reserves and risk-based capital at year-end 2020. Shown below, for all surveyed companies combined, is the increase in total reserves for guaranteed benefits (which excludes the cash surrender value) plus risk-based capital over the baseline.

<table>
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<tr>
<th></th>
<th>Baseline</th>
<th>Increase over Baseline</th>
<th>% Increase over Baseline</th>
</tr>
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<tr>
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<td>$48.2 B</td>
<td>$5.6 B</td>
<td>12%</td>
</tr>
<tr>
<td>Risk-Based Capital</td>
<td>$7.5 B</td>
<td>$1.0 B</td>
<td>13%</td>
</tr>
<tr>
<td>Total</td>
<td>$55.7 B</td>
<td>$6.6 B</td>
<td>12%</td>
</tr>
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Looking at the Reserve for Guaranteed Benefits at the company level, the results ranged from a 250% increase to a 60% decrease.
- Approximately 35% of the companies showed more than a 20% increase over baseline
- Approximately 45% of the companies showed an increase over baseline of 0% to 20%
- Approximately 20% of the companies showed a decrease from the baseline

Stress Test #2 allowed companies to select their own moderately adverse deterministic interest rate scenario. Companies had a wide range of views on what they considered to be the worst moderately adverse, and took a variety of approaches for performing Stress Test #2. These included:
- Assuming level interest rates throughout the projection period
- Using same design as Stress Test #1 but grading to a different long-term rate
- Grading to ultimate interest rate with parallel shift to other points on the treasury curve
- Using non-parallel yield curve shifts
- Setting stress test to produce results similar to the baseline, implying a view that the baseline was the worst moderately adverse

At the company level, changes to Risk-Based Capital ranged from a 100% increase to a 20% decrease.
- Approximately 30% of the companies showed no change
- Approximately 30% of the companies showed an increase
- Approximately 40% of the companies showed a decrease
E. Summary of Actions to Address Risk of Continued Low Interest Rates

Companies were asked, “If interest rates remain low for the next 15-20 years, what, if anything, would your company consider doing differently?” Companies provided open-ended responses that addressed actions already taken as well as potential future actions. A categorized summary of qualitative responses from 24 companies is shown below. (Note that 23 companies were used for the quantitative analysis, as disclosed in the Executive Summary. Due to a special case exception, one company was included in the qualitative count but not the quantitative count.)

III. Update on the Economic Scenario Generator

The implementation of a new ESG is in progress. An ESG Drafting Group, consisting of LATF members, Life Risk-Based Capital (E) Working Group members, the selected ESG vendor (Conning), Academy and ACLI representatives, and subject matter experts, is developing recommendations for calibrating the ESG. An industry field test is planned prior to finalizing the calibration. Ultimately, Valuation Manual amendments and RBC instruction changes will be necessary to incorporate prescription of the new ESG.
IV. Appendix A (Prior Report)

To: Commissioner Marlene Caride, Chair of the Financial Stability (EX) Task Force  
From: Mike Boerner, Chair of the Valuation Analysis (E) Working Group  
Date: November 27, 2019  
Re: Response to Request from the Financial Stability (EX) Task Force

Executive Summary

On 6/17/19, you made a request to the Valuation Analysis (E) Working Group (VAWG) to assess a potential concern related to Economic Scenario Generators (ESGs) developed by the American Academy of Actuaries (Academy). These ESGs are currently prescribed (or encouraged) for the following calculations: (1) Risk-Based Capital for Variable Annuities (C-3 Phase II) and certain annuities or single premium life insurance products (C-3 Phase 1); (2) Statutory Reserves for Variable Annuities (Actuarial Guideline 43 and VM-21 of the Valuation Manual); and (3) Statutory Reserves for Life & Variable Life Insurance (VM-20 of the Valuation Manual). One insurer suggested that there is a deficiency in the current ESG in that it doesn’t adequately consider a very low or negative interest rate environment, and more specifically that this raises a material risk at the macro prudential level in the U.S., particularly for variable annuities.

The Life Actuarial (A) Task Force (LATF) has begun a process to replace the Academy ESGs. However, to allay any concerns during the interim period until a new ESG is in place, you requested that the VAWG assess this insurer’s concern and provide assurance that any issues either have been addressed, or will be able to be addressed.

To assess the concern during the interim period (which is expected to be several years), the VAWG sent an information request to companies representing over 90% of the U.S. variable annuity business inforce. The responses indicate that overall, companies are aware of the significance of variable annuity interest rate risk, and have taken various actions to measure and manage it. However, there were findings for individual companies that will require further review and follow-up. The VAWG also sees a need for continued monitoring via coordinated reviews of companies’ future variable annuity filings, similar to those currently performed for LTC AG51 reports and the VM-31 Life PBR Actuarial Reports.

The VAWG plans to take the following actions to provide assurance that any issues regarding companies’ variable annuity interest rate risk will be addressed: 1) Questions regarding findings of concern and informational questions for individual companies will be developed, for referral to domestic state regulators for review and follow-up; 2) A communication will be sent to state regulators to alert them to the concern raised regarding interest rate risk for variable annuities, and to encourage them to focus on this as they assess risks, conduct financial reviews, and review companies’ asset adequacy testing; 3) A recommendation will be made to review and consider enhancements to the Financial Condition Examiner’s Handbook to address review of proprietary ESGs used for hedging and other purposes; and 4) A coordinated review of the VM-31 Variable Annuity PBR Actuarial Reports and C3 Phase II reports will be performed for all early adopters of the new variable annuity framework for reserves and capital. The framework becomes mandatory for all inforce business in 2020. However, companies may elect to early adopt as of 12/31/19.

This report provides key findings from the information request, including materiality of variable annuity interest rate risk and the approaches companies have taken to measure and manage it. The report concludes with information on current usage of the Academy ESGs, the status of the RFP for a new ESG, and the potential length of the interim period before the new ESG will be implemented.
Industry VA Information Request

To assess the concern raised regarding variable annuity interest rate risk in the interim period before a new ESG is implemented, an information request was sent to 24 companies representing over 90% of the U.S. variable annuity business inforce. Companies were asked to provide the following information:
2. A discussion on how the company is addressing the risks to variable annuities from an extended period of low interest rates, including commentary on actions taken and planned beyond the use of the Academy ESG, if applicable. As part of this discussion companies were asked to include: a) a description of the types of guarantees provided on their variable annuities; b) information on how the company measures and manages interest rate risk from variable annuities and associated guarantees; and c) an assessment of the materiality of this risk to the company.

Key Findings

Summarized below are some of the key findings from the VAWG’s review of industry responses.

Types of Guarantees Provided on Variable Annuities

Nearly all companies offered a Guaranteed Minimum Death Benefit (GMDB) on their products. Most companies also offered one or more of the following types of guaranteed living benefits:
- Guaranteed Minimum Income Benefit (GMIB)
- Guaranteed Minimum Withdrawal Benefit (GMWB)
- Guaranteed Minimum Accumulation Benefit (GMAB)
- A fixed account with or without a market value adjustment, with a guaranteed minimum interest rate

Materiality of Interest Rate Risk

The vast majority of companies acknowledged that interest rate risk from VA guarantees represents a material risk for their company. For the few remaining companies, this risk was not viewed as material either because the VA block represents a relatively small percentage of total inforce business, or because the risk was completely or largely transferred to a reinsurer.

Measurement and Management of Interest Rate Risk

ESGs produce stochastic interest rate scenarios which are used to measure and manage risk. However, ESGs are not the only tools used for this purpose. Pre-defined deterministic scenarios, such as the NY7 scenarios commonly used in asset adequacy testing, can be effective as well. Many companies also monitor earnings volatility (e.g. economic, Statutory, GAAP).

The vast majority of companies have a hedging program in place to manage interest rate risk, and typically other risks as well, such as equity risk. Many of these companies have a Clearly Defined Hedging Strategy, meaning that specific criteria defined in the Valuation Manual have been met. Some companies noted that they have recently made changes to their hedging approach, such as increasing the amount of interest rate hedging.

Some companies disclosed the results of their hedging programs and reported high hedge effectiveness. This information was not specifically requested and was not provided by most companies.

Nearly all companies with a hedging program indicated that they do not rely on the Academy ESGs for hedging. Proprietary ESGs are commonly used for this, as well as other purposes (e.g. economic capital, and day-to-day risk management).
Management Actions

In addition to the activities mentioned above, many companies have taken actions to further address interest rate risk. Actions cited in the survey include but are not limited to those listed below.

- Discontinuing sales - About a third of the companies surveyed are no longer selling variable annuities. Of those currently issuing new business, some have discontinued sales of one or more of their guaranteed living benefits.
- Lowering the guaranteed minimum interest rates offered on fixed accounts for new sales, or discontinuing fixed accounts altogether
- De-risking guaranteed living benefits, e.g. by adjusting fees and/or benefits
- Offering a lump sum to certain contract holders in exchange for termination of a guaranteed living benefit
- Some companies hold additional reserves beyond the minimum requirements

Use of Academy ESGs for Statutory Reserves and Capital

Nearly all companies provided information on the type of ESG used in calculating 2018 statutory reserves and capital. Approximately 75% used an Academy ESG, with or without modifications. Of these companies, many used the Academy VM-20 ESG, which will be prescribed in 2020 under the new VA framework. Some used an older Academy C-3 Phase 1 ESG, which has a higher, less conservative long-term interest rate assumption. However, some companies adjusted this assumption to bring it closer to that used in the Academy VM-20 ESG. Other companies did not specifically state which Academy ESG they used. The remaining 25% of the companies used a proprietary ESG, and about half of these appear to be more conservative than the Academy VM-20 ESG. Companies may continue to use these ESGs under the new VA framework, since the Academy VM-20 ESG is prescribed as the minimum standard.

ESG RFP Status and Potential Length of Interim Period

The process of implementing a new ESG is expected to take several years. There is agreement that the Academy ESGs must be replaced and that various enhancements will be necessary, including adequate consideration of a prolonged low interest rate environment. However, many steps will be needed prior to implementation, since the intent is to consider prescribing the new ESG for all of the calculations noted in the first paragraph of this report.

Progress has been made on this initiative. At the time of your request to the VAWG, an informal subgroup of LATF was considering various alternatives to replace the Academy ESGs. On 7/16/19, an open meeting of the Life RBC Working Group (LRBC WG) and LATF was held to discuss the alternatives, and a request was made that NAIC staff move forward with the RFP process to select an ESG vendor to develop and maintain a new prescribed ESG.

A group consisting of regulators, NAIC staff, Academy representatives, and other industry subject matter experts has been formed and has met several times to work on a draft RFP. The target timeframe for completion is Q1, 2020, although it may take longer. The RFP will then need to be adopted by LATF and the Life Insurance and Annuities (A) Committee and presented to the NAIC Executive (EX) Committee for final approval, including a request for appropriate funding. The NAIC will then issue the RFP, and submissions will be reviewed based upon weighted criteria as specified within the issued RFP. A recommendation for award will then be submitted to the NAIC Executive (EX) Committee for final approval.

Once an ESG vendor has been selected, implementation of the ESG will require additional steps such as the following: 1) consideration and adoption of any potential ESG parameter modifications desired by regulators; 2) an impact study to assess the results; 3) drafting, exposure, and adoption of any Valuation Manual amendments and RBC instruction changes necessary to incorporate prescription of the new ESG; 4) documentation on the ESG methodology and parameters; and 5) training on the use of the ESG. This entire process is expected to be completed no sooner than 2022 (i.e. effective for the 2022 Valuation Manual).
RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE

Receivership and Insolvency (E) Task Force Nov. 30, 2021, Minutes.........................................................................................10-1064
Receivership and Insolvency (E) Task Force Oct. 21, 2021, Minutes (Attachment One).................................................................10-1066
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Receiver’s Handbook (E) Subgroup Nov. 18, 2021, Minutes (Attachment Five).................................................................10-1073

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The Receivership and Insolvency (E) Task Force met Nov. 30, 2021. The following Task Force members participated: Cassie Brown, Chair, represented by Brian Riewe (TX); James J. Donelon, Vice Chair, represented by Tom Travis (LA); Evan G. Daniels represented by Liane Kido (AZ); Michael Conway represented by Rolf Kaumann (CO); Andrew N. Mais represented by Jared Kosky (CT); David Altmaier represented by Toma Wilkerson (FL); Colin M. Hayashida represented by Patrick P. Lo (HI); Doug Ommen represented by Kim Cross (IA); Dana Popish Severinghaus represented by Kevin Baldwin (IL); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Bill Clark (KY); Gary D. Anderson represented by Christopher Joyce (MA); Eric Cioppa represented by Randall Gregg (ME); Anita G. Fox represented by Jackie Obusek (NC); Chlora Lindley-Myers represented by Shelley Forrest (MO); Glen Mulready represented by Donna Wilson (OK); Mike Causey represented by Laura Lyon Slaymaker (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); and Johnathan T. Pike represented by Jake Garn (UT).

1. **Adopted its Oct. 21 Minutes**

Mr. Riewe said the Task Force met Oct. 21 and took the following action: 1) adopted its Summer National Meeting minutes; 2) exposed a referral to the Financial Regulation Standards and Accreditation (F) Committee regarding receivership amendments to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) for a 30-day public comment period ending Nov. 22; 3) exposed a draft memorandum to state insurance departments on receivership and guaranty fund laws for a 30-day public comment period ending Nov. 22; and 4) heard an update on international resolution activities.

Ms. Obusek made a motion, seconded by Ms. Wilkerson, to adopt the Task Force’s Oct. 21 minutes (Attachment One). The motion passed unanimously.

2. **Adopted a Referral to the Financial Regulation Standards and Accreditation (F) Committee**

Mr. Riewe said the Executive (EX) Committee and Plenary adopted the receivership revisions to Model #440 and Model #450 at the Summer National Meeting. During its Oct. 21 meeting, the Task Force exposed for a referral to the Financial Regulation Standards and Accreditation (F) Committee recommending the receivership revisions be “Acceptable, but Not Required” to be adopted by states under Part A Standards, rather than identifying “substantially similar” provisions that would be required for a 30-day public comment period ending Nov. 22. No comments were received.

Ms. Slaymaker made a motion, seconded by Ms. Wilkerson, to adopt the referral to be sent to the Financial Regulation Standards and Accreditation (F) Committee (Attachment Two). The motion passed unanimously.

3. **Adopted a Memorandum to State Insurance Departments**

Mr. Riewe said when the Task Force adopted the final recommendations from the Macroprudential Initiative (MPI), it had identified several provisions of receivership law that were considered important to a multi-jurisdictional receivership. These are provisions for which all states should consider reviewing their laws and potentially make updates. During its Oct. 21 meeting, the Task Force exposed a draft memorandum to state insurance departments encouraging them to consider a review of their laws and adopt updates, including these provisions, the Model #440 and Model #450 receivership amendments, recently adopted guidelines, and the 2017 amendments to the *Life and Health Insurance Guaranty Association Model Act* (#520) for a 30-day public comment period ending Nov. 22.

Mr. Riewe said one comment was received from the National Organization of Life and Health Insurance Guaranty Association (NOLHGA) requesting a correction to the paragraph on “Conflict of Law” (Attachment Three). Mr. Riewe and Mr. Baldwin agreed with NOLHGA’s proposed change.

Ms. Wilson made a motion, seconded by Mr. Kaumann, to adopt the memorandum with the edits from NOLHGA (Attachment Four). The motion passed unanimously.

Ms. Wilkerson said the Receivership Financial Analysis (E) Working Group met Nov. 15, in lieu of the Fall National Meeting, in regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss companies in receivership.

Ms. Wilkerson made a motion, seconded by Mr. Kaumann, to adopt the report of the Receivership Financial Analysis (E) Working Group. The motion passed unanimously.

5. **Adopted the Report of the Receiver’s Handbook (E) Subgroup**

Mr. Baldwin said the Receiver’s Handbook (E) Subgroup met Nov. 18 to expose revisions to Chapter 1 and Chapter 2 of the *Receiver’s Handbook for Insurance Company Insolvencies* (Handbook) for a 30-day public comment period ending Dec. 20. The Subgroup is currently working on revisions to the other chapters of the Handbook.

Ms. Wilkerson made a motion, seconded by Ms. Slaymaker, to adopt the report of the Receiver’s Handbook (E) Subgroup (Attachment Five). The motion passed unanimously.

6. **Heard an Update on Federal Activities**

Patrick Celestine (NAIC) said the NAIC’s proposed State Insurance Receivership Priority (SIRP) Act establishes a claim filing deadline in the Federal Priority Act (FPA) for the U.S. Department of Justice (DOJ) to file claims of the U.S. to insolvent insurance company estates and to ensure state insurance regulators are not held personally liable if claims of the government are not paid first. The Government Relations (EX) Leadership Council approved the SIRP Act in April. Several members of the Task Force and NAIC staff are working with U.S. Rep. Madeleine Dean’s office to finalize edits to the SIRP Act. Rep. Dean’s office plans to introduce the SIRP Act despite the objections that the DOJ has expressed. It is expected to be introduced to the U.S. House of Representatives in early 2022.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.

[https://naiconline.sharepoint.com/w/r/sites/NAICSupportStaffHub/Member%20Meetings/Fall%202021/TF/Receivership/RITF_Minutes113021%20final.docx?d=wdfeb5d0316d4a38ac599eab87f02a86&csf=1&web=1&e=4CG5p](https://naiconline.sharepoint.com/w/r/sites/NAICSupportStaffHub/Member%20Meetings/Fall%202021/TF/Receivership/RITF_Minutes113021%20final.docx?d=wdfeb5d0316d4a38ac599eab87f02a86&csf=1&web=1&e=4CG5p)
The Receivership and Insolvency (E) Task Force met Oct. 21, 2021. The following Task Force members participated: Cassie Brown, Chair, represented by Brian Riewe (TX); James J. Donelon, Vice Chair (LA); Peni Itula Sapini Teo represented by Elizabeth Perri (AS); Michael Conway and Rolf Kaumann (CO); Andrew N. Mais represented by Jared Kosky (CT); David Altmaier represented by Toma Wilkerson (FL); Colin M. Hayashida represented by Patrick P. Lo (HI); Doug Ommen represented by Kim Cross (IA); Dana Popish Severyinghaus represented by Kevin Baldwin (IL); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Bill Clark (KY); Gary D. Anderson represented by Christopher Joyce (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by Randall Gregg (MI); Chlora Lindley-Myers and Shelley Forrest (MO); Mike Causey represented by Jackie Obusek (NC); Eric Dunning and Justin Schrader (NE); Russell Toal represented by Victoria Baca (NM); Glen Mulready represented by Donna Wilson (OK); Jessica K. Altman represented by Laura Lyon Slaymaker (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); Raymond G. Farmer represented by Michael Shull (SC); and Johnathan T. Pike (UT).

1. **Adopted its Summer National Meeting Minutes**

Mr. Riewe said the Task Force met July 27 in lieu of the Summer National Meeting. Ms. Wilkerson made a motion, seconded by Mr. Baldwin, to adopt the Task Force’s July 27 minutes (see [NAIC Proceedings – Summer 2021, Receivership and Insolvency (E) Task Force](#)). The motion passed unanimously.

2. **Exposed a Draft Referral to the Financial Regulation Standards and Accreditation (F) Committee**

Mr. Riewe said the Executive (EX) Committee and Plenary adopted the receivership revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) at the Summer National Meeting. As the Task Force and its working group were responsible for drafting these model revisions, the Task Force will need to send a referral recommending the Part A Standard that should be considered by the Financial Regulation Standards and Accreditation (F) Committee. Part A standards are those laws and regulations that are required to ensure a state has authority to regulate financial solvency of insurers.

Mr. Riewe said the Task Force sought the input of members to draft an initial recommendation. With one exception, the feedback received was in favor of recommending that the revisions be acceptable, but not required to be adopted by states, rather than identifying substantially similar provisions that would be required. Since there were other revisions to these models for group capital and liquidity stress testing, states are hopefully considering all the model revisions together on their merits and the benefits to receiverships regardless of accreditation requirements. Mr. Wake said while he would like to see more substantive accreditation standards for receivership and insolvency, it is an excellent referral.

Hearing no objections, the draft referral was released for a 30-day public comment period ending Nov. 22.

3. **Exposed a Draft Memorandum to State Insurance Departments**

Mr. Riewe said when the Task Force adopted the final recommendations from the Macroprudential Initiative (MPI), it had identified several provisions of receivership law that were considered important to a multi-jurisdictional receivership. These are provisions for which all states should consider reviewing their laws and potentially making updates. This included conflicts of law, continuation of coverage, priority of distribution, full faith, and credit on stays and injunctions. In addition to those, the NAIC has adopted the receivership revisions to Model #440 and Model #450 and adopted the new *Guideline for Administration of Large Deductible Policies in Receivership* (#1980) and *Guideline for Definition of Reciprocal State in Receivership* (#1985). Lastly, while 34 states have adopted those 2017 revisions to the *Life and Health Insurance Guaranty Association Model Act* (#520), the memorandum reminds state insurance departments to consider adoption. The draft memorandum is intended to encourage states to consider a review of their laws and adopt updates. The memorandum is concise and may be used as a starting point for discussion with each state insurance department’s legal or legislative liaison staff. Any volunteers willing to speak at zone meetings could use this memorandum as talking points for those discussions.

Hearing no objections, the draft memorandum was released for a 30-day public comment period ending Nov. 22.

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4. **Heard an Update on International Resolution Activities**

Mr. Wake said the International Association of Insurance Supervisors (IAIS) Resolution Working Group adopted the *Application Paper on Resolution Powers and Planning*. The Working Group began work on an application paper on policyholder protection schemes. Mr. Wake said the U.S. is undergoing a targeted jurisdictional assessment regarding the holistic framework, which includes an assessment of resolution and crisis management.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.
On August 17, 2021, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). The revisions help ensure efficient coordination with affiliates and to enforce the continuation of essential services by an affiliate to an insurer in the event of insolvency.

These revisions were drafted by the Receivership Law (E) Working Group under charges assigned by the Receivership and Insolvency (E) Task Force. These revisions, referred to as the “receivership revisions” do not include recent revisions to Models #440 and #450 for group capital calculation or liquidity stress test. The receivership revisions address the continuation of essential services through affiliated intercompany agreements with an insurer that is placed into receivership by: 1) bringing affiliate service providers deemed “integral” or “essential” to an insurer’s operations under the jurisdiction of a rehabilitator, conservator, or liquidator for purposes of interpreting, enforcing, and overseeing the affiliate’s obligations under the service agreement and give the commissioner authority to require that “integral” or “essential” affiliate service providers consent to such jurisdiction; 2) further clarifying the ownership of data and records of the insurer that are held by the affiliate; and 3) clarifying that premiums of the insurer held by the affiliate are the property of the insurer and rights of offset are determined by receivership law. See attachment A for a copy of the amendments.

The recommendation for Part A Accreditation Standards is that these receivership revisions be considered acceptable, but not required to be adopted by states. However, the revisions are considered important and all states are encouraged to adopt them. States may consider adoption of the changes in conjunction with opening their holding company laws to consider adoption of the Group Capital Calculation and Liquidity Stress Test revisions.

The Task Force will continue to encourage states to adopt these revisions based on the benefits these revisions add to state regulation, and to the goal of improving efficiencies in receivership and reducing costs to a receivership estate.
11/29/21
Comments from Joni Forsythe, NOLHGA:

We were looking over the materials for the upcoming RITF meeting tomorrow and wanted to raise a concern with respect to Attachment Three, the Memo re Recently Adopted Model Amendments. We support the NAIC’s outreach effort with respect the model laws, but believe there is a correction needed in the first bullet point relating to conflicts of laws. As written, it appears to contradict the actual text of IRMA section 102, which is pasted immediately below.

Here is the actual text of section 102

Section 102. Conflicts of Law

This Act, Title [XXX], and the state insurance guaranty association acts constitute this state’s insurer receivership laws, and these laws shall be construed together in a manner that is consistent. In the event of a conflict between the insurer receivership laws and the provisions of any other law, the insurer receivership laws shall prevail.

IRMA section 102 provides that the state receivership act and the state GA acts collectively constitute the state’s insurer receivership laws. The receivership and GA statutes are to be construed in a manner that is consistent, and if there is a conflict between these laws and other state laws, the state’s insurer receivership laws prevail. The bullet point in the memo does not address the collective reference to receivership acts and GA acts as the state’s insurer receivership laws and instead comments on potential conflicts between the two. This was an important and much negotiated provision that was ultimately adopted into IRMA. We would ask that the memo be adjusted to reflect that correction. The language noted in blue below could be used in place of the current bullet. The substitution should not be controversial since it tracks the language actually adopted into IRMA.

Insurer Receivership Model Act (#555, “IRMA”)

- Conflicts of Law (IRMA §102) was added as a new section in IRMA. It provides that the state’s receivership act and insurance guaranty association acts constitute the state’s insurer receivership laws, and these laws shall be construed together in a manner that is consistent. In the event of a conflict between the insurer receivership laws and the provisions of any other law, the insurer receivership laws shall prevail.

Please let us know if you should have any questions about our request or if we can be of further assistance. We are happy to discuss if that would be helpful.

Best Regards,
Joni
In 2020, the Task Force concluded its Macroprudential Initiative (MPI) to evaluate receivership and guaranty fund laws. Through this process the Task Force highlighted several topics that it identified as being critical for states laws with respect to a multi-jurisdictional receivership and which may require a state’s attention.

The Task Force encourages state insurance departments to review their receivership and guaranty fund laws to ensure it addresses the following topics.

**Insurer Receivership Model Act (#555, “IRMA”)**

- **Conflicts of Law (IRMA §102)** was added as a new section in IRMA. It provides that the state’s receivership act and insurance guaranty association acts constitute the state’s insurer receivership laws, and these laws shall be construed together in a manner that is consistent. In the event of a conflict between the insurer receivership laws and the provisions of any other law, the insurer receivership laws shall prevail. The benefit of having this provision is that it prevents potential legal delays in the administration of a receivership.

- **Continuation of Coverage (IRMA §502)** provides that all insurance policies, excluding life, disability, long term care, health, or annuities, are cancelled at a specified time unless the Liquidator, with the consent of the receivership court, extends the period. This provision was re-written and improved in IRMA.

  The Task Force conducted a survey in 2019 that showed that states’ laws differ with respect to IRMA §502 from having provisions substantially similar to IRMA §502B, or to a prior version of Model #555, or a state has no continuation of coverage provision, or no exclusions for life and health lines of business. This provision has been the subject of litigation in receivership. For these reasons, states are encouraged to review their law against IRMA and consider amendments.

- **Priority of Distribution (IRMA §801)** of estate assets is a provision that was rewritten in IRMA. It outlines the priority scheme for payment of claims, which places policyholder claims above that of unsecured creditors or shareholders. The benefit of having this provision is that it furthers state insurance department goals to protect policyholders in the administration of a receivership.

**Reciprocal State; Full Faith and Credit on Stays and Injunctions**

An effective stay provision promotes judicial economy and predictability, which benefits all participants in the receivership process. However, the significant improvements in IRMA regarding stays have not been widely adopted.
Further background on the topic is available in the 2017 Financial Condition (E) Committee memorandum posted to the NAIC website. States are encouraged to review their receivership laws, and consider the following:

1) States with no stay provisions, or provisions based on older NAIC models, should compare their laws to the more recent NAIC Models, and evaluate the benefits of a more comprehensive stay. (IRMA §108)

2) States with no reciprocity provisions, or provisions based on older NAIC models, should consider adopting a provision similar to IRLMA § 5 (C) (2) or IRMA § 1002 (A). In the alternative, a state could update its definition of a “reciprocal state.” In 2021, the NAIC adopted the Guideline for Definition of Reciprocal State in Receivership Laws (GDL#1985) that defines reciprocal state as any state that has enacted a law setting forth a scheme for receivership.

Ancillary Conservation of Foreign Insurers (IRMA §1001) provides for ancillary conservation of an insurer writing in the state but domiciled in another state, in limited circumstances. Ancillary conservation is relevant to insurers conducting business in multiple jurisdictions, should be coordinated with the domiciliary state, and may require consideration of whether the involved states are reciprocal.

2021 Revisions to the Insurance Holding Company System Model Act and Regulation (#440 & #450)

In 2021, the NAIC adopted receivership revisions to the NAIC Insurance Holding Company System Regulatory Act (#440) and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). The revisions address the continuation of essential services through affiliated agreements with an insurer that is placed into receivership by bringing affiliate service providers deemed “integral” or “essential” to an insurer’s operations under the jurisdiction of the receiver; clarify the ownership of data and records and premiums of the insurer that are held by the affiliate; and, outline provisions that should be included in affiliated management services and cost sharing agreements in the event the insurer is placed into receivership.

The Task Force encourages state insurance departments to consider these Model amendments based on the benefits these revisions add to state regulation, and to the goal of improving efficiencies in receivership and reducing costs to a receivership estate.

Treatment of Workers Compensation Large Deductible Policies

In 2021, the NAIC adopted the Guideline for Administration of Large Deductible Policies in Receivership (GDL#1980) to address the treatment of large deductible policies in receivership. The Guideline makes significant improvements over IRMA §712 Administration of Loss Reimbursement Policies, and the National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Legislation, Administration of Large Deductible Policies and Insured Large Deductible Collateral. The Guideline provides that the guaranty associations, on behalf of the claimants, are entitled to any deductible reimbursements from the policyholder and the right to draw on the collateral. While some states already have existing laws on this topic, states that do not or that wish to update their existing laws, are encouraged to consider Guideline #1980.

2017 Revisions to the Life and Health Insurance Guaranty Association Model Act (#520)

The 2017 amendments to Model #520 aimed to address issues arising in connection with guaranty fund coverage in insolvencies of insurers writing long-term care insurance. While states have made good progress adopting these
amendments with 34 states adopting to date, remaining states are encouraged to consider adoption. Further guidance is available in the Task Force’s 2018 memorandum, which is posted to the NAIC website.¹

For further resources or information about these Model Laws and Guidelines, states may contact NAIC staff, jkoenigsman@naic.org.

The Receiver’s Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force met Nov. 18, 2021. The following Subgroup members participated: Kevin Baldwin, Chair (IL); Toma Wilkerson, Vice Chair (FL); Joe Holloway (CA); Jared Kosky (CT); James Gerber (MI); Leatrice Geckler (NM); Donna Wilson and Jamin Dawes (OK); Laura Lyon Slaymaker and Crystal McDonald (PA); and Brian Riewe (TX).

1. **Adopted its June 14 Minutes**

   The Subgroup met June 14 and took the following action: 1) adopted its May 26 minutes; 2) discussed the drafting group process; and 3) demonstrated the SharePoint Collaboration website to the drafting groups. Mr. Baldwin noted that the minutes from the June meeting were in the meeting materials.

   Mr. Geckler made a motion, seconded by Ms. Wilson, to adopt the Subgroup’s June 14 minutes (*see NAIC Proceedings – Summer 2021, Receivership and Insolvency (E) Task Force, Attachment Two*). The motion passed unanimously.

2. **Exposed Revised Chapter 1 and Chapter 2 of the Receiver’s Handbook**

   Mr. Baldwin thanked the volunteers who had participated in the drafting groups for Chapters 1 and Chapter 2 of the *Receiver’s Handbook for Insurance Company Insolvencies* (Receiver’s Handbook). Chapter 1 had extensive revisions and was presented in the meeting materials as a clean copy. To view the original Receiver’s Handbook, the current Receiver’s Handbook version is posted on the Subgroup’s website under the documents tab. Chapter 2 was presented in the materials as a markup version of the original Receiver’s Handbook chapter. The Subgroup considered public exposure of revised Chapter 1 and Chapter 2 for a 30-day period with all comments to be sent to Sherry Flippo (NAIC).

   Mr. Holloway made a motion, seconded by Ms. Wilkerson, to expose Chapters 1 and Chapter 2 of the Receiver’s Handbook for a 30-day public comment period ending Dec. 20. The motion passed unanimously.

   Having no further business, the Receiver’s Handbook (E) Subgroup adjourned.
REINSURANCE (E) TASK FORCE

Reinsurance (E) Task Force Dec. 13, 2021, Minutes ................................................................. 10-1075
Nov. 11, 2021, Draft ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction
Reinsurers (Attachment One) ........................................................................................................... 10-1077
Sept. 17, 2021, Draft ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction
Reinsurers (Attachment Two) ........................................................................................................... 10-1091
Comment Letters to the Reinsurance (E) Task Force from Karalee C. Morell (Reinsurance Association of
America—RAA) and Thomas M. Dawson (McDermott Will & Emery), Dated Oct. 8, 2021, Regarding
Sept. 17, 2021, Draft ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction
Reinsurers (Attachment Three) ......................................................................................................... 10-1105
Maps Showing Implementation of the 2019 Revisions to the Credit for Reinsurance Model Law (#785) and the
Credit for Reinsurance Model Regulation (#786) as of Dec. 1, 2021 (Attachment Four) .................. 10-1109
Map Showing Implementation of the Term and Universal Life Insurance Reserve Financing Model Regulation
(#787) as of Nov. 30, 2021 (Attachment Five) ............................................................................... 10-1111
Reinsurance (E) Task Force
San Diego, California
December 13, 2021

The Reinsurance (E) Task Force met in San Diego, CA, Dec. 13, 2021. The following Task Force members participated: Chlora Lindley-Myers, Chair, and John Rehagen (MO); Raymond G. Farmer, Vice Chair, represented by Daniel Morris (SC); Lori K. Wing-Heier represented by David Phifer (AK); Jim L. Ridling represented by Sean Duke (AL); Alan McClain, represented by Chris Erwin (AR); Ricardo Lara represented by Virginia Christy and Robert Ridenour (FL); John F. King, represented by Geraldine Farr (GA); Doug Ommen represented by Kim Cross (IA); Dana Popish Severinghaus represented by Susan Berry (IL); Amy L. Beard represented by Roy Eft (IN); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Vicki Lloyd (KY); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by Christopher Joyce (MA); Eric A. Cioppa represented by Robert Wake (ME); Troy Downing, represented by Steve Matthews (MT); Mike Causey represented by Jackie Obusek (NC); Jon Godfread represented by Matt Fischer (ND); Eric Dunning represented by Lindsay Crawford (NE); Chris Nicolopoulos represented by Doug Bartlett (NH); Marlene Caride represented by David Wolf (NJ); Russell Toal, represented by Jennifer Catechis (NM); Adrienne A. Harris represented by Roberto Paradis (NY); Judith L. French represented by Dale Bruggeman (OH); Glen Mulready represented by Eli Snowbarger (OK); Elizabeth Kelleher Dwyer represented by Jack Broccoli (RI); Cassie Brown represented by Jamie Walker (TX); Jonathan T. Pike represented by Jake Garn (UT); Scott A. White represented by Greg Chew and Doug Stolte (VA); and Mark Afable represented by Amy Malm (WI).

1. Adopted its Summer National Meeting Minutes

Mr. Eft made a motion, seconded by Ms. Cross, to adopt the Task Force’s July 27 minutes (see NAIC Proceedings – Summer 2021, Reinsurance (E) Task Force). The motion passed unanimously.


Jake Stultz (NAIC) provided the report of the Reinsurance Financial Analysis (E) Working Group. He stated that the Working Group met in regulator-to-regulator session pursuant to paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings. He stated that the Working Group met Aug. 25 to discuss the comments received by the Reinsurance (E) Task Force on the ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers (ReFAWG Process). He noted that the Working Group then met on Oct. 13 and Nov. 23 to complete the annual certified reinsurer reviews and to approve the first four reciprocal jurisdiction reinsurers for passporting. He stated that the Working Group intends to meet one more time in 2021 to approve several more reciprocal jurisdiction reinsurers for passporting.

Mr. Hudson made a motion, seconded by Mr. Wake, to adopt the Working Group’s report. The motion passed unanimously.

3. Adopted the ReFAWG Process

Mr. Rehagen stated that the ReFAWG Process is based on the Reinsurance Financial Analysis (E) Working Group Procedures Manual (ReFAWG Manual), which is a regulator-only document. He noted that the ReFAWG Manual will be updated to reflect the adoption of the 2019 revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) after the ReFAWG Process has been adopted. Mr. Rehagen noted that the ReFAWG Process was initially exposed on June 17 for a 30-day public comment period and that six comment letters were received. The ReFAWG Process was discussed by the Task Force at the Summer National Meeting and was then exposed on Sept. 17 (Attachment Two), and two comment letters (Attachment Three) were received. The Task Force again exposed the ReFAWG Process on Nov. 11 for a 21-day public comment period, and no public comments were received.

Dan Schelp (NAIC) stated that revisions included in the ReFAWG Process to be adopted today are mostly stylistic in nature. He stated that the provisions in Model #785 and Model #786 align closely with the original provisions of the “Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance” (EU Covered Agreement) and the “Bilateral Agreement Between the United States of America and the United Kingdom on Prudential Measures Regarding Insurance and Reinsurance,” and that the ReFAWG Process was drafted to mirror Model #785 and Model #786. Mr. Schelp noted that NAIC staff had discussions with representatives from the Federal Insurance...
Office (FIO), and that they are supportive of the efforts to provide guidance to both the states and insurers regarding the passporting process. He noted that the Working Group would review and verify if any changes are needed in the Uniform Checklist for Reciprocal Jurisdiction Reinsurers based on the revisions to the ReFAWG Process document or the ReFAWG Manual.

Mr. Hudson made a motion, seconded by Mr. Phifer, to adopt the ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers (Attachment One). The motion passed unanimously.

4. Received a Status Report on the Reinsurance Activities of the Mutual Recognition of Jurisdictions (E) Working Group

Mr. Wake stated that the Working Group met Sept. 22 in regulator-to-regulator session to discuss the Process for Evaluating Jurisdictions that Recognize and Accept the Group Capital Calculation (GCC Process). He stated that the Working Group met Nov. 18 to adopt the GCC Process for consideration by the Financial Condition (E) Committee and to reapprove the status of Bermuda, France, Germany, Ireland, Japan, Switzerland, and the United Kingdom (UK) as qualified jurisdictions and Bermuda, Japan, and Switzerland as reciprocal jurisdictions.

Mr. Wake stated that on May 27, the Mutual Recognition of Jurisdictions (E) Working Group recommended the Republic of Korea be approved as a qualified jurisdiction and that on June 3, the Task Force exposed the Republic of Korea: Final Evaluation Report for a 30-day public comment period. He noted that the Task Force was notified of an ongoing issue with data localization requirements in the Republic of Korea that needed to be remediated before the process can move forward. He stated that at the Summer National Meeting, the Task Force referred this issue back to the Working Group. Mr. Wake stated that a small group of regulators have held calls with the Republic of Korea Financial Supervisory Service (FSS) and the Financial Services Commission (FSC) and with U.S. insurance trade groups to better understand the situation. He said he will provide an update to the Task Force when he has additional information.

5. Received a Status Report on the States’ Implementation of the 2019 Revisions to Model #785 and Model #786

Mr. Stultz stated that as of Dec. 9, 46 U.S. jurisdictions have adopted the 2019 revisions to Model #785, while four jurisdictions have action under consideration. He noted that 25 states have adopted the revisions to Model #786, and 11 jurisdictions currently have action under consideration. He stated that the maps showing the adoption of the 2019 revisions to Model #785 and Model #786 were included in the meeting materials (Attachment Four).

Mr. Stultz stated that the 2019 revisions to the models must be adopted by the states prior to Sept. 1, 2022, which is the date when the FIO must complete its federal preemption reviews under the Covered Agreements. He stated that the Task Force will provide support to the states to meet this deadline. Mr. Stultz recommended that all states and jurisdictions adopt the 2019 revisions to Model #785 and Model #786 as soon as possible and no later than July 1, 2022, in order to give the FIO sufficient time for its federal preemption analysis.

Mr. Stultz stated that the current adoption maps can be found on the Task Force’s web page. He noted that he and Mr. Schelp can answer any technical questions during the legislative process, and Holly Weatherford (NAIC) is working directly with the states on the adoption of the 2019 revisions to Model #785 and Model #786.

6. Received a Status Report on the States’ Implementation of Model #787

Mr. Stultz stated that the Term and Universal Life Insurance Reserve Financing Model Regulation (#787) becomes an accreditation standard on Sept. 1, 2022, with enforcement beginning on Jan. 1, 2023. He noted that as of Nov. 30, eight jurisdictions have adopted Model #787, with another 10 jurisdictions with action under consideration. He stated that the map showing the current adoption status for Model #787 was included in the meeting materials (Attachment Five) and added that the adoption of Model #787 is unrelated to the Covered Agreements and is not potentially subject to federal preemption.

Mr. Stultz noted that Model #787 mirrors Actuarial Guideline XLVIII—Actuarial Opinion and Memorandum Requirements for the Reinsurance of Policies Required to be Valued under Sections 6 and 7 of the NAIC Valuation of Life Insurance Policies Model Regulation (AG 48), and that under the accreditation standards, a state may meet the requirements through an administrative practice, such as an actuarial guideline, and added that if a state adopts Model #787, it also will need to adopt Section 5B(4) of Model #785.

Having no further business, the Reinsurance (E) Task Force adjourned.
ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers

Reinsurance Financial Analysis (E) Working Group
ReFAWG Review Process for Passporting
Certified and Reciprocal Jurisdiction Reinsurers
(“ReFAWG Review Process”)

1. ReFAWG Review Process

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

a. In November 2011, the NAIC adopted revisions to its Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) which reduce the prior reinsurance collateral requirements for non-U.S. licensed reinsurers that are licensed and domiciled in Qualified Jurisdictions and establish a certification process for reinsurers under which a Certified Reinsurer is eligible for collateral reduction with respect to contracts entered into or renewed subsequent to certification. The authority to issue individual ratings of certified reinsurers is reserved to the NAIC member jurisdictions under their respective statutes and regulations. While this forum is intended to strengthen state regulation and prevent regulatory arbitrage, it is not within the authority of the Working Group to assign collateral requirements for individual reinsurers.

b. On June 25, 2019, the NAIC adopted further revisions to the models, which implement the reinsurance collateral provisions of the Covered Agreements with the European Union (EU) and the United Kingdom (UK). The revisions eliminate reinsurance collateral requirements and local presence requirements for EU and UK reinsurers that maintain a minimum amount of own-funds equivalent to $250 million USD and a solvency capital requirement (SCR) of 100% under Solvency II. The revisions also incorporate the “Reciprocal Jurisdiction” concept. Reciprocal Jurisdiction status is afforded to (1) jurisdictions subject to an in-force Covered Agreement within the U.S.; (2) accredited U.S. jurisdictions; and (3) Qualified Jurisdictions if they meet certain requirements in the credit for reinsurance models. ReFAWG has also been given additional responsibilities with respect to these “Reciprocal Jurisdiction Reinsurers.” ReFAWG will coordinate its efforts with the Mutual Recognition of Jurisdictions (E) Working Group (formerly known as the Qualified Jurisdictions (E) Working Group).

c. Issues upon which the Working Group may provide advisory support and assistance include but are not limited to:

i. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for
reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.

ii. Provide a forum for discussion, among NAIC jurisdictions, of reinsurance issues related to specific companies, entities or individuals.

iii. Support, encourage, promote and coordinate multi-state efforts in addressing issues related to certified reinsurers, including but not limited to multi-state recognition of certified reinsurers.

iv. Provide analytical expertise and support to the states with respect to certified reinsurers and applicants for certification.

v. Interact with domiciliary regulators of ceding insurers and certifying states to assist and advise on the most appropriate regulatory strategies, methods and actions with respect to certified reinsurers.

vi. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.

vii. Ensure the public passporting website remains current.

viii. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective approaches for the financial solvency surveillance to assist the states in their work to protect the interests of policyholders.

2. **Lead States and Passporting Process**

a. A reinsurer seeking recognition as either a Certified Reinsurer or a Reciprocal Jurisdiction Reinsurer must submit certain information to each state in which it seeks such recognition. A reinsurer may decide to make a filing with a Lead State and use the NAIC Passporting process to facilitate multi-state recognition or a reinsurer may decide to submit the information to each state as a separate application. Under the ReFAWG Review Process, ReFAWG will assist the states with the initial review of this information and provide guidance to the states in making their review of the reinsurer to determine whether it has met the regulatory requirements to be recognized as a Certified Reinsurer and/or a Reciprocal Jurisdiction Reinsurer.

b. **Passporting for Certified Reinsurers** - In addition to this assistance to individual states, ReFAWG will also assist with a passporting process for the states. “Passporting” refers to the process under which a state has the discretion to defer to the certification of a reinsurer (and the rating assigned to that certified reinsurer) by another state. Under this process, a reinsurer will apply to an initial state for certification, referred to as the “Lead State,” which will begin its analysis of the reinsurer and notify ReFAWG of the application. The Lead State will complete its initial analysis and will submit filing information and other documentation to ReFAWG for a peer review. Upon completion of the confidential peer review process, ReFAWG will make its recommendation concerning both the certified status of the reinsurer and its rating. The Lead State then makes the final determination regarding certification, upon which the Lead State notifies ReFAWG and the certified reinsurer is eligible to apply for passporting into other states. States are encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings.
c. **Passporting for Reciprocal Jurisdiction Reinsurers** - A similar Passporting Process is in place with respect to Reciprocal Jurisdiction Reinsurers as outlined in Sections 5 and 6 below. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination with respect to compliance with this section. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings.

d. **Discretion to Defer to Lead State** - If an NAIC accredited jurisdiction has determined that the conditions set forth for recognition as a Reciprocal Jurisdiction Reinsurer have been met, the commissioner of any other state has the discretion to defer to that jurisdiction’s determination and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit. The commissioner may accept financial documentation filed with the Lead State or with the NAIC and is encouraged to support a uniform submission and approval process among the states of the NAIC. ReFAWG and the Mutual Recognition of Jurisdictions (E) Working Group will coordinate efforts to obtain and disseminate to the states financial information regarding both Certified Reinsurers and Reciprocal Jurisdiction Reinsurers and disseminate it to the states.

e. **Communication with ReFAWG** - The ReFAWG Review Process is designed to facilitate communication of relevant information with respect to individual reinsurers or reinsurance related issues by allowing interested state insurance regulators the opportunity to monitor the ReFAWG meetings and discussion. It should be noted that the process for engaging ReFAWG in the consideration of an application is intended to be flexible. Specific circumstances may necessitate discussion between ReFAWG and any states that have received any application in order to determine an appropriate lead state on a case-by-case basis.

f. **Change of Lead State** - The Lead State for a Certified Reinsurer and/or a Reciprocal Jurisdiction Reinsurer may change based upon mutual agreement between the current lead state and any other state where the reinsurer is recognized or certified, with input to be provided by ReFAWG. Upon a change in lead state, NAIC staff will provide timely notification to all states. In order to facilitate a change of lead state from one state to another, both states should discuss the rationale for the change during a regulator-only ReFAWG meeting. NAIC Staff will update the lead state and note such change on NAIC systems and send notice to ReFAWG and interested regulators.

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

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

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

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

a. **Qualified Jurisdiction** - The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction. The applicant must be in good standing and provide a copy of the certificate of authority or license to transact insurance and/or reinsurance business.

b. **Capital and Surplus** - The assuming insurer must maintain capital and surplus of no less than $250,000,000 as reported within its audited financial statement. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

c. **Financial Strength Ratings** - The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. The applicant must provide the rating agency report. If the rating is a group rating, the rationale for the group rating must be provided. Initial or Affirmed financial strength rating dates must be within 15 months of the application date/renewal filing date. Acceptable rating agencies include: A.M. Best, Fitch Ratings, Moody’s, Standard & Poor’s or any other Nationally Recognized Statistical Rating Organization by the SEC. *Kroll is not recognized as an acceptable rating organization in Model #786 but has been recognized as an acceptable rating organization by the Reinsurance (E) Task Force.*

d. The following table outlines the necessary ratings needed to meet a secure level:
### Ratings Collateral Required A.M. Best Standard & Poor’s Moody’s Fitch Kroll

| Secure – 1 | 0% | A++ | AAA | Aaa | AAA | AAA |
| Secure – 2 | 10% | A+ | AA+, AA, AA- | Aa1, Aa2, Aa3 | AA+, AA, AA- | AA+, AA, AA- |
| Secure – 3 | 20% | A | A+, A | A1, A2 | A+, A | A+, A |
| Secure – 4 | 50% | A- | A- | A3 | A- | A- |
| Secure – 5 | 75% | B++, B+ | BBB+, BBB, BBB- | Baa1, Baa2, Baa3 | BBB+, BBB, BBB- | BBB+, BBB, BBB- |

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

i. For reasons set forth in the rating agency report or its published ratings standards or guidelines, the rating agency utilizes the group rating as a consequence of finding that the company had sufficient interconnectivity with the group;

ii. For reasons set forth in the rating agency report or its published ratings standards or guidelines, the rating agency enhances the group rating due to the subsidiary’s potential benefit of capital support from one or more affiliated companies;

iii. The group rating was utilized because the subsidiary derives benefit from its inclusion within a financially strong and well-capitalized insurance group;

iv. The lead state has contacted the rating agency and was provided a written explanation for the use of the group rating;
v. Other factors deemed appropriate by the Reinsurance Financial Analysis (E) Working Group; or

vi. To assist the Lead State in the assessment of the appropriateness of the use of a group rating, applicants are encouraged to provide their rational for the use of a group rating.

f. Changes in Ratings

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

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

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

g. Schedule F/S (Ceded Reinsurance) – Applicants domiciled in the U.S. must provide the most recent NAIC Annual Statement Blank Schedule F (property/casualty) and/or Schedule S (life and health). Applicants domiciled outside the U.S. must provide Form CR-F (property/casualty) and/or Form CR-S (life and health), completed in accordance with the instructions.
h. **Disputed and/or Overdue Reinsurance Claims** - The applicant must provide a detailed explanation regarding reinsurance obligations to U.S. cedents that are in dispute and/or more than 90 days past due that exceed 5% of its total reinsurance obligations to U.S. cedents as of the end of its prior financial reporting year or reinsurance obligations to any of the top 10 U.S. cedents (based on the amount of outstanding reinsurance obligations as of the end of its prior financial reporting year) that are in dispute and/or more than 90 days past due exceed 10% of its reinsurance obligations to that U.S. cedent. The applicant must then provide a description of its business practices in dealing with U.S. ceding insurers and a statement that the applicant commits to comply with all contractual requirements applicable to reinsurance contracts with U.S. ceding insurers.

i. **Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer** - The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. Use of multi-beneficiary trust must include: (1) approval from the domiciliary regulator; (2) the form of the trust that will be used as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant’s certified reinsurer status (if applicable).

j. **Regulatory Actions** – The applicant must provide a description of any regulatory actions taken against the applicant. Include details on all regulatory actions, fines, and penalties. Further, a description of any changes in with respect to the provisions of the applicant’s domiciliary license should be provided.

k. **Audited Financial Report and Actuarial Opinion** – As filed with its non-U.S. jurisdiction supervisor, with a translation into English, the applicant must file audited financial statement for the current and prior year and an actuarial opinion (must be stand-alone, or the functional equivalent under the Supervisor’s applicable Actuarial Function Holder Regime).

l. **Solvent Schemes of Arrangement** - The applicant must provide a description of any past, present, or proposed future participation in any solvent scheme of arrangement, or similar procedure, involving U.S. ceding insurers.

m. **Form CR-1** - The applicant must provide a state lead state specific Form CR-1, which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form.

n. **Other Requirements** - The applicant must commit to comply with other reasonable requirements deemed necessary for certification by the certifying state. Further, the applicant must provide a statement that it agrees to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.

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

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

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

a. **Qualified Jurisdiction** - The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction.

b. **Verification of Certification Issued by an NAIC Accredited Jurisdiction** – The applicant must provide a copy of the approval letter or other documentation provided to the applicant by the NAIC accredited jurisdiction. The letter should include the state, rating and collateral percentage assigned, effective date, lines of business, and the applicant’s statement on compliance. ReFAWG may also verify a certification issued by an NAIC accredited jurisdiction through its internal processes.

c. **Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer** - The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. Use of multi-beneficiary trust must include: (1) approval from the domiciliary regulator; (2) the form of the trust that will be used as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant’s certified reinsurer status (if applicable).

d. **Form CR-1** - The applicant must provide a state lead state specific Form CR-1, which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form.

e. **Other Requirements** - The applicant must commit to comply with other reasonable requirements deemed necessary for certification by the certifying state. Further, they must provide a statement that they agree to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.

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

**Annual Verification of Minimum Standards:**

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

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

a. **Status of Reciprocal Jurisdiction** - The assuming insurer must be licensed to write reinsurance by, and have its head office or be domiciled in, a Reciprocal Jurisdiction that is listed on the *NAIC List of Reciprocal Jurisdictions*. A “Reciprocal Jurisdiction” is a jurisdiction, as designated by the commissioner, that meets one of the following: (1) a non-U.S. jurisdiction that is subject to an in-force Covered Agreement with the United States; (2) a U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Standards and Accreditation Program; or (3) a Qualified Jurisdiction that has been determined by the commissioner to meet all applicable requirements to be a Reciprocal Jurisdiction. The Reciprocal Jurisdiction Reinsurer should identify which type of jurisdiction it is domiciled in and provide any documentation to confirm this status if requested by the commissioner.

b. **Minimum Capital and Surplus** - The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction: no less than $250,000,000 (USD); or if the assuming insurer is an association, including incorporated and individual unincorporated underwriters: minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least $250,000,000 (USD); and a central fund containing a balance of the equivalent of at least $250,000,000 (USD). The assuming insurer’s supervisory authority must confirm to the Lead State commissioner on an annual basis according to the methodology of its domiciliary jurisdiction that the assuming insurer satisfies this requirement. The Mutual Recognition of Jurisdictions (E) Working Group will coordinate the confirmations of the domiciliary jurisdictions with ReFAWG with respect to individual Reciprocal Jurisdiction Reinsurers.
c. **Minimum Solvency or Capital Ratio** - The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio: The ratio specified in the applicable in-force Covered Agreement where the assuming insurer has its head office or is domiciled; or if the assuming insurer is domiciled in an accredited state, a risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, calculated in accordance with the formula developed by the NAIC; or if the assuming insurer is domiciled in a Reciprocal Jurisdiction that is a Qualified Jurisdiction, such solvency or capital ratio as the commissioner determines to be an effective measure of solvency. The assuming insurer’s supervisory authority must confirm to the Lead State commissioner on an annual basis that the assuming insurer complies with this requirement. The Mutual Recognition of Jurisdictions (E) Working Group will coordinate the confirmations of the domiciliary jurisdictions with ReFAWG with respect to individual Reciprocal Jurisdiction Reinsurers.

d. **Form RJ-1** - The assuming insurer must provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.

e. **Audited Financial Report** - The assuming insurer’s annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report as provided under Section 9C(5)(a) of Model #786.

f. **Solvency and Financial Condition Report or Actuarial Opinion** – The applicant must submit a solvency and financial condition report or actuarial opinion, if filed with the assuming insurer’s supervisor as provided under Section 9C(5)(b) of Model #786.

g. **Overdue Reinsurance Claims** – The applicant must submit a list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States as provided under Section 9C(5)(c) of Model #786. The commissioner shall request the reinsurer to provide the information required to demonstrate the reinsurer’s practice of prompt payment of claims under its reinsurance agreements prior to entry into a reinsurance agreement, and annually thereafter, in order to demonstrate compliance with Section 9C(6) of Model #786.

h. **Assumed and Ceded Reinsurance Schedules** – The applicant must submit information regarding the assuming insurer’s assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer as provided under Section 9C(5)(d) of Model #786. Applicants domiciled in the U.S. must provide the most recent NAIC Annual Statement Blank Schedule F (property/casualty) and/or Schedule S (life and health). Applicants domiciled outside the U.S. may provide this information using Form CR-F (property/casualty) and/or Form CR-S (life and health), which ReFAWG considers sufficient to meet this requirement. Alternatively, information as outlined in paragraph 3.h of the ReFAWG Review Process regarding the U.S. cedents of Reciprocal Jurisdiction Reinsurers that is voluntarily submitted may also be accepted by states. If the commissioner has reason to believe the reinsurer has material unpaid claims outside of the U.S., the commissioner may request the reinsurer to
provide the information required to demonstrate the reinsurer’s practice of prompt payment of claims under its reinsurance agreements.

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

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

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

a. **Form RJ-1** - The assuming insurer must provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.

b. **Verification of Determination Issued by an NAIC Accredited Jurisdiction** – The applicant must provide a copy of the approval letter or other documentation provided to the applicant by the NAIC accredited jurisdiction. The letter should include the state, effective date, and lines of business.

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

The reinsurer will file this information with the initial reviewing state and such Lead State will submit the information to ReFAWG in accordance with the applicable information sharing process. This submission by the Lead State will also facilitate other states’ access to the information. NAIC staff shall prepare a report for review by ReFAWG intended to provide information regarding whether the Lead State’s submission meets the requirements of the ReFAWG Review Process, and to determine whether there are any deficiencies in the application. This report will be considered confidential but may be made available to states through the NAIC’s information sharing process.
NAIC Staff under the direction of ReFAWG will assist in the review of the filings and in monitoring the ongoing condition of the reinsurers. If during the review process or during an interim period ReFAWG determines that a reinsurer’s assigned rating or status may warrant reconsideration, notice will be sent to the Lead State. The specific issues identified will be presented for discussion during the next ReFAWG meeting.

8. Process for Ongoing Monitoring of Reinsurers

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

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

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

10. Interaction Between Certified Reinsurers and Reciprocal Jurisdiction Reinsurers Status

a. Under Section 8A(5) Model #786, credit for reinsurance shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer with respect to Certified Reinsurers. Under Section 2F(7) of the Credit for Reinsurance Model Law (#785), credit shall be taken with respect to Reciprocal Jurisdiction Reinsurers only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements to be designated a Reciprocal Jurisdiction Reinsurer, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.

b. It is expected that certain assuming insurers may be considered to be Certified Reinsurers for purposes of in-force business or business with existing liabilities and Reciprocal Jurisdiction Reinsurers with respect to reinsurance agreements entered into, amended, or renewed on or after the effective date. In addition, these same reinsurers may also have certain blocks of business that are fully collateralized under the prior provisions of Model #785 and Model #786. The NAIC Blanks have been amended to reflect the status of these reinsurers with respect to each type of insurance assumed.

c. With respect to those reinsurers that are currently Certified Reinsurers but are seeking recognition by ReFAWG as Reciprocal Jurisdiction Reinsurers for passporting purposes, the same process as
outlined in paragraphs 3-6 of this ReFAWG Review Process must be followed. A Form RJ-1 must be filed with each state in which the reinsurer seeks recognition as a Reciprocal Jurisdiction Reinsurer, and the reinsurer must meet all other applicable requirements. However, states may share this information with other states through the NAIC and the ReFAWG Review Process, and previously filed information used in the review of the reinsurer as a Certified Reinsurer may also be utilized in its review as a Reciprocal Jurisdiction Reinsurer. For example, a Reciprocal Jurisdiction Reinsurer may cross reference information/documentation that has been filed with respect to its status as a Certified Reinsurer, so that it is not necessary to file duplicative documents. ReFAWG will take full advantage of the passporting process, with the intent of reducing the amount of documentation filed with the states and reduce duplicate filings.

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

11. Commissioner Shall Create and Publish Lists

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

Reinsurance Financial Analysis (E) Working Group
ReFAWG Review Process for Passorting
Certified and Reciprocal Jurisdiction Reinsurers
(“ReFAWG Review Process”)

1. ReFAWG Review Process

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

a. In November 2011, the NAIC adopted revisions to its Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) which reduce the prior reinsurance collateral requirements for non-U.S. licensed reinsurers that are licensed and domiciled in Qualified Jurisdictions and establish a certification process for reinsurers under which a Certified Reinsurer is eligible for collateral reduction with respect to contracts entered into or renewed subsequent to certification. The authority to issue individual ratings of certified reinsurers is reserved to the NAIC member jurisdictions under their respective statutes and regulations. While this forum is intended to strengthen state regulation and prevent regulatory arbitrage, it is not within the authority of the Working Group to assign collateral requirements for individual reinsurers.

b. On June 25, 2019, the NAIC adopted further revisions to the models, which implement the reinsurance collateral provisions of the Covered Agreements with the European Union (EU) and the United Kingdom (UK). These revisions create a new type of jurisdiction, which is called a Reciprocal Jurisdiction and eliminates reinsurance collateral requirements and local presence requirements for EU and UK reinsurers that maintain a minimum amount of own-funds equivalent to $250 million USD and a solvency capital requirement (SCR) of 100% under Solvency II. The revisions also provide incorporate the “Reciprocal Jurisdiction” concept. Reciprocal Jurisdiction status is afforded to (1) jurisdictions subject to an in-force Covered Agreement within the U.S.; (2) accredited U.S. jurisdictions; and (3) Qualified Jurisdictions if they meet certain requirements in the credit for reinsurance models. ReFAWG has also been given additional responsibilities with respect to these “Reciprocal Jurisdiction Reinsurers.” ReFAWG will coordinate its efforts with the Mutual Recognition of Jurisdictions (E) Working Group (formerly known as the Qualified Jurisdictions (E) Working Group).

c. Issues upon which the Working Group may provide advisory support and assistance include but are not limited to:
i. Provide advisory support and assistance to states in the review of reinsurance collateral reduction applications. Such a process with respect to the review of applications for reinsurance collateral reduction and qualified jurisdictions should strengthen state regulation and prevent regulatory arbitrage.

ii. Provide a forum for discussion, among NAIC jurisdictions, of reinsurance issues related to specific companies, entities or individuals.

iii. Support, encourage, promote and coordinate multi-state efforts in addressing issues related to certified reinsurers, including but not limited to multi-state recognition of certified reinsurers.

iv. Provide analytical expertise and support to the states with respect to certified reinsurers and applicants for certification.

v. Interact with domiciliary regulators of ceding insurers and certifying states to assist and advise on the most appropriate regulatory strategies, methods and actions with respect to certified reinsurers.

vi. Provide advisory support with respect to issues related to the determination of qualified jurisdictions.

vii. Ensure the public passporting website remains current.

viii. For reinsurers domiciled in Reciprocal Jurisdictions, determine the best and most effective approaches for the financial solvency surveillance to assist the states in their work to protect the interests of policyholders.

2. **Lead States and Passporting Process**

a. A reinsurer seeking recognition as either a Certified Reinsurer or a Reciprocal Jurisdiction Reinsurer must submit certain information to each state in which it seeks such recognition. A reinsurer may decide to make a filing with a Lead State and use the NAIC Passporting process to facilitate multi-state recognition or a reinsurer may decide to submit the information to each state as a separate application. Under the ReFAWG Review Process, ReFAWG will assist the states with the initial review of this information and provide guidance to the states in making their review of the reinsurer to determine whether it has met the regulatory requirements to be recognized as a Certified Reinsurer and/or a Reciprocal Jurisdiction Reinsurer.

b. **Certified Reinsurers** - In addition to this assistance to individual states, ReFAWG will also assist with a passporting process for the states. “Passporting” refers to the process under which a state has the discretion to defer to the certification of a reinsurer (and the rating assigned to that certified reinsurer) by another state. Under this process, a reinsurer will apply to an initial state for certification, referred to as the “Lead State,” which will begin its analysis of the reinsurer and notify ReFAWG of the application. The Lead State will complete its initial analysis and will submit filing information and other documentation to ReFAWG for a peer review. Upon completion of the confidential peer review process, ReFAWG will make its recommendation concerning both the certified status of the reinsurer and its rating. The Lead State then makes the final determination regarding certification, upon which the Lead State notifies ReFAWG and the certified reinsurer is eligible to apply for passporting into other states.
c. **Reciprocal Jurisdiction Reinsurers** - A similar Passporting Process is in place with respect to Reciprocal Jurisdiction Reinsurers. In order to facilitate multi-state recognition of assuming insurers and to encourage uniformity among the states, the NAIC has initiated a process called “passporting” under which the commissioner has the discretion to defer to another state’s determination with respect to compliance with this section. Passporting is based upon individual state regulatory authority, and states are encouraged to act in a uniform manner in order to facilitate the passporting process. States are also encouraged to utilize the passporting process to reduce the amount of documentation filed with the states and reduce duplicate filings.

d. If an NAIC accredited jurisdiction has determined that the conditions set forth for recognition as a Reciprocal Jurisdiction Reinsurer have been met, the commissioner of any other state has the discretion to defer to that jurisdiction’s determination and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit. The commissioner may accept financial documentation filed with the Lead State or with the NAIC and is encouraged to support a uniform submission and approval process among the states of the NAIC. ReFAWG and the Mutual Recognition of Jurisdictions (E) Working Group will coordinate efforts to obtain and disseminate to the states financial information regarding both Certified Reinsurers and Reciprocal Jurisdiction Reinsurers.

e. The ReFAWG Review Process is designed to facilitate communication of relevant information with respect to individual reinsurers or reinsurance related issues by allowing interested state insurance regulators the opportunity to monitor the ReFAWG meetings and discussion. It should be noted that the process for engaging ReFAWG in the consideration of an application is intended to be flexible. Specific circumstances may necessitate discussion between ReFAWG and any states that have received any application in order to determine an appropriate lead state on a case-by-case basis.

f. **Change of Lead State** - The Lead State may change based upon mutual agreement between the current lead state and any other state where the reinsurer is certified, with input to be provided by ReFAWG. Upon a change in lead state, NAIC staff will provide timely notification to all states. In order to facilitate a change of lead state from one state to another, both states should discuss the rationale for the change during a regulator-only ReFAWG meeting. NAIC Staff will update the lead state and note such change on NAIC systems and send notice to ReFAWG and interested regulators.

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

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

The following provide a timeline for filings:

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

a. **Qualified Jurisdiction** - The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction. The applicant must be in good standing and provide a copy of the certificate of authority or license to transact insurance and/or reinsurance business.

b. **Capital and Surplus** - The assuming insurer must maintain capital and surplus of no less than $250,000,000 as reported within its audited financial statement. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

c. **Financial Strength Ratings** - The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. The applicant must provide the rating agency report. If the rating is a group rating, the rationale for the group rating must be provided. Initial or Affirmed financial strength rating dates must be within 15 months of the application date/renewal filing date. Acceptable rating agencies include: A.M. Best, Fitch Ratings, Moody’s, Standard & Poor’s or any other Nationally Recognized Statistical Rating Organization by the SEC. *Kroll is not recognized as an acceptable rating organization in Model #786 but has been recognized as an acceptable rating organization by the Reinsurance (E) Task Force.*

d. The following table outlines the necessary ratings needed to meet a secure level:
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<thead>
<tr>
<th>Ratings</th>
<th>Collateral Required</th>
<th>A.M. Best</th>
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<th>Fitch</th>
<th>Kroll</th>
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<td>A-</td>
<td>A3</td>
<td>A-</td>
<td>A-</td>
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<td>BBB+, BBB, BBB-</td>
<td>BBB+, BBB, BBB-</td>
</tr>
</tbody>
</table>

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

i. For reasons set forth in the rating agency report or its published ratings standards or guidelines, the rating agency utilizes the group rating as a consequence of finding that the company had sufficient interconnectivity with the group;

ii. For reasons set forth in the rating agency report or its published ratings standards or guidelines, the rating agency enhances the group rating due to the subsidiary’s potential benefit of capital support from one or more affiliated companies;

iii. The group rating was utilized because the subsidiary derives benefit from its inclusion within a financially strong and well-capitalized insurance group;

iv. The lead state has contacted the rating agency and was provided a written explanation for the use of the group rating;
v. Other factors deemed appropriate by the Reinsurance Financial Analysis (E) Working Group; or

vi. To assist the Lead State in the assessment of the appropriateness of the use of a group rating, applicants are encouraged to provide their rational for the use of a group rating.

f. Changes in Ratings

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

Changes requiring action by a certifying state in accordance with statute and/or regulation may include but are not limited to: deterioration in financial condition; downgrade in a financial strength rating; change in the status of its domiciliary license; change in the qualification status of its domestic jurisdiction; and the triggering of certain thresholds with respect to reinsurance obligations to U.S. ceding insurers that are past due (in accordance with Section 8(B) of Model #786). While such changes may require action under statute or regulation, the ReFAWG process is intended to facilitate communication and coordination with respect to the date upon which changes in a certified reinsurer’s rating/status are effective, as well as discussion of any other relevant issues. As part of the ongoing review process, other information may come to the attention of a certifying state and/or ReFAWG that warrants consideration with respect to a certified reinsurer’s rating/status. While ReFAWG cannot require a state to delay any action with respect to a certified reinsurer’s rating/status, certifying states are strongly encouraged to notify ReFAWG prior to taking any related action, as the ReFAWG process will serve to provide a proactive regulatory mechanism for communication of such information, discussion among regulators with respect to changes being considered on the basis of subjective rating criteria, and possible coordination of applicable effective dates if such changes are enacted. Upon receipt of any such information, ReFAWG will send notification to the NAIC Chief Financial Regulators listing and may coordinate an interim meeting as deemed appropriate in order to discuss the issue(s).

g. Schedule F/S (Ceded Reinsurance) – Applicants domiciled in the U.S. must provide the most recent NAIC Annual Statement Blank Schedule F (property/casualty) and/or Schedule S (life and health). Applicants domiciled outside the U.S. must provide Form CR-F (property/casualty) and/or Form CR-S (life and health), completed in accordance with the instructions.
h. **Disputed and/or Overdue Reinsurance Claims** - The applicant must provide a detailed explanation regarding reinsurance obligations to U.S. cedents that are in dispute and/or more than 90 days past due that exceed 5% of its total reinsurance obligations to U.S. cedents as of the end of its prior financial reporting year or reinsurance obligations to any of the top 10 U.S. cedents (based on the amount of outstanding reinsurance obligations as of the end of its prior financial reporting year) that are in dispute and/or more than 90 days past due exceed 10% of its reinsurance obligations to that U.S. cedent. The applicant must then provide a description of its business practices in dealing with U.S. ceding insurers and a statement that the applicant commits to comply with all contractual requirements applicable to reinsurance contracts with U.S. ceding insurers.

i. **Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer** - The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. Use of multi-beneficiary trust must include: (1) approval from the domiciliary regulator; (2) the form of the trust that will be used as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant’s certified reinsurer status (if applicable).

j. **Regulatory Actions** – The applicant must provide a description of any regulatory actions taken against the applicant. Include details on all regulatory actions, fines, and penalties. Further, a description of any changes in with respect to the provisions of the applicant’s domiciliary license should be provided.

k. **Audited Financial Report and Actuarial Opinion** – As filed with its non-U.S. jurisdiction supervisor, with a translation into English, the applicant must file audited financial statement for the current and prior year and an actuarial opinion (must be stand-alone, or the functional equivalent under the Supervisor’s applicable Actuarial Function Holder Regime).

l. **Solvent Schemes of Arrangement** - The applicant must provide a description of any past, present, or proposed future participation in any solvent scheme of arrangement, or similar procedure, involving U.S. ceding insurers.

m. **Form CR-1** - The applicant must provide a state lead state specific Form CR-1, which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form.

n. **Other Requirements** - The applicant must commit to comply with other reasonable requirements deemed necessary for certification by the certifying state. Further, the applicant must provide a statement that it agrees to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.

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

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

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

a. **Qualified Jurisdiction** - The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction.

b. **Verification of Certification Issued by an NAIC Accredited Jurisdiction** – The applicant must provide a copy of the approval letter or other documentation provided to the applicant by the NAIC accredited jurisdiction. The letter should include the state, rating and collateral percentage assigned, effective date, lines of business, and the applicant’s statement on compliance. ReFAWG may also verify a certification issued by an NAIC accredited jurisdiction through its internal processes.

c. **Mechanisms Used to Secure Obligations Incurred as a Certified Reinsurer** - The applicant must specify the mechanisms it will use to secure obligations incurred as a Certified Reinsurer. Use of multi-beneficiary trust must include: (1) approval from the domiciliary regulator; (2) the form of the trust that will be used as a certified reinsurer; and (3) the form of the trust that will be used to secure obligations incurred outside of the applicant’s certified reinsurer status (if applicable).

d. **Form CR-1** - The applicant must provide a state lead state specific Form CR-1, which must be properly executed by an officer authorized to bind the applicant to the commitments set forth in the form.

e. **Other Requirements** - The applicant must commit to comply with other reasonable requirements deemed necessary for certification by the certifying state. Further, they must provide a statement that they agree to post 100% security upon the entry of an order of rehabilitation or conservation against the ceding insurer or its estate.

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

### Annual Verification of Minimum Standards:

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

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

a. **Status of Reciprocal Jurisdiction** - The assuming insurer must be licensed to write reinsurance by, and have its head office or be domiciled in, a Reciprocal Jurisdiction that is listed on the NAIC List of Reciprocal Jurisdictions. A “Reciprocal Jurisdiction” is a jurisdiction, as designated by the commissioner, that meets one of the following: (1) a non-U.S. jurisdiction that is subject to an in-force Covered Agreement with the United States; (2) a U.S. jurisdiction that meets the requirements for accreditation under the NAIC Financial Standards and Accreditation Program; or (3) a Qualified Jurisdiction that has been determined by the commissioner to meet all applicable requirements to be a Reciprocal Jurisdiction. The Reciprocal Jurisdiction Reinsurer should identify which type of jurisdiction it is domiciled in and provide any documentation to confirm this status if requested by the commissioner.

b. **Minimum Capital and Surplus** - The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction: no less than $250,000,000 (USD); or if the assuming insurer is an association, including incorporated and individual unincorporated underwriters: minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least $250,000,000 (USD); and a central fund containing a balance of the equivalent of at least $250,000,000 (USD). The assuming insurer’s supervisory authority must confirm to the Lead State commissioner on an annual basis according to the methodology of its domiciliary jurisdiction that the assuming insurer complies with satisfies this requirement. The Mutual Recognition of Jurisdictions (E) Working Group will coordinate the confirmations of the domiciliary jurisdictions with ReFAWG with respect to individual Reciprocal Jurisdiction Reinsurers.
c. **Minimum Solvency or Capital Ratio** - The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio. The ratio specified in the applicable in-force Covered Agreement where the assuming insurer has its head office or is domiciled; or if the assuming insurer is domiciled in an accredited state, a risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, calculated in accordance with the formula developed by the NAIC; or if the assuming insurer is domiciled in a Reciprocal Jurisdiction that is a Qualified Jurisdiction, such solvency or capital ratio as the commissioner determines to be an effective measure of solvency. The assuming insurer’s supervisory authority must confirm to the Lead State commissioner on an annual basis that the assuming insurer complies with this requirement. The Mutual Recognition of Jurisdictions (E) Working Group will coordinate the confirmations of the domiciliary jurisdictions with ReFAWG with respect to individual Reciprocal Jurisdiction Reinsurers.

d. **Form RJ-1** - The assuming insurer must agree to and provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.

e. **Audited Financial Report** - The assuming insurer’s annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report as provided under Section 9C(5)(a) of Model #786.

f. **Solvency and Financial Condition Report or Actuarial Opinion** – The applicant must submit a solvency and financial condition report or actuarial opinion, if filed with the assuming insurer’s supervisor as provided under Section 9C(5)(b) of Model #786.

g. **Overdue Reinsurance Claims** – The applicant must submit a list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States as provided under Section 9C(5)(c) of Model #786.

h. **Assumed and Ceded Reinsurance Schedules** – The applicant must submit information regarding the assuming insurer’s assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer as provided under Section 9C(5)(d) of Model #786. Applicants domiciled in the U.S. must provide the most recent NAIC Annual Statement Blank Schedule F (property/casualty) and/or Schedule S (life and health). Applicants domiciled outside the U.S. may provide this information using Form CR-F (property/casualty) and/or Form CR-S (life and health), which ReFAWG considers sufficient to meet this requirement. **This is for purposes of evaluating Prompt Payment of Claims. Alternatively, information as outlined in paragraph 3.h of the ReFAWG Review Process regarding the U.S. cedents of Reciprocal Jurisdiction Reinsurers that is voluntarily submitted may also be accepted by states. If the commissioner has reason to believe the reinsurer has material unpaid claims outside of the U.S., the commissioner may request the reinsurer to provide the information required to demonstrate the reinsurer’s practice of prompt payment of claims under its reinsurance agreements.**
i. **Prompt Payment of Claims** - The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met: (1) more than fifteen percent (15%) of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the commissioner; (2) more than fifteen percent (15%) of the assuming insurer’s ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer $100,000, or as otherwise specified in a Covered Agreement; or (3) the aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds $50,000,000, or as otherwise specified in a Covered Agreement.

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

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

a. **Form RJ-1** - The assuming insurer must agree to and provide a signed Form RJ-1, which must be properly executed by an officer of the assuming insurer.

b. **Verification of Determination Issued by an NAIC Accredited Jurisdiction** – The applicant must provide a copy of the approval letter or other documentation provided to the applicant by the NAIC accredited jurisdiction. The letter should include the state, effective date, and lines of business.

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

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

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

Certified and Reciprocal Jurisdiction Reinsurers are required to file specific information to a certifying state on an ongoing basis. NAIC Staff and ReFAWG will review this information in an effort to assist states with the ongoing monitoring of the reinsurers. **Subject to applicable state law, all non-public information submitted by reinsurers shall be kept confidential and regulator only.** which is not otherwise public information subject to disclosure shall be exempted from disclosure under the state’s law equivalent of its Freedom of Information Act and shall be withheld from public disclosure.

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

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

10. **Interaction Between Certified Reinsurers and Reciprocal Jurisdiction Reinsurers**

   a. Under Section 8A(5) Model #786, credit for reinsurance shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer with respect to Certified Reinsurers. Under Section 2F(7) of the **Credit for Reinsurance Model Law (#785)**, credit shall be taken with respect to Reciprocal Jurisdiction Reinsurers only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements to be designated a Reciprocal Jurisdiction Reinsurer, and (ii) the effective date of the new reinsurance agreement, amendment, or renewal.

   b. It is expected that certain assuming insurers may be considered to be Certified Reinsurers for purposes of in-force business **or business with existing liabilities** and Reciprocal Jurisdiction Reinsurers with respect to reinsurance agreements entered into, amended, or renewed on or after the effective date. In addition, these same reinsurers may also have certain blocks of business that are fully collateralized under the prior provisions of Model #785 and Model #786. The NAIC Blanks will be amended to reflect the status of these reinsurers with respect to each type of insurance assumed.

   c. With respect to those reinsurers that are currently Certified Reinsurers but are seeking recognition by ReFAWG as Reciprocal Jurisdiction Reinsurers for passporting purposes, the same process as outlined in paragraphs 3-6 of this ReFAWG Review Process must be followed. A Form RJ-1 must be filed with each state in which the reinsurer seeks recognition as a Reciprocal Jurisdiction Reinsurer, and the reinsurer must meet all other applicable requirements. However, states may share this information with other states through the NAIC and the ReFAWG Review Process, and previously filed information used in the review of the reinsurer as a Certified Reinsurer may also...
be utilized in its review as a Reciprocal Jurisdiction Reinsurer. For example, a Reciprocal Jurisdiction Reinsurer may cross reference information/documentation that has been filed with respect to its status as a Certified Reinsurer, so that it is not necessary to file duplicative documents. ReFAWG will take full advantage of the passporting process, with the intent of reducing the amount of documentation filed with the states and reduce duplicate filings.

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

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

Section 2E(3) of Model #785 and Section 8C(1) of Model #786 require the commissioner to publish a list of Qualified Jurisdictions, while Section 2E(4) of Model #785 and Section 8B(2) of Model #786 require the commissioner to publish a list of all Certified Reinsurers and their ratings. Section 2F(2) & (3) of Model #785 and Section 9D and E of Model #786 require the commissioner to (a) timely create and publish a list of Reciprocal Jurisdictions; and (b) timely create and publish a list of Reciprocal Jurisdiction Reinsurers. It is expected that the commissioner will publish these respective lists on the insurance department’s website, along with special instructions or other guidance as to how Certified Reinsurers and Reciprocal Jurisdiction Reinsurers may meet the applicable filing requirements under the models. There currently are no specific requirements as to the format in which these lists must be published, but ReFAWG and NAIC staff will assist the states with questions on the publication of these lists. In addition, ReFAWG will maintain links on its NAIC webpage to the lists published on the insurance departments’ webpages.
October 8, 2021

VIA ELECTRONIC MAIL

Mr. Jake Stultz  
Senior Accounting and Reinsurance Policy Advisor  
National Association of Insurance Commissioners  
1100 Walnut Street Suite 1500  
Kansas City, MO 64106-2197

Mr. Daniel Schelp  
Chief Counsel, Regulatory Affairs  
National Association of Insurance Commissioners  
1100 Walnut Street, Suite 1500  
Kansas City, MO 64106-2197


Dear Mr. Stultz and Mr. Schelp:

Thank you for the opportunity to again, on behalf of the International Underwriting Association of London (IUA), submit comments on the Review Process. The IUA and its members that maintain certified reinsurer status and that plan to obtain reciprocal reinsurer status remain vitally interested in working with the NAIC and state regulators in these two areas. The IUA and its members truly appreciate the changes that have been made in the September 17th draft of the Review Process, particularly:

- the statement in section 2.d. that encourages states “to support a uniform submission and approval process” for both certified and reciprocal reinsurers;

- the affirmations: (i) in section 3.f. that ReFAWG will seek to centralize notifications to certifying states as to ratings changes, and (ii) in section 5.b. that ReFAWG will coordinate with the Mutual Recognition Working Group to ensure that with respect to reciprocal reinsurers that a single annual home country regulator certification as to maintenance of minimum capital and surplus and satisfaction of minimum capital and solvency ratios will be made available to all states; and

- in section 10.c. permitting reinsurers that have secured certified reinsurer status to cross-reference information and documentation already compiled and filed so that duplicate filings of such information and documentation can be eliminated in the reciprocal reinsurer process.
October 8, 2021
Page 2

As you know, in our initial July 19th comment letter, we addressed at length the subject of disputed and overdue claims and the disclosure differences between certified and reciprocal reinsurers in the event that there are disputed or overdue claims. For reinsurers that will maintain status as both certified and reciprocal reinsurers, we continue to urge that lead states and ReFAWG adopt what would be in essence a two stage review process at least during a transition period when the same reinsurer has both certified and reciprocal reinsurer status—first, apply the certified reinsurer metrics and second, as and when necessary, apply the reciprocal reinsurer metrics. We have quoted below for ease of reference the relevant paragraph from our July 19th letter

“…assuming that the Certified/Reciprocal Reinsurer making a filing triggers either of the Certified Reinsurer disputed and overdue metrics—one for individual cedents (more than 10% of obligations owed to any Top 10 cedent) and the other for the reinsurer’s portfolio of assumed reinsurance from U.S. cedents (5% of all U.S. reinsurance obligations), the Lead State or ReFAWG could then require preparation of a Reciprocal Reinsurer-specific disputed or overdue claims report using the metrics in the two Covered Agreements and in Section 5.i. of the ReFAWG Review Process. Specifically, for the reinsurer’s book of U.S. reinsurance business overall are the disputed or overdue obligations in excess of 15% of the reinsurer’s total book? And for individual reinsureds, if more than 15% of them have overdue (undisputed) recoverables, does the reinsurer owe more than $100,000 to each of them?”

For all reinsurers that will be both certified and reciprocal reinsurers for the foreseeable future, we believe that the September 17th draft of the Review Process materially advances the overarching goal of promoting uniformity and consistency with respect to the passport processes for both certified and reciprocal reinsurers. The IUA and its members will be pleased to continue working with lead states and the ReFAWG to improve and fine tune the review process based on experience in the coming years.

Yours sincerely,

[Signature]

Thomas M. Dawson

Cc: A. Best – MWE
    J. Finston - MWE
October 8, 2021

Director Chlora Lindley-Myers, Chair
Reinsurance (E) Task Force
National Association of Insurance Commissioners
c/o Mr. Dan Schelp and Mr. Jake Stultz
Via e-mail: dschelp@naic.org, jstultz@naic.org

Re: NAIC Request for Comments on Revised ReFAWG Review Process for Passporting Certified and Reciprocal Jurisdiction Reinsurers

Dear Director Lindley-Myers:

The Reinsurance Association of America (RAA) appreciates the opportunity to submit comments on the NAIC’s revised exposure draft of the ReFAWG Review process for Passporting Certified and Reciprocal Jurisdiction Reinsurers. The Reinsurance Association of America (RAA) is a national trade association representing reinsurance companies doing business in the United States. RAA membership is diverse, including reinsurance underwriters and intermediaries licensed in the U.S. and those that conduct business on a cross-border basis. The RAA also has life reinsurance affiliates and insurance-linked securities (ILS) fund managers and market participants that are engaged in the assumption of property/casualty risks. The RAA represents its members before state, federal and international bodies.

We appreciate the Reinsurance Task Force’s continued thoughtful engagement with respect to implementation of its 2019 revisions to the NAIC Credit for Reinsurance Model Law and Model Regulation, including its continued work on the passporting process for certified and reciprocal jurisdiction reinsurers. As we have stated previously, this is an important part of the implementation process for the U.S./EU and U.S./UK covered agreements and in the NAIC’s broader revision of the credit for reinsurance framework in the U.S. The revised draft of the ReFAWG Review process for Passporting Certified and Reciprocal Jurisdiction Reinsurers provides needed clarification and guidance for industry and we support the changes as reflected in the draft.

In addition, we continue to urge states to include guidance regarding the NAIC ReFAWG passporting process – along with other NAIC resources relating to Certified and Reciprocal Reinsurers and Qualified and Reciprocal Jurisdictions – on state websites. In addition, each state should specify on its website its process for entertaining applications for Reciprocal Reinsurers, including whether they are open to passporting so that a company seeking to do business through this process knows and understands the process it must complete in that jurisdiction. Further, we believe it would be helpful for ReFAWG and the NAIC to draft sample document(s) that states could evaluate, use or adapt in developing their own websites and related processes for Certified and Reciprocal reinsurers. This would help ensure clarity, consistency and expediency in the process for both state regulators and applicants.
We would be happy to answer any questions or discuss any concerns.

Sincerely,

Karalee C. Morell  
SVP and General Counsel  
Reinsurance Association of America
Implementation of the 2019 Revisions to the Credit for Reinsurance Model Law #785
[status as of December 1, 2021]

Disclaimer: This map represents state action or pending state action regarding NAIC amendments to the model(s). This map does not reflect a determination as to whether the pending or enacted legislation contains all elements of NAIC amendments to the model(s) or whether a state meets any applicable accreditation standards.
Implementation of the 2019 Revisions to the Credit for Reinsurance Model Regulation #786
[status as of December 9, 2021]

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Disclaimer: This map represents state action or pending state action regarding NAIC amendments to the model(s). This map does not reflect a determination as to whether the pending or enacted legislation contains all elements of NAIC amendments to the model(s) or whether a state meets any applicable accreditation standards.

https://naiconline.sharepoint.com/:b/r/sites/NAICSupportStaffHub/Member%20Meetings/Fall%202021/TF/Reinsurance/National%20Meeting/Minutes/Att%204%20785%20786%202019%2012.9.2021%20final.pdf?csf=1&web=1&rls=en
Implementation of Model #787 (XXX/AXXX)
Term and Universal Life Insurance Reserve Financing Model Regulation
[status as of November 30, 2021]

Disclaimer: This map represents state action or pending state action regarding NAIC amendments to the model(s). This map does not reflect a determination as to whether the pending or enacted legislation contains all elements of NAIC amendments to the model(s) or whether a state meets any applicable accreditation standards.

https://naiconline.sharepoint.com/sites/NAICSupportStaffHub/Member%20Meetings/Fall%202021/TF/Reinsurance/National%20Meeting/Minutes/Att%205%20787%2011.30.2021%20FINAL.pdf?csf=1&web=1&hash=F13Wb3WqYqgZs8bNQ41DnTQmgOa3Cj5E
RISK RETENTION GROUP (E) TASK FORCE

Risk Retention Group (E) Task Force Nov. 30, 2021, Minutes.................................................................10-1113
Preliminary Memorandum Regarding Initial Licensing of the Risk Retention Group (RRG) (Attachment One).10-1115
The Risk Retention Group (E) Task Force met Nov. 30, 2021. The following Task Force members participated: Michael S. Pieciak, Chair, represented by Sandra Bigglestone (VT); Karima M. Woods, Vice Chair, represented by Sean O'Donnell (DC); Andrew N. Mais represented by Fenhua Liu (CT); Sharon P. Clark represented by Russell Coy (KY); and Russell Toal (NM). Also participating were: Steve Kinion (DE); and Christine Brown (VT).

1. **Adopted its Summer National Meeting Minutes**

   Mr. O'Donnell made a motion, seconded by Mr. Coy, to adopt the Task Force’s July 26, minutes (see NAIC Proceedings – Summer 2021, Risk Retention Group (E) Task Force) minutes. The motion passed unanimously.

2. **Discussed a Proposed Preliminary Memorandum**

   Ms. Bigglestone stated that during its July 26 meeting, the Task Force discussed results of the survey conducted earlier this year and formed an initial plan to address concerns. There were two areas of focus. The first is the preparation of a template that can be completed by a domiciliary state when a new risk retention group (RRG) is formed and there is no Insurer Profile Summary (IPS) available. This template can be provided upon request to states the RRG is registering in. The second is to review the registration form and consider if additional guidance or instructions for either the state or the RRG would help reduce the delays that occur when the form is incomplete. A group of volunteers took on these tasks. They completed a template for what is now called the Preliminary Memorandum, (Attachment One). They also discussed the NAIC Uniform Registration Form (registration form), but they thought that the Preliminary Memorandum may address many of the concerns of state insurance regulators reviewing the registration form. The volunteers also discussed that there may still be questions/concerns from RRGs completing the forms, but they thought they lacked the necessary perspective to address concerns from the insurer side.

   Ms. Brown provided an overview of the memorandum, stating that the volunteers believe it will be a helpful tool for sharing with non-domiciliary regulators, and it will form the basis of the IPS once the company files its annual statement.

   Ms. Bigglestone and Ms. Liu agreed the memorandum would be helpful and should be considered by the Task Force.

   Ms. Bigglestone stated that the memorandum will likely be exposed in spring 2022 for further consideration by the Task Force.

3. **Received Updates Regarding the Proposed Accreditation Standard for the GCC**

   In 2020, the NAIC adopted revisions to the Insurance Holding Company System Regulatory Act (#440) and the Insurance Holding Company System Model Regulation with Reporting Forms and Instructions (#450). The revisions include a requirement for all groups to submit a group capital calculation (GCC). Per the models, all groups with at least one insurer and one affiliate are subject to the filing, at least once. The Financial Regulation Standards and Accreditation (F) Committee discussed a referral recommending that the changes become an accreditation standard for all states. As a result of this discussion, the Committee voted to expose the referral for a one-year public comment period beginning Jan. 1, 2022. The exposure is subject to final approval by Plenary at the Fall National Meeting. The exposure by the Committee also altered two key items from the initial referral. First, the Committee proposes an effective date of Jan. 1, 2026, for all states. Second, and most important to the discussion at this Task Force, the Committee proposed an accreditation standard that does not include the requirement for each group to file the GCC at least once before an exemption can be granted. This means that a commissioner has discretion to grant an exemption to the filing without receiving an initial filing from the insurance group. Ms. Bigglestone noted that this is not an automatic exemption; it must specifically be granted by the commissioner. However, it does allow states more flexibility.

   Ms. Bigglestone stated that per the Task Force’s charges, it intends to provide a comment letter during the one-year exposure period next year regarding the application of the standard to RRGs.

   Mr. O’Donnell said the additional flexibility would be helpful for RRGs in a holding company group. Mr. Kinion asked for clarification regarding which groups are subject to the GCC, including whether captives were subject to the GCC. Robert Myers
(National Risk Retention Association—NRRA) also asked for clarification regarding a size threshold for groups filing the GCC. Dan Schelp (NAIC) confirmed that a group is defined as at least one insurer and at least one affiliate. There is no threshold for filing a GCC. There is a threshold in Model #450 that allows groups with less than $1 billion in premium to request an exemption from the filing after at least one initial filing. The proposed accreditation requirement does not include the requirement to file at least once prior to a commissioner granting an exemption. Captives are generally excluded from the accreditation program. Therefore, they are not required to be subject to the holding company models and, as a result, the GCC. However, RRGs licensed as captives are subject to accreditation, and each standard must be considered for applicability to RRGs, including the GCC.

Ms. Bigglestone noted that additional guidance for considerations when granting exemptions may need to be developed if the accreditation standard is adopted as proposed.

4. Received Updates on Related NAIC and/or Federal Actions

Ms. Bigglestone noted that the Task Force continues its ongoing commitment to promote educational and communication opportunities. One such opportunity was the NRRA conference in early November, which included a state insurance regulator panel discussing regulation of RRGs. Anyone aware of future educational opportunities or resources is encouraged to communicate with the Task Force.

Ms. Bigglestone noted that the Surplus Lines (C) Task Force is working to update the Nonadmitted Insurance Model Act (#870). On Nov. 23, the NRRA sent a letter to the drafting group working on updates to Model #870, which comments on the definition of “home state” as it relates to an insured being a member of an unaffiliated group. The revisions in the NAIC model act establish the allocation of premium for affiliated groups, but they do not address unaffiliated groups. Since risk purchasing groups (RPGs) are primarily made up of unaffiliated members or insurance buyers, the current draft revisions complicate how premium tax will be collected from RPGs. The NRRA’s letter also draws attention to previous discussions and conclusions reached by the Surplus Lines (E) Task Force with respect to RPGs that may contradict current discussions. The work of the drafting group is still ongoing.

Having no further business, the Risk Retention Group (E) Task Force adjourned.

Risk Retention Group E Task Force 11-30-21 Minutes
RRG Preliminary Memorandum

An RRG Preliminary Memorandum is developed by the domestic state for a risk retention group (RRG) upon approving the initial licensing of the RRG. The information in this document will serve as a summary of key considerations in assessing and approving the license. The information will also serve as the base for developing an Insurer Profile Summary (IPS) once the RRG begins writing business and files its annual statement. The role of the RRG Preliminary Memorandum is for both internal communication within the domestic state and for external communication with other states in which the RRG is authorized to register and has submitted a registration form. In accordance with the federal Liability Risk Retention Act (LRRA) a non-domestic state must rely on the domestic state to approve which states the RRG may write in. The non-domestic state does not perform their own review of the application for licensing in the domestic state but relies on the information in the RRGs registration form and communication from the domestic regulator. The RRG Preliminary Memorandum is not required, however, its use can help improve transparency and communication between regulators and reduce potential delays in registration. Additional recommendations regarding transparency and communication can be found in the RRG best practices and frequently asked questions documents on the Risk Retention Group (E) Task Force website.

A template that can be used to develop the RRG Preliminary Memorandum is provided below; however, the actual form and content should be determined by each respective state.
XX DEPARTMENT OF INSURANCE
RRG PRELIMINARY MEMORANDUM
COMPANY NAME
Date of Review

BUSINESS SUMMARY
Provide a brief description of the risk retention group (RRG) and a summary of the business operations of the RRG. Consider inclusion of the following.

- Purpose of the RRG and the benefits gained by creating the RRG (i.e., is it meeting a need not met in the commercial market, formed by a promoter looking for a group, etc.).
- Describe the approved coverages and comment on their compliance with the LRRA. Include policy limits and net retention.
- Describe the ownership structure and/or key members, association, or sponsor.
- Describe the capital structure of the RRG. Include minimum capital and surplus requirements, use of letters of credit, surplus notes, ability to raise additional capital, etc.
- Comment on how the business is produced (i.e., direct writings, agent(s), managing general agent (MGA), managing general underwriter (MGU)).

GOVERNANCE
Discuss the makeup of the board of directors and other oversight considerations including compliance with governance requirements in the Model Risk Retention Act (#705).

Discuss if the RRG is MGA or producer controlled.

Discuss service providers used.

Confirm background checks were done.

PROFORMA FINANCIAL SNAPSHOT
Proforma financial data may be summarized in a narrative format, chart format, or a combination. Information may include key financial statement items and/or key ratios. Sample data is shown below but the format, number of years of data, line items and ratios included should be customized. Consideration should be given to what information provides the most insight for the newly formed RRG. Information related to the feasibility study, including who performed the study may also be included.

<table>
<thead>
<tr>
<th>Assets and Liabilities</th>
<th>20XX</th>
<th>20XX</th>
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</thead>
<tbody>
<tr>
<td>Total Invested Assets</td>
<td>219</td>
<td>253</td>
</tr>
<tr>
<td>Other Assets</td>
<td>111</td>
<td>131</td>
</tr>
<tr>
<td>TOTAL ASSETS</td>
<td>330</td>
<td>384</td>
</tr>
<tr>
<td>LIABILITIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance reserves, net</td>
<td>97</td>
<td>95</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>169</td>
<td>193</td>
</tr>
<tr>
<td>TOTAL LIABILITIES</td>
<td>266</td>
<td>288</td>
</tr>
</tbody>
</table>
## Capital and Surplus

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<thead>
<tr>
<th></th>
<th>64</th>
<th>96</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL LIABILITIES AND C&amp;S</td>
<td>330</td>
<td>384</td>
</tr>
</tbody>
</table>

## Operations

<table>
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<tr>
<th></th>
<th>20XX</th>
<th>20XX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premiums, net</td>
<td>218</td>
<td>233</td>
</tr>
<tr>
<td>Investment income (net of gains/losses)</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Other income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total revenues</td>
<td>219</td>
<td>241</td>
</tr>
</tbody>
</table>

## LOSSES, BENEFITS AND EXPENSES

<table>
<thead>
<tr>
<th></th>
<th>20XX</th>
<th>20XX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incurred losses, net</td>
<td>177</td>
<td>157</td>
</tr>
<tr>
<td>Expenses</td>
<td>77</td>
<td>80</td>
</tr>
<tr>
<td>Total losses and expenses</td>
<td>254</td>
<td>237</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>NET INCOME</td>
<td>(35)</td>
<td>2</td>
</tr>
</tbody>
</table>

### AREAS OF INTEREST

Provide a brief summary of the following items when applicable or noteworthy.

- Reinsurance
- Investment policy
- Related Parties
- Restrictions or special requirements such as permitted practices
- Additional details for coverages that require special underwriting, discounting and tail coverages
- Other

### IMPACT OF HOLDING COMPANY ON INSURER

Summarize the evaluation of the impact of the holding company system on the domestic insurer. Or state that the RRG is not part of a holding company group. The summary should include whether a disclaimer of affiliation or any other exemption or waiver related to holding company requirements has been granted, and the rationale for the determination.

### KEY RISKS AND SUPERVISORY PLAN

Summarize key risks identified and/or items that require further monitoring by the analyst or specific testing by the examiner. In addition, indicate if the Company is or should be subject to any enhanced monitoring, such as monthly reporting, a targeted examination or a more frequent exam cycle. Key risks may relate to the areas of interest above or may be separate considerations. Information should be brief and include prospective considerations.

Document the date of the first expected examination and the planned examination cycle.

## Analysis Follow-Up

## Examination Follow-Up
The domiciliary state maintains authority and has responsibility to regulate the formation and operation of a Risk Retention Group (RRG). Therefore, when concerns arise in a non-domiciliary state about a RRG, the best resource is the domiciliary state. This includes concerns about solvency and capital levels, financial condition, or other non-compliance of an RRG as well as operational questions and concerns that should be directed to the domiciliary state.

States are encouraged to examine their RRG laws to make certain that they are consistent with (1) the federal Liability Risk Retention Act (LRRA) and (2) the NAIC Model Risk Retention Act (#705).

**Questions/Concerns from Non-domiciliary State**

Upon initial registration of an RRG in a non-domiciliary state, it is not uncommon for questions to arise that are best directed to the domiciliary state. Attachment A outlines a sample Inquiry Template that can be used to request this information. The template may be customized as deemed appropriate by the non-domiciliary state. Domiciliary states should respond in a timely manner to such requests.

Questions about operations and financial solvency that arise following initial registration should also be addressed to the domiciliary state.

If significant concerns still exist after communication with the domiciliary state and the non-domiciliary state concludes that the RRG is not compliant with any of the specific procedures set forth in the LRRA, the following steps may be undertaken:

- a. Refer to your own state RRG statute to ensure compliance of your prospective action;
- b. Provide written notice of any non-compliance directly to the RRG;
- c. Submit a demand for examination of the RRG to the domiciliary regulator, as provided by the LRRA ([15 U.S.C. S3902(a)(1)(E)])
- d. Institute suit in a court of competent jurisdiction.

A non-domiciliary state may request the following from the domiciliary state and similarly, the domiciliary state should be prepared to provide the following to the non-domiciliary state:

- e. Insurer Profile Summary (IPS)
- f. Inquire about the extent of biographical affidavit review and results of background checks
- g. Most recent examination report (may be obtained from I-Site)
- h. Amendments to the RRG’s business plan or feasibility study
- i. Verification of domiciliary state approval to expand into non-domiciliary state

Alternatively, **the following documents may be used for this request with modifications as necessary:**

- **Attachment A – Inquiry Template** (when specific questions or concerns not typically addressed on the above documents arise) may be used for this request with modifications as necessary.
- **Attachment B – RRG Preliminary Memorandum** (for a new RRG in which the IPS is not yet available)
**Registration Timeline**

The registration process for RRGs should be shorter than the licensing process for other types of insurers as the RRG is responsible only for a complete registration form* and the related attachments. The non-domiciliary state cannot reject a complete registration* that complies with those laws of the non-domiciliary state that are not preempted under the LRRA. In the event a non-domiciliary state has concerns with an RRG registration, such concerns should be raised with the domiciliary state, who has the authority to regulate the formation and operation of an RRG. The following guidelines take into consideration similar guidelines for ordinary insurance companies, and adherence is at the discretion of each state.

- A non-domiciliary state should review the registration form to ensure all required information is entered on the form within 10 business days of its receipt of the form and notify the Risk Retention Group of the need to submit any missing elements.
- Following receipt of a complete registration*, a non-domiciliary state should notify the RRG within 30 days that its registration is confirmed.
- The domiciliary state should respond to inquiries from a non-domiciliary state in a prompt manner, typically no later than 10 business days after receiving the inquiry.

*Refer to the document titled “Risk Retention Groups: Frequently Asked Questions”, 3(c) for the definition of a complete registration form.

**Domiciliary State Responsibilities**

When a domiciliary state identifies an RRG as troubled or potentially troubled, the State insurance regulator should make efforts to communicate proactively with other state insurance regulators in which the RRG is registered (consistent with the **Troubled Insurance Company Handbook**). Although the domiciliary regulator is responsible for taking actions involving their domiciliary RRGs, awareness by a non-domiciliary state may help them to proactively do what they can to protect their residents and respond to policyholder complaints or concerns directed to them.

**General Licensing Guidance**

Domiciliary states should ensure the RRG’s application for licensing, which includes the plan of operation and feasibility study, includes the following, at a minimum:

- information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations;
- information sufficient to verify that the liability insurance coverage to be provided by the Risk Retention Group will only cover the members of the Risk Retention Group;
- for each state in which it intends to operate, information regarding the liability insurance coverages, deductibles, coverage limits, rates and/or rating/underwriting methodology for each line of commercial liability insurance the group intends to offer;
historical and expected loss experience of proposed members and national experience of similar exposures to the extent that this experience is reasonably available;
- appropriate opinions/feasibility work by a qualified independent casualty actuary, including a determination of minimum premium participation levels required to commence operation and to prevent a hazardous financial condition;
- pro forma financial statements and projections, including assumptions, on an expected and adverse basis;
- identification of Board of Directors, including independence determination;
- biographical affidavits for all BOD members;
- evidence of compliance with corporate governance standards, including draft policies;
- underwriting and claim procedures;
- marketing methods and materials if available;
- draft insurance policies;
- names of reinsurers and reinsurance agreements, if available;
- investment policies;
- identification of each state in which the RRG intends to write business/register;
- identification of service providers, including fee structure and relationships to members; and
- subsequent material revisions to the plan of operation or feasibility study.
Attachment A – Inquiry Template

The above-subject company has applied for Registration as a Risk Retention Group (“RRG”) in the State of _______ to write __________ liability coverage to its members who are in the business of __________________________. As you can appreciate, due to the provisions of the Liability Risk Retention Act of 1986 the (state) has limited authority to regulate RRGs and therefore to a large extent, the (state) relies on the RRGs’ domiciliary state to exercise general oversight and responsibility in the areas of licensing, solvency, rates and marketing. As part of our due diligence, we would appreciate any information your office can share with us regarding the company with respect to the following items, some of which may be satisfied by providing the Insurer Profile Summary:

1. Any significant concerns the State of [domicile] has regarding the company.
2. Any issues that may have a significant impact on the company going forward.
3. Any issues regarding the number of consumer complaints the company has in [state of domicile] or other states that may have been brought to your attention.
4. Comments and/or concerns about the financial condition of the company.
5. Comments and/or concerns about the management or performance of the company.
6. Results of any financial analysis and/or market conduct findings.
7. The company’s priority level within the Financial Analysis Division.
8. Any conditions imposed by your Department upon the company’s license.
9. Any significant non-compliance issues with the State of [domicile] regulatory authority including filing requirements and corrective action, if any.
10. Comments regarding the company’s application for registration in the State of [state registering].
11. Approval from State of [domicile] for the RRG to register in the State of [state registering].
VALUATION OF SECURITIES (E) TASK FORCE

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P&P Manual Amendment for Private Letter Rating Securities and the Corresponding NAIC Designation Category for NAIC 5GI (Attachment Six) ..................................................................................................... 10-1173
The Valuation of Securities (E) Task Force met in San Diego, CA, Dec. 12, 2021. The following Task Force members participated: Dana Popish Severinghaus, Chair, represented by Kevin Fry (IL); Doug Ommen, Vice Chair, represented by Carrie Mears (IA); Lori K. Wing-Heier represented by David Pfifer (AK); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kathy Belfi and Ken Cotrone (CT); Trinidad Navarro represented by Rylynn Brown (DE); David Altmaier represented by Ray Spudeck and Virginia Christy (FL); Dean L. Cameron represented by Eric Fletcher (ID); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Kathleen A. Birrane represented by Matt Kozak (MD); Gary D. Anderson represented by John A. Turchi (MA); Chlora Lindley-Myers represented by Debbie Doggett (MO); Eric Dunning represented by Lindsay Crawford and Justin Schrader (NE); Marlene Caride represented by John Sirovetz (NJ); Russell Toal represented by Lea Geckler (NM); Adrienne A. Harris represented by Jim Everett (NY); Cassie Brown represented by Jamie Walker (TX); Jonathan T. Pike represented by Jake Garn (UT); Scott A. White represented by Doug Stolte and Greg Chew (VA); Mike Kreidler represented by Tim Hays (WA); and Mark Afable represented by Amy Malm (WI).

1. **Adopted its Nov. 17, Sept. 30, and Summer National Meeting Minutes**

   Mr. Fry said the first item on our agenda is to consider the adoption of the minutes from the Summer National Meeting, and the Sept. 30 and Nov. 17 interim meeting conference calls.

   Ms. Belfi made a motion, seconded by Ms. Walker, to adopt the Task Force’s July 15 (see NAIC Proceedings – Summer 2021, Valuation of Securities (E) Task Force, Nov. 17 (Attachment One), and Sept. 30 (Attachment Two) minutes. The motion passed unanimously.

2. **Adopted an Amendment to the P&P Manual to Remove Residual Tranches from Receiving an NAIC Designation**

   Mr. Fry said our next agenda item is to discuss and consider adoption of a proposed amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) to remove residual tranches from receiving an NAIC Designation. Residual tranches capture securitization tranches and beneficial interests that reflect loss layers without any contractual payment of principal or interest. Instead, residual tranches are paid after contractual payments of principal or interest have been made to other tranches and are based on the remaining available funds.

   Charles Therriault (NAIC) said the Statutory Accounting Principles (E) Working Group identified inconsistencies in how residual tranches and interests were being reported, with some entities reporting them on Schedule BA: Other Long Term Invested Assets and others reporting them on Schedule D-1: Long-Term Bonds with either self-assigned NAIC 5GI or NAIC 6 Designations. To prevent further inconsistency and direct appropriate reporting, on Nov. 10, the Working Group adopted an amendment to SSAP 43R – Loan Backed and Structured Securities to clarify that residual tranches and interests shall be reported on Schedule BA. To accommodate the timeframe needed for a Blanks (E) Working Group proposal to expand reporting lines on Schedule BA to capture residual tranches and interests, the Working Group’s amendment permits residual tranches and interests currently reported on Schedule D-1 to continue to be reported on Schedule D-1 for 2021 reporting with an ultimate effective date of Dec. 31, 2022.

   The SVO staff agree with the Working Groups recommendation that during this window when residual tranches currently reported on Schedule D-1 are permitted to stay on Schedule D-1, they should be allowed to do so only with an NAIC 6* Designation and not an NAIC 5GI Designation. This is consistent with the Working Group’s adopted change. The NAIC 5GI Designation is not appropriate for residual tranches and interests because according to the P&P Manual, “an insurance company is permitted to self-assign an NAIC 5GI to an obligation if it meets all of the following criteria:

   1. Documentation necessary to permit a full credit analysis of the security by the SVO does not exist or an NAIC CRP rating for an FE or PL security is not available.
   2. The issuer or obligor is current on all contracted interest and principal payments.
   3. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.
Assignment of an NAIC 5GI Designation for residual investments is an incorrect application of the guidance as: there are no contracted interest and principal payments to certify as current and the insurer cannot have an actual expectation of receiving all contractual principal and interest of the underlying collateral as these tranches absorb the losses first for the securitization structure. Although cash flows may pass through to the residual holders at periodic intervals under the waterfall, ultimate returns depend on continued performance so, therefore, there can be no actual expectation that future payments will be received. Along with the proposed P&P Manual language requiring residuals to be reported on Schedule BA, there is a proposed provision stating that for 2021 year-end reporting residuals will be permitted on Schedule D-1 with an NAIC 6. If adopted, the SVO requests the Task Force’s permission to remove that provision from the 2022 version of the P&P Manual, without further authorization.

There were other requests from the Working Group related to NAIC 5GI and 6 that the SVO would like to bring up with the Task Force next year (Attachment Three). The SVO staff recommends adoption of this amendment today.

Mr. Kozak made a motion, seconded by Mr. Chew, to adopt the amendment to the P&P Manual to clarify proper reporting and designation for residual tranches and interests (Attachment Four). The motion passed unanimously.

3. **Adopted an Amendment to the P&P Manual to Clarify 5GI Mapping to NAIC Designation Category**

Mr. Fry said the next item is to discuss and consider adoption of a technical correction amendment to the P&P Manual clarifying 5GI mapping to a Designation Category in the recently amended Private Letter Rating section.

Marc Perlman (NAIC) said at the May 24 meeting the Task Force adopted an amendment to the P&P Manual requiring the submission of Private Rating Letter Rationale Reports with certain Private Rating Letters filed with the SVO. In the May amendment certain language, which is currently in the printed December 2020 version of the P&P, which clarifies that an NAIC 5GI Designation is the equivalent of an NAIC 5.B Designation Category, was mistakenly omitted. The SVO proposes a non-substantive technical amendment to the May amendment to reinsert the omitted language (Attachment Five).

Ms. Doggett made a motion, seconded by Ms. Clements, to adopt this amendment to the P&P Manual to clarify the mapping of NAIC 5GI to a Designation Category (Attachment Six). The motion passed unanimously.

4. **Exposed an Amendment to the P&P Manual to Update the Definition of Other Non-Payment Risk Assigned a Subscript “S”**

Mr. Fry said the next agenda item is to discuss and consider exposure of a proposed amendment to the P&P Manual to update the Definition of Other Non-Payment Risks Assigned a Subscript “S.”

Charles Therriault (NAIC) said securities that possess “Other Non-Payment Risks” are intended to be reviewed by the SVO but these investments have not been explicitly included on the list of Specific Populations of Securities Not Eligible For Filing Exemption in Part Three of the P&P Manual. Securities with other non-payment risks are identified through assignment of the Administrative Symbol “S” as a subscript to the NAIC Designation. This amendment would add “Securities with Other Non-Payment Risks” to the list of securities that are ineligible for filing exemption.

As noted in Part One, paragraph 90, of the P&P Manual:

> An objective of the VOS/TF is to assess the financial ability of an insurer to pay claims. For example, the regulatory assumption is that a fixed income instrument called debt by its originator or issuer requires that the issuer make scheduled payments of interest and fully repay the principal amount to the insurer on a date certain. A contractual modification that is inconsistent with this assumption creates a rebuttable inference that the security or instrument contains an additional or other non-payment risk created by the contract that may result in the insurer not being paid in accordance with the underlying regulatory assumption. The SVO is required to identify securities that contain such contractual modifications and quantify the possibility that such contracts will result in a diminution in payment to the insurer, so this can be reflected in the NAIC Designation assigned to the security through the application of the notching process.

The proposed amendment would further clarify through additional illustrations securities that would also be considered as having “Other Non-Payment Risks”. These would include securities that:
a) Incorporate the performance of other assets to determine their contractual payments, either directly or indirectly through reference pools, equity baskets, or indices.

b) Receive payments as the remainder or residual cashflow after all other payment obligations have been made.

c) Receive additional performance or bonus cashflows; or have no contractual events of payment default.

Mr. Fry said this amendment enhances the guidance around the subscript “S” and does not change policy in any way but makes it clearer with additional examples.

Mr. Fry directed the SVO to expose the proposed amendment to the P&P Manual to update the definition of Other Non-Payment Risks Assigned a Subscript “S” for a 60-day public comment period ending Friday, Feb. 11, 2022.

5. Exposed an Amendment to the P&P Manual to Update the Definition of PPS

Mr. Fry said next is to discuss and consider exposure of a proposed amendment to the P&P Manual to update definition of principal protected securities. In May of last year, the Task Force adopted an amendment to the P&P defining principal protected securities and making them ineligible for Filing Exemption. The SVO has seen new transactions with similar risks, but which do not precisely fit the current definition.

Marc Perlman (NAIC) said last May the Task Force adopted an amendment to the P&P to include principal protected securities (PPS) as a new security type ineligible for the filing exempt process. At the time, the types of PPS which the SVO had seen were mixes of a traditional bond or bonds with additional assets that could possess any characteristic. These additional assets, which the SVO called “performance assets,” were intended to generate excess return. They included, among other things, derivatives, common stock, commodities and equity indices. The performance assets often included undisclosed assets and were typically not securities that would otherwise be permitted on Schedule D, Part 1 as a bond. In each case, the external credit rating was based solely on the component dedicated to the repayment of principal and ignored the risks and statutory prohibitions of reporting the performance asset on Schedule D, Part 1.

Recently, the SVO received a proposal for a security which poses many of the same risks as a PPS but was structured in a way that it did not cleanly fit the definition in the P&P. In this example, the security was not issued by a special purpose vehicle (SPV) holding an “underlying” principal protection bond and the performance asset. “Underlying” is a key component of the current definition. Rather, the security was the direct obligation of a large financial institution whose obligation it was to pay principal at maturity and a premium based on the performance of referenced indices, including an equity index and an index comprised of equities, fixed-income instruments, futures and other financial assets. Though the obligation was solely that of the issuing financial institution, meaning there were no underlying bonds or performance assets, the structure posed the same risk of exposure to a performance asset because the amount of the issuer’s payment obligation was directly dependent on the performance of the referenced indices. Additionally, unlike a PPS transaction with an underlying bond and performance asset, the likelihood of payment of that performance asset premium, whatever the amount might be, was linked directly to the creditworthiness of the issuer. As such, the SVO proposes amending the P&P Manual definition of Principal Protected Securities to account for alternate structures which pose similar risks.

Mr. Fry said the objective of this amendment is to take the PPS methodology and expanded it to include these newer securities. Mr. Fry directed the SVO to expose this proposed amendment to the P&P Manual to update the definition of Principal Protected Security for a 60-day public comment period ending, Friday, Feb. 11, 2021.

6. Exposed an Amendment to the P&P Manual to Assign NAIC Designations to Investments with a Fixed Income Component for Reporting on Schedule BA

Mr. Fry said next is to discuss and consider exposure of a proposed amendment to the P&P Manual to add guidance on the designation of Schedule BA assets with fixed income characteristics. There are potentially many securities which do not qualify as bonds for purposes of reporting on Schedule D-1 but which have fixed income characteristics. If it were possible to assign a designation to these investments, they could potentially benefit from more favorable RBC treatment on Schedule BA.

Marc Perlman (NAIC) said the SVO recommends updating the instructions in Part Three of the P&P Manual to include guidance related to the assignment of NAIC Designations to Schedule BA assets with underlying characteristics of bonds or fixed income instruments. Part One of the P&P Manual currently permits the SVO to assign NAIC Designations to Schedule BA assets with underlying characteristics of bonds or fixed income instruments, but there is currently no specific guidance for the SVO in Part Three. Including the proposed provisions would enable the SVO to assign NAIC Designations to Schedule BA assets which are not expressly covered by other sections of the P&P Manual (such as Schedule BA Funds). Schedule BA assets
for life and fraternal insurers would benefit from NAIC Designations because they would be eligible for more favorable RBC treatment.

The SVO’s authority to assign NAIC Designations to certain Schedule BA assets already exists. Part One of P&P Manual states that, “The SVO is assigned to assess investment securities reported to state regulators on Schedule D and Schedule BA.”. Additionally, the P&P explains that to be eligible for the assignment of an NAIC Designation a Schedule BA asset must have underlying characteristics of a bond or fixed income instrument. This proposed amendment would potentially make various types of assets eligible for an NAIC Designation which currently are not. Each asset would need to be individually assessed by the SVO for bond or fixed income characteristics.

Mr. Fry said this issue has been around for a while where on Schedule BA a fixed income like investment receives an NAIC designation from the SVO for a life or fraternal insurer but a property and casualty insurer would not receive that same risk-based capital (RBC) treatment. There are a lot of asset classes that maybe are not specifically designed as a bond but the SVO could assign a designation to it. Thinking forward with the bond project, if any assets fall off schedule D-1, this would at least give it a potential home if they can satisfy the requirements of the SVO with the designation.

Mr. Fry directed the SVO to expose this proposed amendment to the P&P Manual to add guidance on the designation of Schedule BA assets with fixed income characteristics for a 60-day public comment period ending, Friday, Feb. 11, 2021.

7. **Exposed an Amendment to the P&P Manual to Permit the SVO to Assign NAIC Designations to Unrated Subsidiaries of in WCFI Transactions**

Mr. Fry said the next item on the agenda is to discuss and consider exposure of a proposed amendment to the P&P Manual to permit the SVO to Assign NAIC Designations to unrated subsidiaries in Working Capital Finance Investment (WCFI) transactions. The Task Force has gone through several iterations of this amendment over the past year. In this latest version the SVO is reintroducing a proposal under which the Task Force would give the SVO discretion to notch down from the parent’s rating in certain circumstances. It adheres very closely to an earlier version of the proposal.

Marc Perlman (NAIC) said the SVO received comments from certain insurers and other interested parties that it should assign NAIC Designations to WCFIs with unguaranteed and unrated obligors, based on the implied support from an obligor’s NAIC Credit Rating Provider rated parent.

In November 2020, the Task Force exposed a proposed amendment to the P&P Manual to direct the SVO to rely upon the NAIC Designation or NAIC CRP Rating equivalent of the subsidiary obligor’s parent entity, with allowance for the SVO to notch down from the parent’s rating or NAIC Designation due to its assessment of certain factors regarding the parent/subsidiary relationship. In response to feedback from some Task Force members and interested parties, the SVO subsequently presented a revised proposal to the Task Force at the Summer 2021 National Meeting to remove its discretion to notch because, as demonstrated in our memorandum to the Task Force of Oct. 16 of last year, the SVO found no generally accepted analytical technique or methodology to support the assumption that a parent entity will necessarily support its subsidiary in times of financial distress. That revised amendment was also not adopted by the Task Force.

The SVO is now proposing a new clean amendment which is substantially similar to the original and reflects the comments from some Task Force and Statutory Accounting Principles (E) Working Group members that they would like the SVO to retain discretion to notch down, as it deems appropriate. Like the November 2020 amendment, the Task Force would direct the SVO to imply the parent’s support of its subsidiary and would give the SVO discretion to assign an NAIC Designation to the subsidiary which is lower than that of the parent based on its assessment of the parent/subsidiary relationship. However, this new proposal clarifies that if the SVO notches the NAIC Designation of a subsidiary obligor down from that of its parent resulting in a credit assessment below an NAIC 2, the WCFI program would not be eligible for an NAIC Designation because it would no longer meet the definition of an eligible “Obligor” in SSAP 105R – Working Capital Finance Investments.

Mr. Fry said one thing that is important to regulators is that the Task Force created a framework for working capital finance investments and put a lot of guardrails around them. This is one of the reasons why the Task Force got comfortable with this asset class. Some these subsidiaries that issue the working capital finance notes do not have a rating but are consolidated into a larger group and a top entity is rated. There are a lot of interconnectedness and relationships between those entities short of a full guarantee of it, but it has a place in the structure. In those cases, the Task Force could use this policy to just use the top rating. If the SVO saw something abnormal or something that was a little out of place from that what would be normally seen, the SVO could notch. If it does not pass the NAIC smell test for any reasons, the SVO can notch it down. If it falls below investment grade it will not even be allowed to be admitted. It will make a lot of sense for the Task Force, if it decides to go
with this policy, to monitor the activity and what the transaction looking like. If there was anything about them that is concerning, the policy could always be adjusted. The Financial Accounting Standards Board (FASB) and U.S. Securities Exchange Commission (SEC) are looking at these investments too. FASB is looking at possibly creating new disclosure requirements.

Mr. Fry directed the SVO to expose this proposed amendment to the P&P Manual to assign NAIC Designations to unrated subsidiaries in Working Capital Finance Investment transactions for a 60-day public comment period ending Friday, Feb. 11, 2021.

8. **Heard a Staff Report on the Use of NAIC Designations by Other Jurisdictions in the Regulation of Insurers**

Mr. Fry said the next item is to discuss a recent request that the SVO received related to non-U.S. jurisdictions wishing to reference NAIC Designations.

Charles Therriault (NAIC) said the SVO was made aware of regulators or insurers in non-U.S. jurisdictions, such as the Bermuda Monetary Authority and Japan’s Financial Services Agency, either referencing NAIC Designations in their regulatory processes or wanting to reference them. The P&P Manual is very specific that NAIC Designations are only intended for NAIC members consisting of the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories. For example, the P&P says of the intended, proper and authorized use of NAIC Designations is the following:

1. An NAIC designation for quality (NAIC Designation) of a security is produced solely for NAIC members who should interpret the designation for quality, in the context of the NAIC Financial Regulation Standards and Accreditation Program, a member’s state insurance laws and regulations, and the regulatory or financial solvency profile of a specific insurance company.

2. Because an NAIC Designation, is not produced to aid the investment decision-making process, NAIC Designations are not deemed to be suitable for use by anyone but NAIC members.

3. NAIC Designations are not intended to be and should not be used as if they were the functional equivalent of the credit ratings of nationally recognized statistical rating organizations or other rating organizations whose ratings are intended to be used by investors as predictive opinions of default risk.

4. The use or adoption of NAIC Designations by anyone other than NAIC members is improper and is not authorized by the NAIC.

5. NAIC Designations and other analytical products of the SVO and SSG are produced solely for the benefit of NAIC members in their capacity as state insurance department officials for use in the NAIC Financial Regulation Standards and Accreditation Program.

If, despite the noted restrictions on the use of NAIC Designations, NAIC members consider it worthwhile to have the ability to approve the use of NAIC Designations by the insurance regulators of certain non-member jurisdictions, the SVO would recommend certain conditions to be met. These conditions would include acknowledgement by the requesting regulator in a memo of understanding (i) of the intended purposes of NAIC Designations (including that NAIC Designations are not the functional equivalent of credit ratings), and (ii) that the requesting regulator’s uses may deviate from the NAIC’s intended purposes. Additionally, a formal process would need to be created, involving necessary amendments to the P&P Manual, to authorize and rescind authorization of the requesting jurisdiction. Consideration of the jurisdiction’s recognition by the Mutual Recognition of Jurisdictions (E) Working Group could be another requirement of authorization. Once authorized and listed in the P&P Manual, insurers in that jurisdiction could then be given access to the SVO List of Investment Securities compiled in AVS+ and be permitted to file securities with the SVO. The SVO is issuing this report just to request guidance from the Task Force on how to proceed forward.

Mr. Fry said as a regulator over the years, there are certain jurisdictions, i.e. Cayman, if you form an insurer or reinsurer there, it can also select the accounting methodology to use there, the U.S. RBC system is an option. And in that case, regulators are very comfortable with that as the ratings are understandable and how they are used. In that context, it would seem useful. It is important to acknowledge that NAIC designations are produced for NAIC members and intended for NAIC regulatory purposes. From a legal perspective, it would be important to be upfront with the limitations of NAIC designations. Before pursuing all that, this is letting the Task Force know it is something being considered. If there are no concerns, the SVO staff will proceed along these lines of developing some guidance that would clarify the issues. Task Force member can reach out to the SVO staff if they have any comments. No action is needed at this time other than soliciting input from the Task Force.
9. **Heard a Staff Report on Rating Issues and Proposed Changes to the FE Process**

Mr. Fry said the next item is to hear a report from the Investment Analysis Office on issues they are seeing with the NAIC’s use of ratings. This issue has been before the Task Force several times, most recently it was discussed at the Task Force’s Educational Session this October during a confidential session. The themes in this memo echo the findings of the Rating Agency Working Group that was formed to study the NAIC’s reliance on rating agencies after the Financial Crisis in 2008. The Working Group’s recommendation were adopted by the NAIC in 2010 and it may be time for the Task Force to refresh themselves on these adopted items.

Charles Therriault (NAIC) said the SVO, Structured Securities Group (SSG) and Capital Markets Bureau (CMB) staff have raised our concerns about the NAIC’s reliance on rating agency ratings several times. The SVO staff have twice before analyzed cross rating agency rating differences and the results of this most recent analysis is consistent with the prior reviews. As was requested by the Task Force last year when it was discussing private letter rating rationale reports, the SVO provided the Task Force with an in-depth review into some of the specific issues and inconsistencies it is seeing. The SVO walked the Task Force through 43 different privately rated securities that had risk assessments that were materially different that the SVO staff’s assessment, material being 3-6+ rating notches higher or 1-2 full ratings categories higher. This was not intended to be an exhaustive audit of all privately rated securities was only highlighting to the Task Force that there are meaningful deviations that SVO is seeing in risk assessment that can result in inappropriately low Risk Based Capital (RBC) for very risky assets.

The NAIC relies heavily on credit rating providers to assess the risk for the vast majoring of insurer investments. This reliance comes with no oversight as to the analytical basis for those ratings, the applicability or strength of the methodology, or the consistency of the resulting risk assessments. The SVO is not charged with monitoring credit rating providers or authorized to use its judgement or discretion to determine how, when and if a CRP rating should be used for NAIC purposes. Quoting from some of the Rating Agency (E) Working Groups recommendations from 2010:

> VOS should continue to develop independent analytical processes to assess investment risks. These mechanisms can be tailored to address unique regulatory concerns and should be developed for use either as supplements or alternatives to ratings, depending upon the specific regulatory process under consideration.

> ARO (we now call them credit rating providers or CRPs) ratings have a role in regulation; however, since the ratings cannot be used to measure all the risk that a single investment or a mix of investments may represent in an insurer’s portfolio, NAIC policy on the use of ARO ratings should be highly selective and incorporate both supplemental and alternative risk assessment benchmarks.

> NAIC should evaluate whether to expand the use of SVO and increase regulator reliance on the SVO for evaluating credit and other risks of securities.

> Consideration should be given to modifying the filing exempt rule to adjust for securities with new additional ARO ratings and other measures (such as V Scores and Parameter Sensitivities) when deemed applicable. The need for difference RBC and/or some other additional regulatory process should be evaluated. Such processes could include the use of market information on price direction and of yield trends in addition to ARO ratings for some or all filing exempt securities. Securities highlighted by this process can be reviewed by the SVO with the objective of adjusting the ARO rating to help ensure an accurate RBC charge.

The Working Group’s recommendations are matched by staff’s concerns today, that CRP rating does not reflect a reasonable assessment of a security’s risk and the validity of the resulting RBC ratio, that relies upon that CRP rating to determine the factor to apply to that security, may be significantly compromised.

Marc Perlman (NAIC) said a common misconception about SEC oversight of rating agencies. Many people think that the SEC’s recognition of a rating agency as an NRSRO means that the SEC has reviewed and approved of that rating agency’s criteria and methodologies. That is not the case. NRSROs are regulated by the SEC, but under the Credit Rating Agency Reform Act of 2006, (which introduced Section 15 of the Securities Exchange Act) the SEC and States are forbidden from regulating NRSRO methodologies. The SEC cannot approve of or regulate the substance of a rating agency’s methodologies.

It cannot opine on the quality of a methodology. The SEC can enforce adherence to the process by which those methodologies were created and are applied.
The purpose of rating agency regulation is to improve ratings quality through transparency and competition. It’s not to create uniform rating agencies with fungible methodologies and ratings but rather to expose the differences between the agencies. Like other federal approaches to securities regulation, NRSRO regulation focuses on accurate disclosure, allowing users of ratings, like the NAIC, to choose the NRSRO that best meets their needs.

Charles Therriault (NAIC) said in the attachment there are three different types of analysis comparing rating agency ratings, one looking the absolute values of rating notch differences between CRPs that rated the same security, the next cross-correlations between each CRP on securities rated by both and finally a principal component analysis that statistically portrays how alike or dissimilar each CRP is to one another. The identity of each rating agency was concealed to maintain confidentiality, but these charts show that there are significant differences between ratings agencies. Ratings are not fungible; a AAA is not a AAA no matter which CRP generates it. And because CRP assessments of risk are different, IAO staff believe, as did the Rating Agency (E) Working Group, that how each CRP’s ratings are used in NAIC processes should also be different.

Eric Kolchinsky (NAIC) said some of the options that could be used for a better use of rating agency information are listed in the memo. The first option is to require at least two or sometimes more ratings for each security and then use the lowest of the two. If a security only has one rating, there is a process by which it is identified so that the SVO can look at the quality of that rating. Option two is a study, so this would look at the process by which the NAIC came up to the risk-based capital analysis. Those provide specific thresholds for each performance, rating, and the historical performance of each rating agency could be compared to those benchmarks, the thresholds. That is a lengthy process, but quite doable. Option three is something like what the NAIC does for RMBS and CMBS. The rating agencies are one of the few vendors that do not go through a RFQ or request for qualifications. Under this option they would be looked at like any other vendor and set up qualifications. The NAIC could look at that process of using that information at the NAIC and create a closer contractual relationship between the NAIC and rating agencies. Option four is for the Task Force to eliminate one or more rating agencies that could be done based on criteria, based on recommendations from a state or based on recommendations from another group such as the Financial Analysis (E) Working Group (FAWG). And lastly, a combination of one or more of these options as well, the options are not exclusive to one another.

Mr. Fry said the filing exempt (FE) process is something that Task Force has looked at a lot over the years. In 2004 the idea about letting companies self-designate was talked about but did not come to fruition. Rating agencies have been the NAIC’s best option for RBC framework, leveraging off their credit ratings to turn them into a factor and that runs through RBC. The Task Force has seen some securities that do draw questions. This memo that was put out is a great starting point. There are a lot of questions that will be generated from this memo and a lot of people would like to understand the sample better and understand some of the statistics behind it. This document best purpose will be a starting point of discussion for the Task Force. One approach could be as Task Force goes into next year, form a smaller group of regulators, industry participants, and rating agencies, in a regulator only setting. This document could be used and gather everyone else's ideas because feedback is needed. Something needs to be done with FE, like anything else, it needs to be enhanced over time and doing what it's supposed to do. The SVO and regulators do not want to go fast and cause market turmoil and uncertainty. This must be a careful and collaborative approach.

Ms. Mears said she supports the idea of moving forward with a small study group that includes industry and has seen the benefits of that in other Working Groups and Task Forces. That collaboration between regulators, industry, other potential interested parties, and stakeholders can result in a proposal here that makes a lot of sense and addresses the core issues that has been seen. She appreciates the work that the SVO has done to bring these issues to light and agrees that it should be a priority next year.

Mr. Schrader said there are a number of different asset classes that are rated. The Task Force needs to look holistically at some rating agencies that have different methodologies and different types of classes. Is very important to make sure the regulators who are relying upon this understand what they are relying upon. If there are issues or concerns, the states have the authority to take action within their statute. It is most important to be consistent and hold the entire industry to the same standard. As Ms. Mears and Mr. Fry mentioned, to give the industry some certainty that when they invest in an asset, they sort of know upfront have a reasonable assumption of what the effects may be.

Mr. Fry received the report to use it as a basis for beginning discussions in 2022 and encouraged feedback.

10. **Heard a Staff Report on a Project of the Statutory Accounting Principles (E) Working Group**

Mr. Fry said the next agenda item is to hear a report on projects before the Statutory Accounting Principles (E) Working Group.
Julie Gann (NAIC) said this report is just more of the coordination initiative to identify key items that the Working Group addressed to this Task Force as well. The Working Group met Saturday, Dec. 12th with a full agenda and addressed several items.

With regards to adopted items, the first is related to credit tenant loans. The Working Group adopted revisions to SSAP No. 43R – Loan-Backed and Structured Securities to explicitly identify the SVO identified credit tenant loans in scope. It is the final step with the credit tenant loan discussions over the last couple of years. With that adoption, examples from paragraph 27 were removed, which is not a scope paragraph, from the contents of the statements of statutory accounting principles (SSAP). The Working Group also explicitly notified the INT on credit tenant loans, which is 20-10 and had already expired. The Working Group wanted to identify the revisions that were adopted by the Task Force and the action by the Working Group was explicitly noted for historical purposes. The Working Group disposed the agenda item that had been drafted for credit tenant loans as it was no longer necessary.

The Working Group also adopted an agenda item indicating support for enhanced reporting of Federal Home Loan Bank borrowings in Exhibit 7 when they are structured as deposit type contracts. There were no statutory accounting revisions for that item, but it is support for a blanks proposal which is currently out there. It will be in effect for 2022, not for this year end. There was some regulator feedback wanting to have those breakouts on Exhibit 7 as to where the Federal Home Loan Bank borrowings were captured. These changes will have a 2022 effective date.

With regards to exposures, first, the Working Group exposed revisions to SSAP No. 25 – Affiliates and Other Related Parties and SSAP No. 43R to improve the reporting of related party investments. This agenda item does two things. First, it clarifies the reporting of affiliated investments in accordance with the existing definition of an affiliate that is in the model law, SSAP No. 25 and SSAP No. 97 – Investments in Subsidiary, Controlled and Affiliated Entities. The Working Group is trying not to conflict with that existing definition, but what it also does is it proposes new reporting of related party investments through an electronic column in the investment schedule that would encompass all investments that are reported on the investment schedules. The goal there is to identify the involvement of related parties with regards to investments held. A key element has to do with if the related party is an originator or a sponsor of an investment, but the investment may not reflect an investment in the related party, per se. That is currently exposed for comment. It is also going to have a blanks proposal with an anticipated effective date of 2022, and it is anticipated that the blanks proposal will be exposed by the end of the year, if not early January.

The Working Group also exposed revisions to SSAP No. 43R are to reflect adopted changes from this Task Force as it pertains to the NAIC designation and the designation category for RMBS/CMBS under the financial modeling procedure. This has two options in the exposure. The first one is to reflect the revisions that were adopted by this Task Force in the SSAP No. 43R. The second option is to remove all that guidance from SSAP No. 43R and instead refer to the P&P Manual for guidance. And if you go back in time, that was the original process for those designations. In 2008, in response to the financial crisis and when the financial modeling was created, the Working Group pulled that guidance into SSAP No. 43R. The question is being asked if there is a need to continue that guidance in the SSAP or just refer to the P&P Manual. The Working Group would like feedback from the Task Force and industry with regards to those two options.

With regards to the bond proposal project, two items were exposed. The first is a reporting option discussion draft that presents different options for changes on Schedule D-1. This is a sizable change that is being considered for reporting on Schedule D-1, and the full intent is to have improved granularity and transparency on the investments that are being reported. In addition to reporting lines for the types of investments. It also asks questions on the current columns are captured, such as the code column, the collateral type of column, the bond characteristic column and asks questions on what information is currently being utilized, what is beneficial, what should be added. There are a lot of questions in that discussion draft, so definitely looking for feedback from regulators and industry with regards to that. Also on the bond proposal project, the Working Group exposed tracked changes to the principal concepts for a credit enhancement which is a required component for classifying an investment as an asset backed security. Originally, the terminology was for it a sufficient credit enhancement, and that was revised to be a substantive credit enhancement to better reflect the principal intent of that guidance. That is reflected both in the principle-based bond definition guidance, as well as in the examples that go along with that principle-based bond definitions.

The Working Group also exposed revisions to expand the information that is reported for subsidiary controlled and affiliated investments (SCA) on Schedule D-6-1. Those SCAs are filed with the NAIC and used to go to the New York office. Now they come to the Kansas City Office. NAIC staff have seen over time where there may be NAIC staff adjustments based on the guidance that is in SSAP No. 97 and those revisions are not reflected in the next year's report in Schedule D-6-1. It is a recurring issue with regards to the adjustments not being made. These enhancements to Schedule D-6-1 are also in the electronic columns, and they just identify the NAIC adjusted value from the prior year, as well as additional information on the filing information. It is easier for the regulators to see if there is a sizable difference from what the company reported to what the NAIC adjusted
value was. The comment deadline for all these exposures is Feb. 18, 2022. There were two other exposures not discussed today that had an earlier comment deadline of Jan. 14. All the adoptions and exposures are on the SAPWG summary, which should be posted.

11. **Discussed Other Matters**

Charles Therriault (NAIC) said the licensing for AVS+ system, where the NAIC produces and publishes NAIC designations and prices, has now moved to a full calendar year for 2022. There was a transition period in 2021 where the fee was adjusted for the 11-month period last year. The licenses used to renew in January and now it will be for the full calendar year. The 2022 fee is a little different from 2021 because it represents a full year, whereas last year it was just the 11-month period.

Mr. Fry announced that Kathy Belfi and himself are retiring in 2022.

Having no further business, the Valuation of Securities (E) Task Force adjourned.
The Valuation of Securities (E) Task Force met Nov. 17, 2021. The following Task Force members participated: Dana Popish Severinghaus, Chair, represented by Kevin Fry (IL); Doug Ommen, Vice Chair, represented by Carrie Mears (IA); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kenneth Cotrone (CT); Dean L. Cameron represented by Eric Fletcher (ID); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Matt Kozak (MD); Chlora Lindley-Myers represented by Debbie Doggett (MO); Eric Dunning represented by Lindsay Crawford (NE); Marlene Caride represented by Nakia Reid (NJ); Adrienne A. Harris represented by Jim Everett (NY); Cassie Brown represented by Amy Garcia (TX); Jonathan T. Pike represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); Mike Kreidler represented by Tim Hays (WA); and Mark Afable represented by Michael Erdman (WI).

1. **Adopted an Amendment to the P&P Manual to Add the DFC to the U.S. Government Full Faith and Credit – Filing Exempt List**

Mr. Fry said the first agenda item is to discuss and consider adoption of an amendment to the *Purposes & Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) for the addition of the U.S. International Development Finance Corporation (DFC) to the “U.S. Government Full Faith and Credit – Filing Exempt” list. This list reflects entities that are instrumentalities of the U.S. government, and the debt obligations issued by them must be fully guaranteed or insured as to the timely payment of principal and interest by the full faith and credit of the U.S. government. Satisfying this high standard permits them to be filing exempt (FE) and reported as an NAIC designation category of 1.A.

Marc Perlman (NAIC) said this is an amendment to add the DFC to the “U.S. Government Full Faith and Credit – Filing Exempt” list in Part 1 of the P&P Manual. Under the 2018 Better Utilization of Investments Leading to Development Act (BUILD Act), the U.S. Overseas Private Investment Corporation (OPIC) and the Development Credit Authority of the U.S. Agency for International Development (USAID) were reorganized and merged into a new agency called the DFC. The purpose of the DFC is to facilitate the participation of private sector capital and skills in the economic development of less developed countries and countries transitioning to market economies, while advancing U.S. foreign policy interests. It is authorized to do so by making loans or guaranties according to terms and conditions specified in the BUILD Act.

Under the BUILD Act, the support provided by the DFC, and existing support provided by the OPIC and the USAID, shall continue, to constitute obligations of the U.S., and the full faith and credit of the U.S. is pledged for the full payment and performance of its obligations. The DFC is authorized to borrow from the U.S. Department of the Treasury (Treasury Department) to fulfill such obligations of the U.S.

Based on this express full faith and credit, the Securities Valuation Office (SVO) recommends adding the DFC to the “U.S. Government Full Faith and Credit – Filing Exempt” list in Part 1 of the P&P Manual and recommends maintaining the OPIC and the USAID on the list even though they have been subsumed by the DFC, because certain obligations of those agencies may still be outstanding.

For the avoidance of doubt, any security issued by an entity on the “U.S. Government Full Faith and Credit – Filing Exempt” list shall be filed with the SVO if the security’s principal and interest are not *fully* guaranteed by the U.S. government. For certain entities on the list, statutes may require parties other than the U.S. government full faith and credit guarantor to bear a risk of loss equal to a specified percentage of the guaranteed support. For example, the BUILD Act requires parties to a project to bear the risk of loss in an amount of at least 20 percent of the guaranteed support of the DFC. If an insurance company, as investor, is the party bearing that risk of loss, meaning the securities it purchased are not fully guaranteed by the DFC or another entity on the list, it would need to file those securities with the SVO.

The P&P Manual explains that the SVO has no compliance mechanism for these U.S. government obligations and encourages insurers that are uncertain about the FE status of a security to either file it with the SVO or use the Regulatory Treatment Analysis Service (RTAS) – Emerging Investment Vehicle process.
Mike Reis (American Council of Life Insurers—ACLI and the North American Securities Valuation Association—NASVA) said the ACLI and NASVA support the proposal.

Ms. Doggett made a motion, seconded by Mr. Guerin, to adopt the amendment to the P&P Manual for the addition of the DFC to the “U.S. Government Full Faith and Credit – Filing Exempt” list (Attachment One-A). The motion passed unanimously.

2. **Adopted an Amendment to the P&P Manual to Add Bank Loans**

Mr. Fry said the next agenda item is to discuss and consider adoption of a P&P Manual amendment to include bank loans to the definition of “obligation.”

Mr. Perlman said since 2018 the *Accounting Practices and Procedures Manual* (AP&P Manual) has included bank loans issued directly by a reporting entity or acquired through a participation, syndication, or assignment in *Statement of Statutory Accounting Principles (SSAP) No. 26R—Bonds*. Pursuant to SSAP No. 26R, “bank loans” mean fixed-income instruments, representing indebtedness of a borrower, made by a financial institution.

To maintain consistency with the bond definition in SSAP No. 26R, the SVO proposes amending the P&P Manual to clarify that the SVO can assess and assign NAIC designations to bank loans and the relevant filing instructions and methodology. The filing instructions and methodology would follow that of other corporate obligations. To be clear, SSAP No. 26R already includes bank loans in the definition of “bond,” so this amendment would only align the P&P Manual to the AP&P Manual and would not be changing current statutory guidance.

Mr. Reis said the ACLI and NASVA support the proposal.

Mr. Fletcher made a motion, seconded by Ms. Reid, to adopt the amendment to the P&P Manual to add bank loans (Attachment One-B). The motion passed unanimously.

3. **Exposed a Referral from the Statutory Accounting Principles (E) Working Group and a Proposed Amendment to the P&P Manual to Remove Residuals Tranches From Receiving an NAIC Designation**

Mr. Fry said the next agenda item is to receive a referral from the Statutory Accounting Principles (E) Working Group and consider exposure of a proposed amendment to the P&P Manual to remove residual tranches from receiving an NAIC designation. Residual tranches capture securitization tranches and beneficial interests that reflect loss layers without any contractual payment of principal or interest. Instead, residual tranches are paid after contractual payments of principle and interests have been made to other tranches and are based on the remaining available funds.

Charles A. Therriault (NAIC) said the Statutory Accounting Principles (E) Working Group identified inconsistencies in how residual tranches and interests were being reported, with some entities reporting them on Schedule BA: Other Long-Term Invested Assets, and others reporting them on Schedule D-1: Long-Term Bonds with either self-assigned NAIC 5GI or NAIC 6 designations. To prevent further inconsistency and direct appropriate reporting, on Nov. 10, the Working Group adopted an amendment to SSAP No. 43R—Loan-Backed and Structured Securities to clarify that residual tranches and interests shall be reported on Schedule BA. To accommodate the time frame needed for a Blanks (E) Working Group proposal to expand reporting lines on Schedule BA to capture residual tranches and interests, the Working Group’s amendment permits residual tranches and interests currently reported on Schedule D-1 to continue to be reported on Schedule D-1 for reporting year 2021 with an ultimate effective date of Dec. 31, 2022.

The SVO recommends that during this window when residual tranches currently reported on Schedule D-1 are permitted to stay on D-1, they should be allowed to do so only with an NAIC 6* designation and not an NAIC 5GI designation. This is consistent with the Working Group’s adopted change. The NAIC 5GI designation is not appropriate for residual tranches and interests because according to the P&P Manual, an insurance company is permitted to self-assign an NAIC 5GI to an obligation if it meets all of the following criteria:

- Documentation necessary to permit a full credit analysis of the security by the SVO does not exist or an NAIC credit rating provider (CRP) rating for an FE or private letter (PL) security is not available.
- The issuer or obligor is current on all contracted interest and principal payments.
- The insurer has an actual expectation of ultimate payment of all contracted interest and principal.
Assignment of an NAIC 5GI designation for residual investments is an incorrect application of the guidance because: 1) there are no contracted interest and principal payments to certify as current; and 2) the insurer cannot have an actual expectation of receiving all contractual principal and interest of the underlying collateral as these tranches absorb the losses first for the securitization structure. Although cash flows may pass through to the residual holders at periodic intervals under the waterfall, ultimate returns depend on continued performance. Therefore, there can be no actual expectation that future payments will be received.

Along with the proposed P&P Manual language requiring residuals to be reported on Schedule BA, there is a proposed provision stating that for 2021 year-end reporting, residuals will be permitted on Schedule D-1 with an NAIC 6. If adopted, the SVO requests the Task Force’s permission to remove that provision from the December 2022 version of the P&P Manual without further authorization as it will be an obsolete instruction.

Next year, the SVO would like to address additional items in the Working Group’s referral with the Task Force regarding the meanings of NAIC 5GI and 6, namely:

- Clarifications to ensure that the NAIC 5GI self-assigned designation is permitted only for securities that could be reviewed for an NAIC designation if the documentation to support a credit analysis could be submitted.
- Clarification that self-assigning an NAIC 6* for securities that do not qualify for NAIC 5GI is not a declaration of potential default. Rather, the self-assignment indicates that the security could not be reviewed for a full credit analysis, and the requirements for an NAIC 5GI could not be met.

Mr. Cohen (KKR & Co. Inc.) asked about the definition of the “residual interest.” For structured securities that are unrated at the tranche level but the securitization meets safe harbor rules modeling, should insurers expect to receive modeling results for those securities within the securitization? Eric Kolchinsky (NAIC) said there are a number of other limitations on what does and does not get modeled within the modeling process. Safe harbor is one of them, and the ability and model fit is another issue that is considered when modeling securities. Mr. Cohen said for single-asset, single-borrower commercial mortgage-backed securities (CMBS) transactions, where the securitization is backed by a single mortgage, there are ranging anywhere from 40% loan-to-value (LTV) to up to 75% LTV. The ratings designations are based on rating agency framework. In the cases of tranches that might be above a 60% LTV, there are not a lot of ratings on them and they are unrated, but they do receive contractual principal and interest. For these transactions that are not pool transactions, that are straightforward mortgage securitizations, the question is what should we expect to receive for modeling results. And if not, if capital designations can be provided for the rest of the capital structure, and there is a situation where an insurance company owns mezzanine debt that is junior to this tranche, can some type of designation framework be created? Mr. Therriault suggested taking the question offline because it is unrelated to the amendment the Task Force is considering.

Mr. Fry directed the SVO to expose the P&P Manual amendment to clarify proper reporting and designation for residual tranches and interests for a 15-day public comment period ending Dec. 2 so that the Task Force can consider it for adoption at the Fall National Meeting.

4. Exposed a Proposed Technical Correction Amendment to the P&P Manual Clarifying 5GI Mapping to the NAIC Designation Category

Mr. Fry said the next item is to receive and consider exposure of a technical correction amendment to the P&P Manual clarifying 5GI mapping to a designation category in the recently amended PL rating section.

Mr. Perlman said that during at the Task Force’s May 24 meeting, it adopted an amendment to the P&P Manual requiring the submission of private rating letter rationale reports with certain private rating letters filed with the SVO. In the May amendment, certain language, which is currently in the printed December 2020 version of the P&P Manual and clarifies that an NAIC 5GI designation is the equivalent of an NAIC 5.B designation category, was mistakenly omitted. The SVO proposes a non-substantive technical amendment to the May amendment to reinsert the omitted language.

Mr. Fry directed the SVO to expose this non-substantive technical correction amendment to the P&P Manual to clarify the mapping of NAIC 5GI to a designation category for a 15-day public comment period ending Dec. 2 so that the Task Force can consider it for adoption at the Fall National Meeting.
5. **Receive a Report from the SSG on the Year-End Process**

Mr. Fry said the next agenda item is to receive a report from the Structured Securities Group (SSG) on the year-end process.

Mr. Kolchinsky said everyone should receive two files, one for legacy with breakpoints and one for non-legacy with designations. The year-end process is on time and should be delivered within normal schedule. The SSG has a lot of work to do next year. There are two main issues to deal with: 1) introduce new scenarios through the cycle. For residential mortgage-backed securities (RMBS), the SSG will draw from the same distribution that was done for the current year, and for CMBS, new scenarios will be introduced; and 2) there will be new mappings to map all 20 NAIC designation categories and 19 breakpoints based on the new risk-based capital (RBC) factors. This will all go through the Task Force next year.

Having no further business, the Valuation of Securities (E) Task Force adjourned.

https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2021/12 December FALL NATIONAL METING/01 - Meeting minutes/VOSTF 11.17.21 Meeting Minutes (Final).docx
TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force  
Members of the Valuation of Securities (E) Task Force 

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)  
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO) 

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau 


DATE: September 3, 2021 


In October 2018 the Better Utilization of Investments Leading to Development ("BUILD") Act was signed into law. The BUILD Act reorganized and merged existing United State government development finance and aid programs, the U.S. Overseas Private Investment Corporation ("OPIC") and the Development Credit Authority of the United Stated Agency for International Development ("USAID"), into a new agency called the U.S. International Development Finance Corporation ("DFC"). The purposed of the DFC is to facilitate the participation of private sector capital and skills in the economic development of less developed countries and countries transitioning to market economies, while advancing U.S. foreign policy interests. It is authorized to do so by making loans or guaranties according to terms and conditions specified in the BUILD Act. 

Pursuant to the BUILD Act, the support provided by the DFC shall, and existing support provided by OPIC and USAID shall continue, to constitute obligations of the United States, and the full faith and credit of the United States is thereby pledged for the full payment and performance of such obligations. The DFC is authorized to borrow from the U.S. Treasury to fulfill such obligations of the United States. 

Based on this express full faith and credit, the SVO recommends adding the DFC to the “U.S. Government Full Faith and Credit – Filing Exempt” list in Part One of the P&P. We recommend maintaining OPIC and USAID on the list even though they have been subsumed by the DFC, because certain obligations of those agencies may still be outstanding. 

For the avoidance of doubt, any security issued by an entity on the “U.S. Government Full Faith and Credit – Filing Exempt” list shall be filed with the SVO if the security is not fully guaranteed by the U.S. government. For certain entities on the list, statute may require parties other than the U.S. government
full faith and credit guarantor to bear a risk of loss equal to a specified percentage of the guaranteed support. For example, the BUILD Act requires parties to a project to bear the risk of loss in an amount of at least 20 percent of the guaranteed support of the DFC. If an insurance company, as investor, is the party bearing that risk of loss, meaning the securities it purchased are not fully guaranteed by the DFC or another entity on the list, it would need to file those securities with the SVO.

The P&P explains that the SVO has no compliance mechanism for these U.S. Government Obligations and encourages insurers which are uncertain about the Filing Exempt status of a security to either file it with the SVO or use the Regulatory Treatment Analysis Service (RTAS) – Emerging Investment Vehicle process. (P&P Part One, Paragraphs 75-76).

**Proposed Amendment** - The text changes to include the DFC on the “U.S. Government Full Faith and Credit – Filing Exempt” list is shown below with additions in red underline and deletions in red strikethrough, as it would appear in the 2021 P&P Manual format.
PART ONE

POLICIES OF THE NAIC VALUATION OF SECURITIES (E) TASK FORCE
FILING EXEMPTION FOR U.S. GOVERNMENT SECURITIES

Initial Filing Conventions and Documentation

66. **U.S. Government Securities Required to Be Filed with the SVO** – U.S. Government debt that is not issued by, or guaranteed or insured by, those entities listed in below are subject to the filing exemption when rated by an NAIC CRP, otherwise, they must be filed with the SVO.

SVO Publishing Conventions for Filing Exempt U.S. Government Securities

67. **U.S. Treasury Obligations** – U.S. Treasury Obligations are added to the VOS Process automatically, and they appear in the VOS Product. The NAIC Designation is **NAIC 1** and the NAIC Designation Category is **NAIC 1.A**.

Other Filing Exempt U.S. Government Securities

68. A single entry is in the AVS+ Products in its normal CUSIP sequence, followed by the description “All Issues” for the securities listed below.

69. Because these securities are Filing Exempt, CUSIP numbers are not published in the AVS+ Products. The securities should, however, be reported with a CUSIP in the appropriate section of Schedule D. The NAIC Designation is **NAIC 1** and the NAIC Designation Category is **NAIC 1.A**.

Filing Requirements for U.S. Government Securities

70. No filing is required for the securities deemed exempt from filing below unless a state insurance department has specifically requested the SVO to evaluate an exempt security.

71. For U.S. Government Securities required to be filed with the SVO, the reporting insurance company shall submit:

- A prospectus of the security that includes a description of the U.S. government program under which it is issued; and
- Appropriate evidence that the security or other obligation is backed by the U.S. government, an agency of the U.S. government or a U.S. government sponsored enterprise.

72. A variety of documents are acceptable as evidence that the issuer in question has some degree of support from the U.S. government. A copy of the legislation that created the entity or the program is acceptable as evidence of government support. Additionally, a copy of the guaranty or insurance policy for the transaction is also good evidence of government support. Another acceptable form of evidence is evidence of an NAIC CRP rating with a copy of the rating rationale memorandum discussing the role of U.S. government support. Oftentimes, the prospectus for the security describes in sufficient
detail the relationship of the entity to the U.S. government, its agency or its government-sponsored enterprise.

73. It is not enough to merely establish a relationship between the U.S. government and the entity. It is necessary to provide materials that specifically describe all of the financial terms of the obligation and the manner in which the U.S. government will pay the obligation.

Subsequent Filing
74. No subsequent report (i.e., an annual update filing) is required for non-exempt U.S. government securities. However, a material credit events filing is required for nonexempt U.S. government securities if:

- The legislation authorizing the program has been rescinded;
- The transaction terms and/or the transaction documents have been waived, amended or modified; or
- If the legal commitment of the U.S. government, U.S. government agency or U.S. government sponsored entity has been allowed to lapse or has been withdrawn.

Filing Exemption for Direct Claims on, or Backed by Full Faith and Credit of, the United States
75. This section defines what the NAIC deems to be U.S. Government Obligations. They are not required to be filed with the SVO.

NOTE: Because these filing exemption provisions are set forth without any compliance mechanism, the SVO will not be able to verify whether insurers have filed all securities that are required to be filed with the SVO. State insurance department regulators may wish to create their own compliance mechanisms to protect any interests they may have relative to their domiciliary insurers.

76. The SVO does not have responsibility for determining whether specific securities should be filing exempt. An insurer who is uncertain whether a specific security qualifies for exemption should not contact the SVO for guidance, but should either file the security with the SVO or use the RTAS – Emerging Investment Vehicle Service process and obtain an opinion on exemption for that security.

Definitions
77. U.S. Government Obligation – All direct claims (including securities, loans, and leases) on, and the portions of claims that are directly and unconditionally issued, guaranteed or insured by the U.S. Government or its agencies.

78. U.S. Government Agency – An instrumentality of the U.S. Government the debt
Obligations of which are fully guaranteed or insured as to the timely payment of principal and interest by the full faith and credit of the U.S. Government. This category includes in addition to direct claims on, and the portions of claims that are directly and unconditionally guaranteed by, the U.S. Government agencies listed below, claims collateralized by securities issued or guaranteed by the U.S. Government agencies listed below for which a positive margin of collateral is maintained on a daily basis, fully taking into account any change in the insurance company’s exposure to the obligor or counterparty under a claim in relation to the market value of the collateral held in support of that claim.

<table>
<thead>
<tr>
<th>U.S. Government Full Faith and Credit – Filing Exempt</th>
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<tbody>
<tr>
<td>Army and Air Force Exchange Service (AAFES)</td>
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<td>Commodity Credit Corporation (CCC)</td>
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<tr>
<td>Export–Import Bank of the United States (EXIM Bank)</td>
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<tr>
<td>Farmers Home Administration (FmHA) – Certificates of Beneficial Ownership</td>
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<td>Federal Deposit Insurance Corporation (FDIC)</td>
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<td>Overseas Private Investment Corp (OPIC)</td>
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<td>U.S. Department of Veterans Affairs (VA)</td>
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<td>U.S. International Development Finance Corporation (DFC)</td>
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<td>U.S. Maritime Administration (MARAD)</td>
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<td>Washington Metropolitan Area Transit Authority</td>
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Filing Exemption for Other U.S. Government Obligations

79. Obligations issued and either guaranteed or insured, as to the timely payment of principal and interest, by the government agencies or government-sponsored enterprises listed below are filing exempt. They are not backed by the full faith and credit of the U.S. Government. The filing exemption here is based on an analytical judgment that the combined creditworthiness of the entity itself and U.S. government support for that entity provides confidence that the issuer will be able to pay its obligation on a full and timely basis at the level of an NAIC 1 quality designation and an NAIC Designation Category of NAIC 1.A. For the avoidance of doubt, preferred stock or similar securities of the government agencies or government-sponsored enterprises listed below are not considered guaranteed or insured and hence are not subject of this section.
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<tr>
<th>Filing Exempt Other U.S. Government Obligations if issued and either fully guaranteed or insured by:</th>
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<tr>
<td>Federal Agricultural Mortgage Corporation (Farmer Mac)</td>
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<td>Federal Farm Credit Banks (FFCB)</td>
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<td>Federal Home Loan Mortgage Corporation (Freddie Mac)</td>
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<td>Financing Corporation (FICO)</td>
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<td>Resolution Funding Corporation (REFCorp)</td>
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<td>Tennessee Valley Authority (TVA)</td>
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TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force  
Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)  
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Addition of a Bank Loans section to the Purposes Procedures Manual of the NAIC Investment  
Analysis Office

DATE: September 3, 2021

Summary – Since 2018 the Accounting Practices and Procedures Manual has included bank loans issued directly by a reporting entity or acquired through a participation, syndication or assignment in SSAP No. 26R – Bonds. Pursuant to SSAP No. 26R, bank loans means fixed-income instruments, representing indebtedness of a borrower, made by a financial institution.

In order to maintain consistency with the bond definition in SSAP No. 26R - Bonds, the SVO proposes amending the Purposes and Procedures Manual of the NAIC Investment Analysis Office (the “P&P Manual”) to clarify that the SVO can assess and assign NAIC Designations to bank loans and the relevant filing instructions and methodology. The filing instructions and methodology would follow that of other corporate obligations.

Proposed Amendment - The text changes to add bank loans to the SVO’s credit assessment responsibilities is shown below with additions in red underline and deletions in red strikethrough, as it would appear in the 2021 P&P Manual format.
PART THREE

SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION OF NAIC DESIGNATIONS
GENERAL CORPORATE AND MUNICIPAL METHODOLOGY FOR INDEPENDENT CREDIT QUALITY ASSESSMENT

NOTE: See “Special Instructions” (discussing Short-Term Investments, Circular Transactions, Mandatory Convertible Securities, Unrated Hybrid Securities and Sub-Paragraph D Companies) in Part One for policies that impact assignment of NAIC Designations.

27. Corporate bonds defined as the Obligations² of domestic and foreign corporations, and preferred stock shall be distinguished on the basis of the categories discussed below. The creditworthiness of the issuer of any particular category of Obligation shall be assessed by reference to the general, and any special, rating methodology discussed in this Part, unless the context of the analysis requires a different approach.

² Obligation means bonds, notes, debentures, certificates, including equipment trust certificates, production payments, bank certificates of deposit, bankers’ acceptances, credit tenant loans, loans secured by financing net leases, bank loans made by a financial institution (issued directly by a reporting entity or acquired through a participation, syndication or assignment (each, as defined in SSAP No. 26R – Bonds)), and other evidences of indebtedness for the payment of money (or a participation, certificates or other evidences of an interest in any of the foregoing), whether constituting general obligations of the issuer or payable only out of certain revenues or certain funds pledged or otherwise dedicated for payment.
BANK LOANS
The Valuation of Securities (E) Task Force met Sept. 30, 2021. The following Task Force members participated: Dana Popish Severinghaus, Chair, represented by Kevin Fry (IL); Doug Ommen, Vice Chair, represented by Carrie Mears (IA); Lori K. Wing-Heier represented by Wally Thomas (AK); Ricardo Lara represented by Laura Clements (CA); Andrew N. Mais represented by Kenneth Cotrone (CT); Trinidad Navarro represented by Rylynn Brown (DE); David Altmaier represented by Carolyn Morgan (FL); Dean L. Cameron represented by Eric Fletcher (ID); Vicki Schmidt represented by Tish Becker (KS); James J. Donelon represented by Stewart Guerin (LA); Gary D. Anderson represented by John Turchi (MA); Kathleen A. Birrane represented by Matt Kozak (MD); Chlora Lindley-Myers represented by Debbie Doggett (MO); Marlene Caride represented by Nakia Reid and John Sirovetz (NJ); Adrienne A. Harris represented by Jim Everett (NY); Cassie Brown represented by Amy Garcia (TX); Jonathan T. Pike represented by Jake Garn (UT); Scott A. White represented by Doug Stolte (VA); and Mike Kreidler represented by Tim Hays (WA).

1. **Adopted its 2022 Proposed Charges**

Mr. Fry said the Task Force’s 2022 proposed charges are unchanged, but there was a charge inadvertently omitted in the materials for the Summer National Meeting. That omission has been corrected along with the deletion of a reference to the Investment Risk-Based Capital (E) Working Group, which has been disbanded.

Mr. Thomas made a motion, seconded by Ms. Clements, to adopt the Task Force’s 2022 proposed charges (*see NAIC Proceedings – Fall 2021, Financial Condition (E) Committee, Attachment One-D*). The motion passed unanimously.

2. **Exposed a P&P Manual Amendment to Add the DFC to the “U.S. Government Full Faith and Credit – Filing Exempt” List**

Mr. Fry said the next agenda item is to discuss an amendment to the *Purpose and Procedures Manual of the NAIC Investment Analysis Office* (P&P Manual) to add the U.S. International Development Finance Corporation (DFC) to the “U.S. Government Full Faith and Credit – Filing Exempt” list. This list reflects entities that are instrumentalities of the U.S. government, and the debt obligations issued by them must be fully guaranteed or insured as to the timely payment of principal and interest by the full faith and credit of the U.S. government. Satisfying this high standard permits them to be Filing Exempt (FE) and reported as an NAIC Designation Category of 1.A.

Marc Perlman (NAIC) said an industry participant requested that the Securities Valuations Office (SVO) add the DFC to the “U.S. Government Full Faith and Credit – Filing Exempt” list in Part One of the P&P Manual.

In October 2018, the Better Utilization of Investments Leading to Development (BUILD) Act was signed into law. The BUILD Act reorganized and merged existing U.S. government development finance and aid programs, the Overseas Private Investment Corporation (OPIC), and the Development Credit Authority (DCA) of the U.S. Agency for International Development (USAID) into a new agency; i.e., the DFC. The purpose of the DFC is to facilitate the participation of private sector capital and skills in the economic development of less developed countries and countries transitioning to market economies, while advancing U.S. foreign policy interests. It is authorized to do so by making loans or guaranties according to terms and conditions specified in the BUILD Act.

Pursuant to the BUILD Act, the support provided by the DFC and existing support provided by the OPIC and USAID shall continue to constitute obligations of the U.S., and the full faith and credit of the U.S. is pledged for the full payment and performance of its obligations. The DFC is authorized to borrow from the U.S. Department of the Treasury (Treasury Department) to fulfill such obligations of the U.S. government.

Based on this express full faith and credit, the SVO recommends adding the DFC to the “U.S. Government Full Faith and Credit – Filing Exempt” list in Part One of the P&P Manual. The SVO recommends maintaining the OPIC and USAID on the list even though they have been subsumed by the DFC, because certain obligations of those agencies may still be outstanding.
For the avoidance of doubt, any security issued by an entity on the “U.S. Government Full Faith and Credit – Filing Exempt” list shall be filed with the SVO if the security is not fully guaranteed by the U.S. government. For certain entities on the list, statute may require parties other than the U.S. government full faith and credit guarantor to bear a risk of loss equal to a specified percentage of the guaranteed support. For example, the BUILD Act requires parties to a project to bear the risk of loss in an amount of at least 20% of the guaranteed support of the DFC. If an insurance company, as investor, is the party bearing that risk of loss, meaning the securities it purchased are not fully guaranteed by the DFC or another entity on the list, it would need to file those securities with the SVO.

The P&P Manual explains that the SVO has no compliance mechanism for these U.S. government obligations and encourages insurers that are uncertain about the FE status of a security to either file it with the SVO or use the Regulatory Treatment Analysis Service (RTAS) – Emerging Investment Vehicle process.

Mr. Fry directed the SVO to expose this P&P Manual amendment for the addition of the DFC to the “U.S. Government Full Faith and Credit – Filing Exempt” list for a 30-day public comment period ending Oct. 30.

3. Adopted a P&P Manual Amendment to Add Spanish GAAP to the List of Countries and Associated National Financial Presentation Standards

Mr. Fry said the next agenda item is to discuss and consider for adoption an amendment to the P&P Manual to add Spanish Generally Accepted Accounting Principles (GAAP) to the list of Countries and Associated National Financial Presentation Standards. There is a specific process that must be followed in the P&P Manual to add to the list of accepted National Financial Presentation Standards. Unlike other amendments that the Task Force considers, this process concludes with an assessment and recommendation by the SVO regarding whether the requested national accounting standard leads to an NAIC Designation analogous to those created by the use of a global financial presentation standard such as U.S. GAAP or International Financial Reporting Standards (IFRS).

Charles Therriault (NAIC) said in 2013, the Task Force adopted a procedure, outlined in Part Two, paragraphs 174–181 of the P&P Manual, on how to submit requests to consider other National Financial Presentation Standards and what steps must occur. The process and actions taken are as follows:

- A national insurance association (but not individual insurers or other persons) may, by written request, ask the SVO to study the feasibility of adding a country and the associated National GAAP or National IFRS.

In March 2021, the SVO received a letter from the American Council of Life Insurers (ACLI) requesting the SVO to consider the National GAAP/National IFRS of Spain for addition to the National Financial Presentation Standards.

- The national insurance association will, as necessary, identify an accounting firm that is an expert in the national accounting system of the country proposed for inclusion on the list of Countries and Associated National Financial Presentation Standards.

The requirement of this step has been fulfilled. The ACLI identified Deloitte of Spain as an expert in the national accounting system of Spain.

- The national insurance association will work with the SVO to create an educational session on those aspects of financial presentation relevant to the SVO for the purposes of its credit risk assessment.

This requirement has been fulfilled. On June 22, Joaquin Sánchez-Horneros, Director and member of the IFRS Centre of Excellence at Deloitte Spain, along with Pablo Castillo Lekuona, Senior Manager in the Department of Global Capital Markets and Accounting IFRS, gave a presentation to SVO analysts.

- The educational session will focus on the material differences between accounting methods for the income statement and balance sheet and shall include such further or additional areas as the SVO shall deem necessary in view of the specific country and national accounting system proposed.
The June 22 presentation by Deloitte included detailed differences between Spanish GAAP and IFRS, including a case study demonstrating the financial statement impact on a company over three years, comparing IFRS to Spanish GAAP.

- **At the conclusion of such educational sessions, the SVO shall assess whether the educational session provides a sufficient basis for it to make needed adjustments to the financial information presented under the national accounting standard.**

Based on the Deloitte presentation, including the reconciliation case study, it appears that most differences between Spanish GAAP and IFRS can be identified with additional disclosure sufficient to allow an analyst to make any necessary adjustments to an analysis.

- **The SVO shall then assess whether the application of the adjustments in one or more transactions confirms that the use of the national accounting standard leads to the creation of NAIC Designations analogous (in the information they convey about credit risk) to those created by using a Global Financial Presentation Standard.**

The presentation of the Spanish GAAP review by Deloitte was sufficient for the SVO to draw conclusions as to the ability to analyze credits presented under these accounting guidelines.

The SVO recommends that Spanish GAAP be added to the list of Countries and Associated National Financial Presentation Standards in the P&P Manual, with the additional disclosures noted in the amendment. Catherine Cosentino (NAIC) and Rosemarie Kalinowski (NAIC), the SVO analysts that performed the study, will review the principal differences between Spanish GAAP and IFRS, along with the requested mitigants.

Ms. Cosentino said in reviewing Spanish GAAP versus IFRS, the following differences were identified:

- **Operating Leases** – Spanish GAAP do not bring these leases on to the balance sheet; they are accounted for as operating leases. Operating lease income and expense corresponding to the lessor and lessee are considered to be income and expenses of the year in which they accrue, respectively. The impact is that lessor income is higher and lessee income is lower than that reported for IFRS, and debt is lower than that of IFRS if adjustments are not made.
- **Government Grants** – Spanish GAAP initially accounts for the grants as equity and subsequently charges it to the income statement as amortization over time, whereas IFRS prohibits recognizing them immediately as equity. The impact is that equity will be inflated for capital grants, and related debt to cap will be lower than it would be if calculated under IFRS.
- **Intangible Assets** – Spanish GAAP allows research and development costs to be capitalized with a presumption of a useful life limit of five years. IFRS does not allow research costs to be capitalized. It allows development costs to be capitalized under certain requirements, which will be amortized over their useful life. The impact is that assets are higher than under IFRS since research is capitalized and net income will be lower because of the goodwill amortization, and assets and equity will be undervalued relative to IFRS.
- **Financial Instrument (valuation)** – Spanish GAAP values financial assets at lower acquisition cost and market, while financial liabilities are valued at repayment value. All changes in fair value of financial liabilities are recognized in the income statement. For IFRS, financial assets are valued at fair value, while financial liabilities are valued at amortized cost. All changes in fair value of financial liabilities are recognized in equity. The impact is that asset value will be understated relative to IFRS if fair value and cost are different. Regarding financial liabilities, changes in fair value will affect the income statement under Spanish GAAP, which could affect financial ratio calculations involving net income, as well as the calculation of earnings before interest, taxes, depreciation, and amortization (EBITDA).
- **Financial Instrument (available for sale) Impairment/Reorganization** – Spanish GAAP allows for fresh-start accounting in certain situations, while IFRS does not recognize fresh-start. The impact is that reported assets may be overstated under Spanish GAAP.
- **Joint Ventures** – Spanish GAAP allows for proportionate consolidation, but if it is a 50/50 joint venture, then the equity method can be used. For IFRS, only the equity method is used. The impact is that revenue and operating income will be higher than under IFRS if proportionate consolidation is used. This is likely to significantly distort results if a company has large joint venture holdings.

As just mentioned, there are several important differences between Spanish GAAP and IFRS that will require mitigants. The items referenced will require additional audited disclosures either in the notes to the financial statements or as supplemental
Disclosure, thereby allowing the SVO to adjust the financial statements so that the use of Spanish GAAP will have no impact on the ultimate NAIC Designation. Some of these disclosures may not be contained in the notes to Spanish GAAP financial statements; therefore, the following items should be submitted, along with the Spanish GAAP statements:

- A complete set of audited financial statements, which includes balance sheet, income statement, and consolidated statement of cash flows for at least one year, three years, if available.
- Disclosure of operating lease commitments in a manner similar to that required by IFRS or US GAAP.
- Disclosure of government grants, including initial amount and year-to-date (YTD) and cumulative amortization.
- Disclosure of gross capitalized research costs and cumulative amortization.
- Disclosure of gross goodwill and cumulative amortization, including goodwill created by fresh-start accounting.
- Disclosure in the change in fair value for financial assets and liabilities.
- Disclosure on joint ventures not using the equity method, including full financial results.

Mr. Fry said the SVO made a recommendation to accept Spanish GAAP statements if these disclosures are provided, which has been done for other countries. Mr. Fry asked if any Task Force members object to considering this for adoption, and there were no objections. Michael M. Monahan (ACLI) said the ACLI has reviewed all the required disclosures and agrees that they are fair and adequate; the ACLI supports adoption at this meeting.

Ms. Mears made a motion, seconded by Mr. Thomas, to adopt the amendment to the P&P Manual to add Spanish GAAP to the list of Countries and Associated National Financial Presentation Standards (Attachment Two-A). The motion passed unanimously.

4. Exposed a Proposed Amendment to the P&P Manual to Add Bank Loans

Mr. Fry said the next item on the agenda is to receive and discuss a P&P Manual amendment to include bank loans in the definition of obligation.

Mr. Perlman said since 2018, the Accounting Practices and Procedures Manual (AP&P Manual) has included bank loans issued directly by a reporting entity or acquired through a participation, syndication, or assignment in Statement of Statutory Accounting Principles (SSAP) No. 26R—Bonds. Pursuant to SSAP No. 26R, bank loans means fixed-income instruments, representing indebtedness of a borrower, made by a financial institution.

To maintain consistency with the bond definition in SSAP No. 26R, the SVO proposes amending the P&P Manual to clarify that the SVO can assess and assign NAIC Designations to bank loans and the relevant filing instructions and methodology for them. The filing instructions and methodology would follow that of other corporate obligations.

Mr. Everett asked if given that a lot of these bank loans are not securities, they are different from bonds, they are treated differently, and they are regulated differently with different trade mechanics, there is a way to get an assessment on how these would be assessed compared to bonds.

Mr. Therriault said the traditional methodology would follow that of a corporate bond. A bank loan credit risk would not be viewed differently than a corporate bond credit risk; it would be the same analysis process. They are securities reported on Schedule D with other bonds.

Mr. Everett said there are differences as to trading and other things like that, and their seniority in bankruptcy is not being considered. Mr. Therriault said the SVO would consider those issues in the analysis of any corporate security; i.e., its relative position in the capital structure, how much debt is involved, and whether there is any collateral involved that will support the security. Those are all things normally considered for any security. Mr. Perlman said the SVO considers this a clarification amendment for consistency with the SSAP and not an addition.

Mr. Everett asked if there would be a distinction between secured and unsecured loans. Mr. Perlman said it would be looked at as with a corporate debt, and it is part of the methodology currently in the P&P Manual. Mr. Therriault said this amendment is adding bank loans as a footnote to the corporate debt methodology. There is not a separate methodology section being introduced; the corporate methodology will be applied to bank loans.
Mr. Fry ask how this is identified in SSAP No. 26R. Mr. Perlman said it is listed under the bond definition. Bank loans are listed separately in the back of SSAP No. 26R; there is an exhibit with a glossary with definitions, and that is what is being referred to in the amendment. Mr. Fry said it should be made clear that this is a type of security that falls under what the SVO can apply and review this methodology towards. Mr. Therriault said there is a section in the P&P Manual with a header for bank loans, but it did not have any substance. This amendment is to include bank loans in the corporate methodology section as a footnote and remove that header.

Mr. Everett asked if the securities being discussed are for federal antifraud purposes or just for reporting. If they are securities under the Federal Reserve Act, then they are like bonds, and disclosures must be made. But if they are bank loans, then the disclosure and fraud requirements of the securities laws will not apply. Mr. Therriault said the SVO does not make that level of distinction and neither does the SSAP. Mr. Everett said if they are not securities, then they are not within the purview. Mr. Therriault said the amendment is following the definition of SSAP No. 26R. Mr. Everett said disclosures that are made under the possible sanction of federal securities laws are often different from those that are made outside of those laws. If there is a default in a bank loan, the recovery and cure procedures are dependent on whether the loans are secured or unsecured and where they fit within Articles 8 or 9 of the Uniform Commercial Code (UCC). Those are key differences between loans and bonds, and that is where the question is coming from. Mr. Perlman said there are securities that are unsecured. Mr. Everett said not all loans are securities. Mr. Perlman said Article 9 could also apply to a security with a security interest. Mr. Everett said there is a difference in the priorities setting under Article 9. Mr. Therriault said the SVO looks to see whether there is support to ensure that payments are made. But if there is no credit support, there will be no benefit to collateral if it is not intended to provide a means by which to make payments to the investor. The point of the NAIC Designation is the expectation that principal and interest will be paid on a timely basis. It does not go through the default and recovery process that may occur in bankruptcy.

Mr. Everett said there are also differences in the way they bank loans are traded, which affects liquidity. Mr. Therriault said he would expect liquidity concerns to be reflected in the market value. Mr. Everett said in a bond, there is a promise to pay, but in a syndicated loan, there is an investor that is subject to the decision of the syndicator to collect on the loan.

Mr. Fry directed the SVO to expose the amendment to add bank loans to the definition of obligation to the P&P Manual for a 30-day public comment period ending Oct. 30.

5. Exposed a Proposed Amendment to the P&P Manual to Add Zero-Loss Criteria for Legacy-Modeled RMBS and CMBS

Mr. Fry said the next item on the agenda is to receive and discuss a P&P Manual amendment to add back zero-loss criteria for legacy-modeled residential mortgage-backed securities (RMBS) and commercial mortgage-backed securities (CMBS).

Mr. Therriault said this was initiated from a memo received from the ACLI requesting that the zero-loss rules be applied back to Part Four of the P&P Manual for RMBS and CMBS. The amendment that is being proposed is to add back the zero-loss criteria and map it to an NAIC Designation Category 1.A. for legacy RMBS or CMBS that are financially modeled and experience zero-losses under any of the scenarios being run. As the Structured Securities Group (SSG) moves forward next year in 2022, some of the new scenarios will probably need to be updated in the P&P Manual, but this amendment will provide guidance through year-end 2021. There was a desire to move this through quickly so insurers would know as soon as possible that the Task Force has approved this amendment and they can move forward with system changes and other modifications that may be necessary to accommodate the update.

Tracy Lindsey (North American Securities Valuation Association—NASVA) thanked the SVO for acknowledging the impact to insurers and turning this around quickly to get it into the regulatory systems. Vendors will need to release a change, because it is a late adoption, but completely support the change. Mr. Monahan also said the ACLI appreciates the SVO’s sensitivity of timing in getting this change implemented, and it would support a short exposure period of 10 or 15 days.

Mr. Fry directed the SVO to expose the amendment to the P&P Manual to add back zero-loss criteria for legacy-modeled RMBS and CMBS for a 15-day public comment period ending Oct. 15 and conduct an e-vote if there are no substantive comments.

6. Heard a Report from the SSG on the Year-End Process

Eric Kolchinsky (NAIC) reviewed a presentation for the SSG’s year-end modeling process. The SSG is running through-the-cycle scenarios for RMBS. For CMBS, the SSG is using the normal approach that was used previously. There was an adjustment to the base case; the base case last year had a huge impact for COVID-19, and it was adjusted to make a much smaller impact.

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for COVID-19 this year. There is still a lot of uncertainty, especially in CMBS, but this time, the uncertainty is sort of broad. Last year, it was known that things were going to get worse. In the current case, it is not clear that anyone has a good idea of what will happen. A lot of stress has been taken out of the base case scenario.

The SSG will be implementing zero-loss for legacy bonds. It will be a “Y/N” column in the appropriate file. The securities that are zero-loss for non-legacy will be assigned an NAIC Designation Category 1.A. The others will follow the mid-NAIC Designation categories for each one. The threshold for zero-loss and break points are to be determined and will be disclosed. There will be a mid-year update based on what is expected for scenarios, up-to-date financials, and on a pro forma basis by the end of October or early November. The SSG and BlackRock have been working very hard on this.

The SSG will likely introduce several through-the-cycle scenarios in 2022, both for RMBS and CMBS. The SSG is targeting between eight and 12 scenarios because 19 thresholds or break points will be needed. If only four scenarios were kept, there would be bonds clustering around one or the other. This is intended to be a lot more sensitive, and there is no intention to change which way things go, better or worse. The SSG would like to create something aligned with what has been done in the prior distributions but just a little bit more sensitive, given that there will be many more thresholds or break points. This will be brought to the Task Force for its approval, along with the 19 thresholds and break points based on the new risk-based capital (RBC) standards that were set out.

Zero-loss will not apply to non-legacy that will be assigned NAIC Designation Category 1.A for the smallest loss possible. The SSG would also consider, depending on demand, a mid-year update file 2022 if there is interest. Resecuritizations of real estate mortgage investment conduit (Re-REMICs), in terms of what is a legacy or non-legacy, the SSG looks through to the underlying and if the underlying is legacy, it is treated as legacy for break point or NAIC Designations. The other question is the format; there will be two files: a file for legacy securities and another for non-legacy securities. The legacy securities file will look much like the old file. The non-legacy will look like the Automated Valuation Service (AVS+) file. The NASVA and third-party administrators (TPAs) have been working on all of these files.

Francisco Paez (MetLife) said the approach is clear with the legacy securities with the “yes” or “no” indicator for zero-loss mapping to NAIC Designation Category 1.A. He asked whether non-legacy securities, the ones that do not have any loss, are mapped to NAIC Designation Category 1.A also or if the SSG provides the NAIC Designation. Mr. Kolchinsky said that is correct, those securities that meet the threshold for no loss will be assigned an NAIC Designation Category 1.A directly in the file.

At the beginning of the year, removing the zero-loss completely was discussed. There has since been a request from the ACLI to include it again. For legacy securities, this is becoming a smaller group each year. The SSG does not see an issue with adding back the zero-loss concept for legacy securities; however, since the language was taken out of the P&P Manual, it needs the Task Force’s approval to add it back, which is the request in the prior agenda item. Once the new categories and the new approach for 2022 for the 19 break points and thresholds are set, there will be additional P&P Manual updates needed for next year.

Mr. Fry asked what the ramifications would be if the Task Force does not support adding zero-loss securities. Mr. Kolchinsky said an analysis of the ramifications has not been conducted. He said he supports adding back the zero-loss case for the legacy securities to maintain the status quo from last year and the prior years.

Mr. Paez said the inclusion of the zero-loss securities this year avoids a more asymmetric treatment of modeled security versus other bonds at the AAA level. Most zero-loss securities in modeled securities that are non-legacy are really going to be AAA, and they represent by and large the biggest component of the capital structure of securitizations. From that perspective, including it gives a symmetric treatment of AAA structured securities or non-structured securities.

7. Discussed Other Matters

Ms. Lindsey asked to quickly discuss the status of private rating letters, providing rationale to the SVO, and what that looks like starting Jan. 1, 2022. This was an adopted change, and industry has been working with rating agencies to ensure that they provide that information starting Jan. 1, 2022 and looking at the current private rating letter population to see which ones have rationale that can be provided to the SVO starting Jan. 1, 2022. The NASVA met with the SVO and some folks from Kansas City Managed IT to discuss what that will look like for filers, and it sounds like it will take some time to get VISION and AVS+ updated to accommodate the changes in the filings. Feeds will be a ways out, and manual filings could be a bit of a
challenge in the short term. There was a discussion about timing and what implementation looks like or what the expectations are from state insurance regulators if it is mid-year next year versus Jan. 1.

Mr. Therriault said the expectation is that there will be a VISION enhancement next year to permit the filing of the private letter (PL) rating rationale reports. Hopefully that will be done by mid-year, but that is not certain. It will be a transition over time. The NAIC has spent a tremendous amount of energy this past year on making the modifications necessary for the financially modeled securities. Filers can submit those rational reports if there is a manual PL rating filing, to the extent that they are available. They can also be emailed to the analyst, as necessary, and the SVO will start accumulating them. The expectation is that the VISION application, which is the system that houses all our filings from insurers, will have an acknowledgment field somewhere in the system to be able to identify that a ratings rationale report has been received for the current year. This will permit insurance companies to know whether it was received. It will take time to build out this enhancement, and progress updates will be provided to industry and the Task Force, certainly at each of the national meetings.

Mr. Fry asked for clarification that the adopted amendment require ratings rationale reports to be filed by Jan. 1, 2022. Mr. Therriault said that is correct starting Jan. 1, 2022 but they can be submitted any time during the year.

Mr. Fry said the workaround is to manually send them in until such time as the system can handle them, and the SVO will update the Task Force periodically in between.

Mr. Therriault said there will be manual processes until VISION can be updated, and for a physical PL rating, the rationale report can be attached as an additional document when submitted.

Mr. Lindsey asked if it would it be fair to tell the reporting folks to hold off on that PL suffix until closer to the end of the year, because that is one indicator as to whether the rationale has been filed and accepted. Mr. Therriault agreed that would be fair.

Having no further business, the Valuation of Securities (E) Task Force adjourned.

https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2021/12 December FALL NATIONAL METING/01 - Meeting minutes/VOSTF 9.30.2021 Meeting Minutes (Chair review and approval).docx
TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
     Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
       Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau
     Rosemarie Kalinowski, Sr. Analyst, NAIC Securities Valuation Office (SVO)
     Catherine Cosentino, Analyst III, NAIC Securities Valuation Office (SVO)

RE: Addition of Spanish GAAP in the list of Countries and Associated National Financial Presentation
     Standards (the List) in the Purposes and Procedures Manual of the NAIC Investment Analysis
     Office (the “P&P Manual”)

DATE: September 1, 2021

Summary - At present, financial statements submitted to the Security Valuations Office (SVO) for analysis
must be audited and prepared in accordance with either a Global Financial Presentation Standard (US
Generally Accepted Accounting Principles (US GAAP) or International Financial Reporting Standards (IFRS)
or a Reconciled Financial Presentation Standard (local GAAP reconciled to US GAAP or IFRS) unless the
SVO has been specifically authorized to use a National Financial Presentation Standard.

Currently, the SVO is authorized to accept audited financial statements prepared in accordance with the
following National Financial Presentation Standards:

- Canadian Accounting Standards for Private Enterprises but only for non-financial institutions.
- UK Financial Reporting Standard (FRS) 102 (which encompasses Irish companies reporting
  under FRS 102).
- Australian GAAP.
- German GAAP.
- French GAAP but subject to the presentation of additional documentation as specified above
  and annually thereafter as specified below.
- Dutch (Netherlands) GAAP.
- Italian GAAP but subject to the presentation of additional documentation as specified above
  and annually thereafter as specified below.
- Belgian GAAP.
Swiss GAAP FER presented on the basis of the whole body of rules and regulations of Swiss GAAP FER ("Core FER" and other Swiss GAAP FER Standards), but subject to the presentation of additional documentation as specified in this Manual.

In 2013, the Valuation of Securities (E) Task Force adopted a procedure, as outlined in Part Two, paragraph 174 of the Purposes and Procedures Manual (P&P Manual) of the NAIC Investment Analysis Office, to submit requests to consider other National Financial Presentation Standard as follows:

A national insurance association (but not individual insurers or other persons) may, by written request, ask the SVO to study the feasibility of adding a country and the associated National GAAP or National IFRS. The SVO is authorized, but not required, to hold discussions with representatives of the national insurance association to evaluate whether the criteria specified below has been met and to formulate a recommendation to the VOS/TF. The SVO may not assign an NAIC Designation to or otherwise assess a security under the proposed national standard until the VOS/TF has, by amendment to this Manual, added the proposed country and the associated National GAAP or National IFRS.

In March 2021, the SVO received a letter from the American Council of Life Insurers (ACLI) requesting the SVO to consider the National GAAP/National IFRS of Spain for addition to the National Financial Presentation Standards. This letter included information supporting the request as required in Part Two, paragraph 175, of the P&P Manual, including evidence that certain companies in the targeted country are not required to use a Global Financial Presentation Standard, and that investment opportunities exist in the targeted country.

Having received the industry request and required information, Part Two, paragraphs 177-181 of the P&P Manual further establishes a process that the SVO must follow in order to have a National GAAP or National IFRS accepted as a National Financial Presentation Standards. The steps in this process are as follows:

177. The national insurance association will, as necessary, identify an accounting firm that is an expert in the national accounting system of the country proposed for inclusion on the List of Countries and associated National Financial Presentation Standard.

The requirement of this step has been fulfilled. The ACLI identified Deloitte of Spain as an expert in the national accounting system of Spain.

178. The national insurance association will work with the SVO to create an educational session on those aspects of financial presentation relevant to the SVO for purposes of its credit risk assessment.

This requirement has been fulfilled. On June 22, 2021, Joaquin Sánchez-Horneros, Director and member of the IFRS Centre of Excellence of Deloitte Spain, along with Pablo Castillo Lekuona, Senior Manager in the Department of Global Capital Markets and Accounting IFRS, gave a presentation to SVO analysts.
179. The educational session will focus on the material differences between accounting methods for the income statement and balance sheet, and shall include such further or additional areas as the SVO shall deem necessary in view of the specific country and national accounting system proposed.

The June 22, 2021 presentation by Deloitte included detailed differences between Spanish GAAP and IFRS including a case study demonstrating the financial statement impact on a company over three years, comparing IFRS to Spanish GAAP. The case study demonstrated the adjustments required to bridge from one standard to another, although no one given example is necessarily representative of the absolute magnitude of difference on financial measures for any other company.

180. At the conclusion of such educational session, the SVO shall assess whether the educational session provides a sufficient basis for it to make needed adjustments to the financial information presented under the national accounting standard.

Based on the Deloitte presentation, including the reconciliation case study, it appears that most differences between Spanish GAAP and IFRS can be identified with additional disclosure sufficient to allow an analyst to make any necessary adjustments to an analysis. As noted below, the SVO will request additional information if the footnotes to the financial statements prepared in accordance with Spanish GAAP fail to provide adequate information.

181. The SVO shall then assess whether the application of the adjustments in one or more transactions confirms that the use of the national accounting standard leads to the creation of NAIC Designations analogous (in the information they convey about credit risk) to those created by the use of a Global Financial Presentation Standard.

The presentation of the Spanish GAAP review by Deloitte was sufficient for the SVO to draw conclusions as to the ability to analyze credits presented under these accounting guidelines.

The principal differences between Spanish GAAP and IFRS focus on several categories:

- **Operating Leases**
  - **Spanish GAAP**: Not brought on to the balance sheet; accounted for as operating leases. Operating lease income and expense corresponding to the lessor and lessee are considered respectively, to be income and expenses of the year in which they accrue.
  - **IFRS**: Brought on to the balance sheet. Recorded as an asset (right of use) and a corresponding lease liability by the lessee.
  - **Impact**: Lessor: income is higher / Lessee: income is lower than that reported for IFRS and debt is lower than that of IFRS.

- **Government Grants**
  - **Spanish GAAP**: Initially accounted for as equity and subsequently charged to the income statement as amortization over time.
IFRS: Prohibits recognizing them immediately as equity. In the case of capital grants, it is allowed to record them by reducing assets. Grants related to expenses can be presented in the income statement as income or netting the corresponding expenses.

Impact: Equity will be inflated for capital grants and related debt to cap will be lower than that calculated under IFRS. Net income will be lower in each subsequent year than that under IFRS calculation but should be reconcilable if footnotes provide disclosure.

- **Intangible Assets**
  - Spanish GAAP: Research & development costs can be capitalized. Presumption of a useful life limit of 5 years in the amortization of these costs and computer programs, unless proven otherwise.
  - IFRS: Research costs are not capitalized. Only development costs can be capitalized under certain requirements, which will be amortized over their useful life (no time limit).
  - Impact: Assets are higher than under IFRS since research is capitalized; net income will be lower than under IFRS in each subsequent year due to amortization of research. However, this should be reconcilable if footnotes provide disclosure.

- **Goodwill**
  - Spanish GAAP: Amortizable over 10 years.
  - IFRS: Not amortizable. If fair value goes below historical cost, an impairment must be recorded.
  - Impact: Net income is lower than under IFRS due to ongoing goodwill amortization; assets and equity will be undervalued relative to IFRS due to the amortization. Debt to cap calculations will be higher than under IFRS due to the lower equity. However, this should be reconcilable if footnotes provide disclosure.

- **Financial instrument-valuation**
  - Spanish GAAP:
    - Financial assets: lower of acquisition cost and market
    - Financial liabilities: repayment value
    - Financial liabilities: all changes in fair value are recognized in the income statement
  - IFRS:
    - Financial assets: fair value
    - Financial liabilities: amortized cost
    - Financial liabilities: changes in fair value are recognized in equity
  - Impact:
    - Financial assets: Asset value will be understated relative to IFRS if fair value and cost are different.
    - Financial liabilities: Changes in fair value will impact the income statement under Spanish GAAP, which could affect financial ratio calculations involving net income, such as net income/revenues, as well as the calculation of EBITDA if these adjustments cannot be clearly identified in the footnote disclosure.

- **Financial instruments (available for sale): Impairment/reorganization**
  - Spanish GAAP: Fresh start in certain situations
The conclusion is that there are several important differences between Spanish GAAP and IFRS. The items referenced above will require additional disclosures in the notes or audited supplement to the financial statements, thereby allowing the SVO to adjust the financial statements so that the use of Spanish GAAP financial statements will have no impact on the ultimate designation. Some of these disclosures may not be contained in the notes to Spanish GAAP financial statements, so the following items, certified by the auditor, should be submitted along with the Spanish GAAP statements:

- A complete set of audited financial statements (for at least three years, if available) comprising: balance sheet, income statement and consolidated statement of cash flows;
- Disclosure of operating lease commitments in a manner similar to that required by IFRS or US GAAP;
- Disclosure of Government Grants, initial amount and year-to-date and cumulative amortization;
- Disclosure of gross capitalized research costs and cumulative amortization;
- Disclosure of gross goodwill and cumulative amortization, including goodwill created by fresh-start accounting;
- Disclosure of the change in fair value for financial assets and liabilities;
- Disclosure on joint ventures not using the equity method including full financial results;

Proposed Amendment - The text changes to include Spanish GAAP on the list of Countries and Associated National Financial Presentation Standards is shown below with additions in red underline and deletions in red strikethrough, as it would appear in the 2020 P&P Manual format.
PART TWO
OPERATIONAL AND ADMINISTRATIVE INSTRUCTIONS
APPLICABLE TO THE SVO
Information Requirements Associated with the Use of a National Financial Presentation Standard

182. Insurance companies who file securities whose issuers present financial information in accordance with a National Financial Presentation Standard shall:

- Where materially different from Global Financial Presentation Standards, identify how local accounting standards treat specific issues relevant to assessment of credit risk.

- Provide written descriptions of the accounting difference the insurer considered, and of how it resolved concerns about the accounting differences during the investment decision making process.

- Be prepared to provide the SVO with access to the issuer’s management or to convey questions and retrieve information from the issuer’s management.

- Include a consolidated statement of cash flows for the past three years. See the definition of Audited Financial Statement for additional guidance pertaining to this requirement.

- For filings presented on the basis of French generally accepted auditing standards GAAP, the following additional documentation is required:
  - Disclosure of finance lease obligations;
  - Disclosure of operating lease commitments in a manner similar to that required by IFRS or US GAAP;
  - Disclosure of pension assets and liabilities as well as any other post-employment plan obligations (key is disclosure of any unfunded amount);
  - Disclosure of the amount of treasury stock, if any, and how it is accounted for; and
  - Segment reporting of sales, assets, income and depreciation.

- For filings presented on the basis of Italian GAAP, the following additional documentation is required:
  - A consolidated statement of cash flows for three years;
  - Disclosure of finance lease obligations;
Disclosure of operating lease commitments in a manner similar to that required by IFRS or U.S. GAAP;

Disclosure of pension assets and liabilities, as well as any other post-employment plan obligations, especially of any unfunded amounts; and

Disclosure of the amount of Treasury stock, if any, and how it is accounted for.

For filings presented on the basis of the whole body of rules and regulations of Swiss GAAP FER (“Core FER” and other Swiss GAAP FER Standards), the insurer always provides the following information:

- Full set of audited financial statements, including a statement of cash flows;
- Disclosure of finance lease and operating lease commitments in a manner similar to that required by IFRS or US GAAP;
- Disclosure of pension assets and liabilities as well as any other post-employment plan obligations, especially any unfunded amount;
- Disclosure of the amount of treasury stock, if any, and how it is accounted for;
- Segment reporting of sales, assets, income and depreciation;
- Signed Auditor’s Opinion; and
- Consolidation information and consolidated financial statements where relevant.

For filings presented on the basis of Spanish GAAP, the following additional documentation is required:

- A complete set of audited financial statements (for at least three years, if available) comprising: balance sheet, income statement and consolidated statement of cash flows;
- Disclosure of operating lease commitments in a manner similar to that required by IFRS or US GAAP;
- Disclosure of Government Grants, initial amount and year-to-date and cumulative amortization;
- Disclosure of gross capitalized research costs and cumulative amortization;
- Disclosure of gross goodwill and cumulative amortization, including goodwill created by fresh-start accounting;
Disclosure in the change in fair value for financial assets and liabilities;

Disclosure of joint ventures recorded not using the equity method, including full financial results;

Countries and Associated National Financial Presentation Standards

183. The SVO is authorized to accept Audited Financial Statements prepared in accordance with the following National Financial Presentation Standards:

- Canadian Accounting Standards for Private Enterprises but only for non-financial institutions.
- UK Financial Reporting Standard (FRS) 102 (which encompasses Irish companies reporting under FRS 102).
- Australian GAAP.
- German GAAP.
- French GAAP but subject to the presentation of additional documentation as specified above and annually thereafter as specified below in this Manual.
- Dutch (Netherlands) GAAP.
- Italian GAAP but subject to the presentation of additional documentation as specified above and annually thereafter as specified below in this Manual.
- Belgian GAAP.
- Swiss GAAP FER presented on the basis of the whole body of rules and regulations of Swiss GAAP FER (“Core FER” and other Swiss GAAP FER Standards), but subject to the presentation of additional documentation as specified in this Manual.
- Spanish GAAP but subject to the presentation of additional documentation as specified above and annually thereafter as specified in this Manual.
TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
FROM: Dale Bruggeman, Chair of the Statutory Accounting Principles (E) Working Group
Carrie Mears, Vice-Chair of the Statutory Accounting Principles (E) Working Group
RE: Provisions for NAIC 5GI Designations
DATE: November 15, 2021

The purpose of this referral is to request that the Valuation of Securities (E) Task Force review the NAIC 5GI guidance detailed in the *Purposes and Procedures Manual of the NAIC Investment Analysis Office* and consider whether modifications are necessary to clarify the intent of the guidance and mitigate misapplications. As an example, the Working Group was made aware of situations in which residual tranches, which do not have contractual interest or principal payments, were being designated as NAIC 5GI by reporting entities. Although there was broad agreement by key industry representatives and state insurance regulators that the NAIC 5GI should not be permitted for these residual tranches, potential refinement to clarify the NAIC 5GI provisions may prevent future misapplication.

**Residual Tranches Defined per SSAP No. 43R—Loan-Backed and Structured Securities:**
Reference to “residual tranches or interests” intends to capture securitization tranches and beneficial interests as well as other structures captured in scope of this statement, that reflect loss layers without any contractual payments, whether principal or interest, or both. Payments to holders of these investments occur after contractual interest and principal payments have been made to other tranches or interests and are based on the remaining available funds. Although payments to holders can occur throughout an investment's duration (and not just at maturity), such instances still reflect the residual amount permitted to be distributed after other holders have received contractual interest and principal payments.

In addition to clarifying that the guidance cannot be applied to residual tranches, as defined in SSAP No. 43R, the following concepts are provided as suggestions for possible clarification:

- Clarifications to ensure that the NAIC 5GI self-assigned designation is permitted only for securities that could be reviewed for an NAIC designation if the documentation to support a credit analysis could be submitted. In other words, the 5GI process is not intended to be used for securities that would not qualify for a designation even if a full credit analysis could be performed. Securities that cannot be reviewed for an NAIC designation due to the lack of a process / methodology for the type of security or structure are not permitted to be self-assigned an NAIC 5GI designation.

- Clarification that self-assigning an NAIC 6* for securities that do not qualify for NAIC 5GI is not a declaration of potential default. Rather, the self-assignment indicates that the security...
could not be reviewed for a full credit analysis and the requirements for an NAIC 5GI could not be met.

Thank you for considering these potential clarifications. Please contact Dale Bruggeman, or Carrie Mears, SAPWG Chair and Vice Chair, with any questions.

Cc: Julie Gann, Robin Marcotte, Jim Pinegar, Jake Stultz, Charles Therriault, Marc Pearlman
November 24, 2021

Mr. Kevin Fry, Chairman
Valuation of Securities Task Force
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Exposure Draft to Clarify the Exclusion of Residual Tranches and Interests from Schedule D-1 Reporting and to Provide Temporary NAIC Designation Instructions

Dear Mr. Fry:

The American Council of Life Insurers (ACLI) and the North American Securities Valuation Association (NASVA) (“the undersigned”) appreciate the opportunity to comment on the memo exposed after the November 19th, 2021, Valuation of Securities Task Force meeting to “Clarify the Exclusion of Residual Tranches and Interests from Schedule D-1 Reporting and to Provide Temporary NAIC Designation Instructions.”

The undersigned fully support the proposed criteria addition. We truly appreciate the constructive dialogue with you, and the Securities Valuation Office.

We thank you for your continued engagement on the topic.

Sincerely,

Mike Monahan
Senior Director, Accounting Policy

Tracey Lindsey
NASVA
TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
   Members of the Valuation of Securities (E) Task Force
FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
       Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)
CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau
RE: Amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (the “P&P Manual) to the clarify the exclusion of Residual Tranches and Interests from Schedule D-1 reporting and to provide temporary NAIC Designation instructions
DATE: November 1, 2021

Summary – The Statutory Accounting Principles (E) Working Group (the “Working Group”) identified inconsistencies in how residual tranches and interests were being reported with some entities reporting them on Schedule BA – Other Long Term Invested Assets and others reporting them on Schedule D-1: Long-Term Bonds with either self-assigned NAIC 5GI or NAIC 6 Designations. To prevent further inconsistency and direct appropriate reporting, on September 9, 2021, the Working Group exposed an amendment to SSAP 43R – Loan Backed and Structured Securities to clarify that residual tranches and interests shall be report on Schedule BA. The Working Group plans to consider adoption of this amendment at their November 10, 2021, meeting.

The amendment creates a December 31, 2022 effective date for all residual tranches and interests to be reported on Schedule BA without an NAIC Designation. To accommodate the timeframe needed for Blanks (E) Working Group proposal 2021-21BWG to expand reporting lines on Schedule BA to capture residual tranches and interests, the Working Group’s amendment permits residual tranches and interests currently reported on Schedule D-1 to continue to be reported on Schedule D-1 for reporting year 2021 but only with an NAIC 6* Designation and not an inappropriate NAIC 5GI Designation.

The NAIC 5GI Designation is not appropriate for residual tranches and interests (see definition from SSAP 43R below). Pursuant to the “P&P Manual, an insurance company is permitted to self-assign an NAIC 5GI to an obligation if it meets all of the following criteria:

1. Documentation necessary to permit a full credit analysis of the security by the SVO does not exist or an NAIC CRP rating for an FE or PL security is not available.
2. The issuer or obligor is current on all contracted interest and principal payments.
3. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.

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Assignment of an NAIC 5GI Designation for residual investments is an incorrect application of the guidance as (a) there are no contracted interest and principal payments to certify as current and (b) the insurer cannot have an actual expectation of receiving all contractual principal and interest of the underlying collateral as these tranches absorb the losses first for the securitization structure. Although cash flows may pass through to the residual holders at periodic intervals pursuant to the waterfall, ultimate returns depend on continued performance so, therefore, there can be no actual expectation that future payments will be received.

The proposed amendment to SSAP 43R – Loan Backed and Structured Securities section 26.c., says:

For residual tranches or interestsFN captured in scope of this statement, all reporting entities (regardless of AVR) shall report the item on Schedule BA: Other Long-Term Invested Assets at the lower of amortized cost or fair value. Changes in the reported value from the prior period shall be recorded as unrealized gains or losses.

Footnote: Reference to “residual tranches or interests” intends to capture securitization tranches and beneficial interests as well as other structures captured in scope of this statement, that reflect loss layers without any contractual payments, whether principal or interest, or both. Payments to holders of these investments occur after contractual interest and principal payments have been made to other tranches or interests and are based on the remaining available funds. Although payments to holders can occur throughout an investment’s duration (and not just at maturity), such instances still reflect the residual amount permitted to be distributed after other holders have received contractual interest and principal payments.

The SVO recommends amendments to the P&P Manual to clarify the reporting requirements for residual tranches and interests in line with SSAP 43R, if and as amended.

Proposed Amendment - The text changes to include reporting instructions for residual tranches and interests is shown below with additions in red underline and deletions in red strikethrough, as it would appear in the 2021 P&P Manual format. The SVO requests the Task Force’s permission to remove the paragraph with the “NOTE REGARDING RESIDUAL TRANCHE OR INTERESTS” from the December 31, 2022 version of the P&P Manual, without further authorization from the Task Force, as it will become obsolete at that time.
PART TWO

OPERATIONAL AND ADMINISTRATIVE INSTRUCTIONS APPLICABLE TO THE SVO
NAIC DESIGNATIONS RELATED TO SPECIAL REPORTING INSTRUCTIONS

27. An insurance company that self-assigns a 5GI must attest that securities receiving this designation meet all required qualifications by completing the appropriate general interrogatory in the statutory financial statements. If documentation necessary for the SVO to perform a full credit analysis for a security does not exist or if an NAIC CRP credit rating for an FE or PL security is not available, but the issuer is not current on contractual interest and principal payments, and/or if the insurer does not have an actual expectation of ultimate payment of all contracted interest and principal, the insurance company is required to self-assign this security an NAIC 6*.

28. NAIC 6* is assigned by an insurer to an obligation in lieu of reporting the obligation with appropriate documentation in instances in which appropriate documentation does not exist, but the requirements for an insurance company to assign a 5GI are not met.

29. Securities with NAIC 5GI Designations are deemed to possess the credit characteristics of securities assigned an NAIC 5 Designation. A security assigned an NAIC 5GI Designation incurs the regulatory treatment associated with an NAIC 5 Designation.

30. Securities an insurance company previously assigned as NAIC 5GI are permitted to subsequently receive this designation if the requirements for an NAIC 5GI designation continue to be met.

31. Securities with NAIC 6* Designations are deemed to possess the credit characteristics of securities assigned an NAIC 6 Designation. Therefore, a security assigned an NAIC 6* Designation incurs the regulatory treatment associated with an NAIC 6 Designation.

32. Securities that are residual tranches or interests, as defined in SSAP 43R – Loan Backed and Structured Securities, shall be reported on Schedule BA - Other Long-Term Invested Assets, without an NAIC Designation and are ineligible to be assigned an NAIC 5GI or NAIC 6* Designation.

NOTE REGARDING RESIDUAL TRANCHES OR INTERESTS: For 2021 year-end reporting only, residual tranches or interests previously reported on Schedule D-1: Long-Term Bonds shall be permitted to be reported on Schedule D-1 with an NAIC 6* Designation, however an NAIC 5GI is not permitted.

NOTE: The GI after the quality indicator 5 refers to General Interrogatory and distinguishes NAIC 5GI from an NAIC 5 Designation. The asterisk (*) after the quality indicator 6 distinguishes the NAIC 6* Designation from an NAIC 6 Designation.
PART THREE
SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION OF NAIC DESIGNATIONS
FE SECURITIES

Filing Exemption

3. Bonds, within the scope of SSAP No. 26R and SSAP No. 43R (excluding RMBS and CMBS subject to financial modeling) and Preferred Stock within scope of SSAP No. 32, that have been assigned an Eligible NAIC CRP Rating, as described in this Manual, are exempt from filing with the SVO (FE securities) with the exception of Bonds and/or Preferred Stock explicitly excluded below.

Specific Populations of Securities Not Eligible for Filing Exemption

4. The filing exemption procedure does not apply to:

- **Residual tranches or interests** - As defined in SSAP 43R – Loan Backed and Structured Securities, residual tranches or interests shall be reported on Schedule BA - Other Long-Term Invested Assets, without an NAIC Designation and are therefore not eligible for filing exemption.

https://naiconline.sharepoint.com/teams/SVOVOSTaskForce/Shared Documents/Meetings/2021/12 December FALL NATIONAL METING/02 - Remove Residual Tranches/2021-043.01 Task Force 2021 Amend PP To Remove Residuals v3.docx
November 24, 2021

Mr. Kevin Fry, Chairman
Valuation of Securities Task Force
National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197

RE: Exposure Draft for Private Letter Rating Securities and the Corresponding NAIC Designation Category for NAIC 5G

Dear Mr. Fry:

The American Council of Life Insurers (ACLI) and the North American Securities Valuation Association (NASVA) (“the undersigned”) appreciate the opportunity to comment on the memo exposed after the November 19th, 2021, Valuation of Securities Task Force meeting for “Private Letter Rating Securities and the Corresponding NAIC Designation Category for NAIC 5G.”

The undersigned fully support the proposed criteria addition. We truly appreciate the constructive dialogue with you, and the Securities Valuation Office.

We thank you for your continued engagement on the topic.

Sincerely,

Mike Monahan
Senior Director, Accounting Policy

Tracey Lindsey
NASVA
MEMORANDUM

TO: Kevin Fry, Chair, Valuation of Securities (E) Task Force
Members of the Valuation of Securities (E) Task Force

FROM: Charles A. Therriault, Director, NAIC Securities Valuation Office (SVO)
Marc Perlman, Managing Investment Counsel, NAIC Securities Valuation Office (SVO)

CC: Eric Kolchinsky, Director, NAIC Structured Securities Group (SSG) and Capital Markets Bureau

RE: Non-substantive technical amendment to the P&P Manual for Private Letter Rating Securities and the corresponding NAIC Designation Category for NAIC 5GI

DATE: November 1, 2021

Summary – At the May 24, 2021 Task Force meeting the Task Force adopted an amendment to the Purposes and Procedures Manual of the NAIC Investment Analysis Office (P&P Manual) requiring the submission of Private Rating Letter Rationale Reports with certain Private Rating Letters filed with the SVO. In the May amendment certain language, currently in the printed December 2020 version of the P&P, which clarifies that an NAIC 5GI Designation is the equivalent of an NAIC 5.B Designation Category, was erroneously omitted. The SVO proposes a non-substantive technical amendment to the May amendment by re-inserting the omitted language as shown below in red (additions underlined and deletions with strikethrough), as well as including identical language in one paragraph adopted pursuant to the May 2021 amendment.
PART THREE
SVO PROCEDURES AND METHODOLOGY FOR PRODUCTION
OF NAIC DESIGNATIONS
PROCEDURE APPLICABLE TO FILING EXEMPT (FE) SECURITIES AND PRIVATE LETTER (PL) RATING SECURITIES

12. For (a) PL Securities issued from January 1, 2018 to December 31, 2021 subject to a confidentiality agreement executed prior to January 1, 2022, which confidentiality agreement remains in force, for which an insurance company cannot provide a copy of a private rating letter rationale report to the SVO due to confidentiality or other contractual reasons (“waived submission PLR securities”), the insurer may report such securities on such securities’ General Interrogatory (i.e., a PLGI security), and (b) PL Securities issued after January 1, 2022, for which an insurance company cannot provide a copy of a private rating letter rationale report to the SVO due to confidentiality or other contractual reasons (“deferred submission PLR securities”) the insurer may report such securities on such securities’ General Interrogatory (i.e., a PLGI security) until and including December 31, 2023, after which time, if the insurance company still cannot provide a copy of a private rating letter rationale report for whatever reason, the securities can be reported with an NAIC 5GI Designation and an NAIC Designation Category of NAIC 5.B GI in accordance with the guidance specified below.

Conditions to Filing Exemption for PL Securities Issued on or After January 1, 2018

16. An insurer that owns a PL security that is not filing exempt shall either: (a) file the security with the necessary documentation with the SVO for an analytically determined NAIC Designation; or (b) self-assign an NAIC 5GI and an NAIC Designation Category of NAIC 5.B GI to the security and report using the Interrogatory procedure; in either case within 120 days of purchase.

Producing NAIC Designations for PL Securities

22. If the SVO verifies that the security:

- Has been assigned a credit rating but that the credit rating is not an Eligible NAIC CRP Credit Rating; or
- Has not been rated by an NAIC CRP; or
- Is no longer subject to a private letter rating; or
- Is a type of security that is ineligible to receive an NAIC Designation with a NAIC CRP Credit Rating.

The SVO shall notify the insurer that the security is not eligible for filing exemption. The insurance company shall then either file that security and necessary documentation with the SVO for an independent credit assessment or assign an **NAIC 5GI Regulatory Designation** and an **NAIC Designation Category of NAIC 5.B GI** to the security in the related Interrogatory.

If the SVO deems a security ineligible to receive an NAIC Designation per the instructions in this Manual because (a) the security is ineligible for Filing Exception according to “Specific Populations of Securities Not Eligible for Filing Exemption” in this Part or (b) the security is of a type outside the scope of SSAP No. 26R - Bonds, SSAP No. 32- Preferred Stock, or SSAP No. 43R – Loan Backed and Structured Securities then, for such a security, the SVO will provide a brief explanation in VISION, accessible to all VISION account holders, of why the security will not be provided an NAIC Designation.

23. An **NAIC 5GI Designation** and an **NAIC Designation Category of NAIC 5.B GI** may also be used in connection with the designation of PL securities rated by an NAIC CRP (i.e., for private letter ratings issued on or after January 1, 2018) when the documentation is not available for the SVO to assign an NAIC Designation. For purposes of this section, the documentation is not available for the SVO to assign an NAIC Designation if (a) the NAIC CRP credit rating is not included in the applicable CRP credit rating feed (or other form of direct delivery from the NAIC CRP) and the insurer is unable to provide a copy of the private letter rating documentation, (b) for private letter ratings issued on or after January 1, 2022, an insurance company does not provide a copy of a private rating letter rationale report to the SVO for which there are no confidentiality or contractual limitations or (c) for deferred submission PLR securities, if the insurance company does not submit the private rating letter rationale report to the SVO on or after January 1, 2024.
The Financial Regulation Standards and Accreditation (F) Committee did not meet at the Fall National Meeting.
Draft: 12/20/21

International Insurance Relations (G) Committee
San Diego, California
December 15, 2021

The International Insurance Relations (G) Committee met in San Diego, CA, Dec. 15, 2021. The following Committee members participated: Gary D. Anderson, Chair (MA); Raymond G. Farmer, Vice Chair (SC); Andrew N. Mais (CT); Karima M. Woods (DC); David Altmaier (FL); Doug Ommen (IA); James J. Donelon represented by Tom Travis (LA); Kathleen A. Birrane (MD); Anita G. Fox (MI); Chlora Lindley-Myers (MO); Eric Dunning (NE); Marlene Caride (NJ); Andrew R. Stolfi (OR); and Jessica K. Altman (PA).

1. **Adopted its Summer National Meeting Minutes**

Director Lindley-Myers made a motion, seconded by Director Fox, to adopt the Committee’s Aug. 16 minutes (see NAIC Proceedings – Summer 2021, International Insurance Relations (G) Committee). The motion passed unanimously.

2. **Adopted its 2022 Proposed Charges**

Commissioner Anderson introduced the Committee’s 2022 proposed charges, noting they are the same as those for 2021.

Commissioner Mais made a motion, seconded by Mr. Travis, to adopt the Committee’s 2022 proposed charges (Attachment One). The motion passed unanimously.

3. **Discussed International Efforts on Insurer Culture**

Commissioner Anderson spotlighted the topic of insurer culture, noting that it is a topic just as important to the Committee as any other. He reported that last month, the International Association of Insurance Supervisors (IAIS) released its *Issues Paper on Insurer Culture* (Issues Paper), and it is a theme that will continue to be part of global regulatory discussions. He explained that the purpose of this agenda item was to hear more about work going on at the international level on insurer culture and to hear from an insurer on how it approaches culture.

Julien Reid (Autorité des Marchés Financiers (AMF) gave a review of the Issues Paper, as lead of the drafting team. He noted the Issues Paper explores the concept of insurer culture as a point of intersection for prudential and conduct risks, with examples to illustrate the broader role of culture in managing these risks. Mr. Reid addressed work being done or planning to be done as it relates to culture in Quebec and in Canada more broadly. He explained that conduct of business and customer issues are under the exclusive purview of the provinces in Canada. He also noted that the AMF worked within the topic of culture by issuing first governance guidelines in 2009 and conduct of business guidelines in 2006, which enhanced their supervision work related to culture as well. Lastly, he said that the AMF passed an insurers act that now requires a board member must embed corporate culture throughout their organization, and it provides regulatory action powers if companies do not comply accordingly.

Commissioner Anderson noted that like other jurisdictions, state insurance supervisors recognize the importance of an insurer’s culture within their internal workings. Commissioner Anderson highlighted various insurer culture considerations found in the NAIC *Financial Analysis Handbook* and the *Financial Condition Examiners Handbook*.

Jon Richter (MetLife) and Cindy Pace (MetLife) presented on culture from MetLife’s perspective. They highlighted how MetLife approaches culture, its importance to MetLife’s workings, how to build and support high-functioning culture, and how the commitment to diversity, equity and inclusion (DE&I) fosters open dialogue and ensures high-functioning culture. Mr. Richter outlined the way culture is embedded in the workings of the organization’s Risk, Audit, Governance, and Corporate Responsibility committees. Ms. Pace focused her remarks on why DE&I is pivotal to driving culture. She noted that MetLife has challenged itself to make a bold commitment to their employees and customers at Met Life as a positive step towards shaping their corporate culture.

Director Farmer commented that issues of insurer culture are not a philosophical discussion, but goes to how regulators, insurers, and the industry at large treat customers and their employees. Director Fox asked about sustaining cultural discussions in the new hybrid work reality. Dr. Pace said values, vision, and a purpose are essential to accountability, regardless of whether
an employee is present in an office or not. She mentioned that equity is a core tenant of an employee’s decision of where they want to work, and that must be factored into corporate culture.

With respect to future international work on culture, Jonathon Dixon (IAIS) noted this as a key theme of the IAIS, and he highlighted a recently released statement on the importance of DE&I for the workings and mission of the IAIS. He noted that advancing this topic is not only important for a business imperative, but also it supports sound prudential and consumer outcomes and sustainability objectives.

4. Heard an Update on Key 2021 and 2022 Activities of the IAIS

Commissioner Anderson reported on recent IAIS activities, starting with an update on the development of criteria to assess whether the aggregation method (AM) provides comparable outcomes to the insurance capital standard (ICS). He noted the planned public consultation on draft comparability criteria will be launched in the first half of 2022.

Commissioner Anderson said another important area of work underway is the Global Monitoring Exercise (GME), which is an important component of the holistic framework for systemic risk. He added that the IAIS recently published its GME public report, which draws on data from approximately 60 of the largest international insurance groups and close to 40 insurance supervisors, covering more than 90% of global gross written premiums. The full GME has been completed for the first time as last year’s focused on the impact of COVID-19.

Commissioner Anderson concluded the IAIS update with a review of three recently published papers, which were discussed during previous Committee meetings: 1) an Issues Paper on Insurer Culture; 2) a Revised Application Paper on Supervisory Colleges; and 3) a Revised Application Paper on Combating Money Laundering and Terrorist Financing.

5. Heard an Update on International Activities

a. Regional Supervisory Cooperation

Director Farmer reported that Director Dean L. Cameron (ID) participated virtually in the Taiwan Insurance Institute’s Insurance and Economic Development Forum on Dec. 2, giving remarks on the “New Blue Ocean of the Insurance Industry After the Epidemic.” Next, he noted Commissioner Altmaier and Director Cameron met with Bermuda Monetary Authority (BMA) senior staff while in Hamilton, Bermuda, to participate in the Association of Bermuda Insurers and Reinsurers (ABIR) roundtable webinar “Leveraging International Reinsurance to Address the Climate risk Protection Gap” and to meet with ABIR board members. The NAIC met with the Financial Services Agency (FSA) of Japan for a biannual bilateral dialogue on Nov. 30. The NAIC and the FSA discussed various topics and developments, including climate risk and resilience, liquidity stress testing (LST), innovation and technology, long-term care insurance (LTCI), and DE&I.

Director Farmer said the European Union (EU)-U.S. Insurance Dialogue Project (Project) held a public virtual webinar on Oct. 19 on its continued progress and future priorities, with representatives of the NAIC, including: Commissioner Birrane and Commissioner Ommen; the Federal Insurance Office (FIO) of the U.S. Department of the Treasury (Treasury Department); and the European Insurance and Occupational Pensions Authority (EIOPA). Summary reports of the work conducted by the Project’s three working groups on cybersecurity, cyber insurance, and big data/artificial intelligence (AI) during 2020–2021 were published and are available on the NAIC website. He reported that going forward, the project will focus on three topics: 1) climate risk financial oversight, including climate risk disclosures, supervisory reporting, and other financial surveillance; 2) climate risk and resilience, including innovative technology, pre-disaster mitigation and adaptation efforts, and modelling; and 3) innovation and technology, which will include topics such as big data, AI, and supervisory technology (Suptech) as a regulatory tool.

Director Farmer reported that the 2021 NAIC Fall International Fellows Program was held virtually Oct. 18–22, with more than 90 global regulators from more than 20 countries participating. He noted that beginning in 2022, the Fellows Program’s spring sessions will be held virtually, while the Fall sessions will be held in person. He said that in an effort to plan ahead for the Fall 2022 Fellows Program scheduled to begin Oct. 10, 2022, any state interested in hosting a Fellow next fall should contact NAIC staff.

b. OECD

Director Farmer reported that the Organisation for Economic Co-operation and Development’s (OECD’s) Insurance and Private Pensions Committee (IPPC) met virtually Dec. 9–10 and covered updates on various workstreams underway at the IPPC. This
included a roundtable on the role of the insurance sector in responding to climate change and featured speakers from international organizations including the Sustainable Insurance Forum (SIF), IAIS, and Net-Zero Insurance Alliance (NZIA). He noted that during the meeting, the NAIC provided a brief snapshot of the state of the insurance industry post-pandemic, potential challenges to those market sectors moving forward, and an update on the cyber insurance market.

c. SIF

Director Farmer said the NAIC, alongside individual state SIF members—California, New York, Vermont, and Washington—participated in a virtual meeting in October. The SIF discussed progress relative to the three workstreams agreed to in its work plan: 1) impacts of climate-related risks on insurability of assets; 2) broader sustainability issues beyond climate change; and 3) climate risks in the actuarial processes. He reported that Maryland recently also became a SIF member.

6. Discussed Other Matters

Commissioner Anderson reminded attendees about the NAIC’s 2022 International Insurance Forum to be held in Washington DC, May 12–13, 2022. He also introduced new staff members to the NAIC’s international relations team and thanked Ekrem Sarper as a former staff member for his years of work and dedication to the NAIC’s international efforts and activities.

Having no further business, the International Insurance Relations (G) Committee adjourned.

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

Ongoing Support of NAIC Programs, Products or Services

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

NAIC Support Staff: Ryan Workman/Nikhail Nigam

2022 G Charges.docx
NAIC/CONSUMER LIAISON COMMITTEE

NAIC/Consumer Liaison Committee Dec. 13, 2021, Minutes .................................................................13-2
NAIC/Consumer Liaison Committee Oct. 19, 2021, Minutes (Attachment One)........................................13-8
NAIC/American Indian and Alaska Native Liaison Committee Dec. 11, 2021, Minutes (Attachment Two) ....13-9
NAIC/American Indian and Alaska Native Liaison Committee Oct. 15, 2021, Minutes (Attachment Two-A) .........................................................................................................................13-11
The NAIC/Consumer Liaison Committee met in San Diego, CA, Dec. 13, 2021. The following Committee members participated: Michael Conway, Chair (CO); Andrew R. Stolfi, Vice Chair (OR); Lori K. Wing-Heier represented by Anna Latham (AK); Jim L. Ridling (AL); Evan G. Daniels represented by Maria Ailor (AZ); Ricardo Lara represented by Lucy Jabourian (CA); Andrew N. Mais represented by Kurt Swan (CT); Karima M. Woods represented by Sharon Shipp (DC); Trinidad Navarro represented by Frank Pyle (DE); Dean L. Cameron represented by Randy Pipal (ID); Vicki Schmidt (KS); Sharon P. Clark represented by Vicki Lloyd (KY); James J. Donelon represented by Jeff Zewe (LA); Kathleen A. Berrane represented by Kory Boone (MD); Anita G. Fox represented by Renee Campbell (MI); Mike Chaney, Ryan Blakeney, and Andy Case (MS); Mike Causey represented by Tracy Biethn and Kathy Shortt (NC); Jon Godtfred and Johnny Palsgraaf (ND); Eric Dunning (NE); Adrienne A. Harris, Sumit Sud, My Chi To, and Avani Shah (NY); Judith L. French represented by Jana Jarrett (OH); Jessica K. Altman (PA); and Tanji J. Northrup (UT). Also participating was Paige Duhamel (NM).

1. **Announced Reaffirmation of its 2021 Mission Statement for 2022**

Commissioner Conway said the Committee reaffirmed its mission statement for 2022 via e-vote effective Oct. 19 (Attachment One).

2. **Adopted its Summer National Meeting Minutes**

Commissioner Stolfi made a motion, seconded by Commissioner Altman, to adopt the Committee’s Aug. 14 minutes (see *NAIC Proceedings – Summer 2021, NAIC/Consumer Liaison Committee*). The motion passed unanimously.

3. **Heard a Report on the Activities of the NAIC/Consumer Board of Trustees Activities**

Commissioner Conway said as chair of the NAIC Consumer Board of Trustees that works in conjunction with this committee, he wanted to mention that the Board is composed of six state insurance regulator members and six funded consumer representative members. The Board meets in closed, confidential sessions because it administers the NAIC Consumer Participation Program, which may require discussions of a confidential nature concerning personal information. Commissioner Conway said this Board met earlier today at the Hilton to appoint consumer representatives to serve in 2022; however, he said notifications of status to all applicants will not be announced until February 2022.

4. **Observed the Presentation by Consumer Representatives of their Excellence in Consumer Advocacy Award**

Katie Keith (Out2Enroll) and Harry Ting (Healthcare Consumer Advocate) presented Commissioner Altman with the Consumer Representatives’ Excellence in Consumer Advocacy Award. Commissioner Altman said it was an honor to be selected by consumer representatives to receive their award.

5. **Heard an Update on Federal Health Policy Developments and Recommendations for States**

Deborah Darcy (American Kidney Fund—AKF) said she had hoped to provide an update on the provisions of a recently enacted federal Medicaid Coverage Act (MCA) and Build Back Better Act (BBBA) at this meeting. Since neither of these acts has been enacted yet, she said sharing the major themes of what these two acts hope to accomplish is the next best thing. She said expanded tax credits is one of the main issues, as the prior tax credit period of Feb. 15 – Aug. 15 resulted in 2.8 million Americans being enrolled. She said the Advance Premium Tax Credit (APTC) led to most enrollees saving $67 (or 50%) in premium per month. She said half of those who enrolled during this period had a monthly premium of $10 or less prior to the special enrollment period (SEP), compared with only 25% of that after the regular open enrollment period (OEP). She said the American Rescue Act was enacted to end disparities and inequities because it expanded Medicare in a way that helped people of color. She said Medicaid also expanded benefits and increased coverage by providing enhanced federal matching funds available for the Medicaid expansion population for two years in states that had not yet expanded Medicaid to two years and filled the coverage gap for 2.2 million Americans, as well as extending coverage for postpartum women from 60 days to one year. She said 75% of those helped live in Florida, Georgia, North Carolina, and Texas. She said 58% of people in the Medicaid coverage gap were in racial and ethnic minorities, with 28% identifying themselves as African American/Black, 28% Hispanic/Latino, 1% American Indian or Alaska Native, and 1% Asian or Pacific Islander. She said 550,000 are deemed
essential workers. She said control measures for blood pressure and glucose (diabetes) have improved in expansion states compared with non-expansion states, and the improvements in blood pressure and glucose control are greatest for African American/Black and Hispanic/Latino residents. Compared to states that did not expand Medicaid, she said people with end-stage renal disease (ESRD) living in states that expanded the program had lower mortality rates after going on dialysis, and more patients were preemptively placed on the transplant list so they could be on dialysis for a shorter period. She said the BBBA passed by the U.S. House of Representatives (House) on Nov. 19 included provisions that would: 1) limit the price charged by private group and individual health insurance plans for insulin to no more than $35 a month for pens or vials starting in 2023; 2) implement a phased in Medicare Drug Negotiation Program for Part B starting in 2027 and Part D starting in 2026; 3) limit Part D annual out-of-pocket to $2,000; and 4) implement smoothing, which means deductibles could be paid over several months rather than being hit with a large bill at the beginning of the year. She said she wanted to thank the Consumer Information (B) Subgroup, Brenda J. Cude (University of Georgia), Bonnie Burns (California Health Advocates), and Eric Ellsworth (Consumers Checkbook/Center for the Study of Services) for their work on the consumer education materials for the No Surprises Act (NSA) because getting the word out to consumers in a way that they understand is vital to the success of the program, which begins in a few weeks. She also offered NAIC consumer representatives’ assistance to state insurance regulators in spreading the word and educating consumers about this act.

Carl Schmid (HIV+Hepatitis Policy Institute) said the interim final rule on Drug Transparency was released on Nov. 17 with comments due Jan. 24, 2022, and the first annual filing due Dec. 27, 2022. He said plans must report on: 1) total health care spending by type of cost, including prescriptions; 2) the 50 most frequently dispensed brand prescriptions; 3) the 50 costliest prescriptions by total annual spending; 4) the 50 prescriptions with the greatest increase in plan or coverage expenditures; 5) rebates, fees, and other remuneration paid by drug manufacturers to the plan or issuer in each therapeutic class of drugs, as well as for each of the 25 prescriptions that yielded the highest amount of rebates; and 6) the impact of rebates, fees, and other remuneration on premiums and out-of-pocket costs.

Commissioner Conway said he was sorry to interrupt, but it was necessary to stop Mr. Schmid because they were at the 15-minute mark. He said he is committed to having Mr. Schmid finish his presentation at a future meeting.

6. Heard a Presentation on Insurance Privacy Protection: Do the “Right” Thing – A Consumer Perspective

Dr. Ting said the Privacy Protections (D) Working Group was charged with determining what rights insurance consumers should have regarding the collection and use of their personal data. He said the rights looked at included: 1) the right to opt-in to data sharing; 2) the right to opt-out of data sharing; 3) the right to correct; 4) the right to delete data; 5) the right to data portability; and 6) the right to restrict the use and collection of data. He said these are the types of fundamental or inalienable rights guaranteed to all Americans in the U.S. Declaration of Independence. He said consumer rights should be defined by ethical principles, such as the Fair Information Principles. Commissioner Ridling asked Dr. Ting to explain what such principles include. Dr. Ting said he was referring to the NAIC Code of Fair Information Practices issued in 1973, which requires: 1) openness – personal data record-keeping should not be hidden; 2) access – people should be able to find out what info is collected and its use; 3) secondary use – people should be able to prevent use of their info obtained for one purpose from being used or made available for other purposes without the person’s consent; 4) correction – people should be able to correct or amend an inaccurate record about them; and 5) security – organizations must ensure the reliability of the data for their intended use and take precautions to prevent its misuse. He said the NAIC needs to use its Fair Information Principles for the insurance industry as the basis for revising its model acts and regulations. He said state insurance regulators have had to update its principles due to changes in technology and data practices, new and increasingly invasive technologies, the collection of personal data beyond what is needed, the uses of artificial intelligence (AI) that can have unwanted consequences, significant security breaches posing serious fraud risks, and increasing consumer concerns about privacy. He said NAIC privacy models are outdated and need to be updated using fair information practices that are relevant to the real world.

Dr. Ting said corporate privacy policies are too complex according to a Pew Research Center survey of 4,272 adults in 2019. He said the results of this survey indicated that adults do not understand company privacy policies; only 9% of adults always read the privacy policy; when adults read the policies, only 22% read the policies completely before agreeing to their terms; and 79% are concerned with how companies use their information, especially data consumers that do not wish to share. He said the results of the Ipsos 2018 Global Advisor survey of over 1,000 U.S. adults indicated that 75% said consumers should be able to refuse to let companies collect their data; 66% would be more comfortable if their data were not shared or sold; and 53% did not trust financial services companies to use their data “in the right way.” He said companies collect excessive data according to Bessemer Venture Partners because, “data collection has been the default habit for engineers and database architects for the past few decades…engineers tend to collect more data because they don’t know if an AI model could potentially benefit from it in the future.” He said a survey by Lewis & Ellis Actuaries and Consultants found that most insurance companies surveyed check social media sites during the underwriting process. He said most insurers use Google, and some check LinkedIn,
Facebook, Instagram, or Twitter to collect consumer data. He said collecting consumer data not needed for intended transactions facilitates the insurer’s use of hidden algorithms that may harm certain populations unintentionally or illegally.

Dr. Ting said personal data is poorly protected on the internet as privacy policies note, “[w]e may use cookies and other technologies such as web beacons and pixels to collect information about your online activities over time and across third-party websites or online services which may allow a third party to track your online activities over time and across different sites when you use the Websites; or The Websites may not respond to Do Not Track requests or headers from some or all browsers.” He said “Dark Pattern” interfaces subvert user intent, but Facebook and Google have privacy intrusive defaults, where users who want the privacy friendly option must go through a significantly longer process. He said they even obscure some of these settings so the user cannot know the more privacy intrusive option was preselected. He said the popups from Facebook, Google, and Windows 10 have design, symbols, and wording that nudge users away from the privacy friendly choices. He said choices are worded to compel users to make certain choices, while key information is omitted or downplayed. He said none of them let the user freely postpone decisions. He also said Facebook and Google threaten users with loss of functionality or deletion of the user account if the user does not choose the privacy intrusive option.

Dr. Ting said through Internet of Things (IoT) data collection, U.S. patients may have little access to their raw data collected and held by device manufacturers in the U.S. under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rules. He said under the Sept. 15 Federal Trade Commissioner (FTC) policy statement, the 2009 Health Breach Notification Rule covers personal health information collected by digital apps and wearable devices. He said data breaches are inevitable. He said data breaches occur, no matter how diligent organizations are about data security. He said in the Identity Theft Research Center (ITRC) statement to the U.S. Senate (Senate) Committee on Commerce, Science, and Transportation, 1,291 publicly reported breaches were reported through September 2021, which exceeded those reported in 2020 by 17% and amounted to 160 million people affected in the third quarter of 2021. He said privacy enforcement capability is poor; and current privacy laws are woefully out of date and fail to provide the necessary protections for the modern age. He said consumers also now face threats from foreign adversaries that target the personal data stored in U.S. companies and U.S. government agencies. He said the FTC only has authority to bring enforcement actions against unfair and deceptive practices in the marketplace, and it lacks the ability to create prospective rules for data security. Dr. Ting said the Consumer Financial Protection Bureau (CFPB) similarly lacks data protection authority and only has jurisdiction over financial institutions. He said neither of these agencies possess the resources needed to address data security.

Dr. Ting recommended that the NAIC adopt the following Fair Insurance Industry Information Principles: What I Deserve as a Consumer: 1) notice – notice of purpose and rights at the time of collection; 2) openness – clear and periodic notice of privacy policies and practices, as well as reasons for any adverse actions; 3) collection – data minimization (only data needed for transaction); 4) data quality – keep relevant, accurate, up-to-date as long as used; 5) use limitation – only as needed for provision of insurance, except as permitted or required by law; the ability to opt-out of sharing with affiliates, where not requested; and when sharing with unrelated third parties prohibited unless consent given for specific parties; 6) access – ability to obtain information in consumer-friendly formats and sources of data in reasonable time frames; 7) correction – right to correct, amend, delete, or add information where accuracy is legally disputed; 8) data security – protect all information linked to the consumer through reasonable safeguards and delete or de-identify when no longer used; and 9) accountability – appropriate penalties to incent compliance.

In summary, Dr. Ting said privacy protection should focus on protecting consumers; protections should be based on values and ethics; and the NAIC needs to agree upon Fair Insurance Principles for the insurance industry and then apply those principles to revise its model laws and regulations.

Commissioner Stolfi said he understands that Dr. Ting was instrumental in other meetings and discussions on this topic, and he asked Dr. Ting if he has any suggestions as to legislation that is in effect that could be used as a model for the NAIC. Dr. Ting said the European Union’s (EU’s) General Data Protection Regulation (GDPR), the California’s Privacy Act and Regulation, and other legislation each have aspects that fit his recommendations; however, he said protections of consumers should pertain to all data, not just to personal health data. He also said consumers should have to opt-in to the sharing of any of their data, not just health data. Dr. Ting said other laws he has seen appear to be there to protect Google and its profits more so than consumers.

7. **Heard a Presentation on Regulatory Failures in Credit-Related Insurance**

Birny Birnbaum (Center for Economic Justice—CEJ) said credit-related insurance provides coverage to pay off debt, such as a mortgage loan if the insured dies or becomes disabled or unemployed. He said it is also referred to as title insurance or forced-placed insurance. He said it is the intent of this insurance to provide benefits to the consumer; however, in most cases, he said
lenders get the bulk of the benefits. He said this was evident by the loss ratios for credit insurance that historically run about 44%. He said another disadvantage of credit-related insurance is the lender has all the power, and the consumer has none. He said reverse competition should be the norm for insurance placement though title insurance because when profits are up, underwriting costs are down, and data collection is automated; then title insurers should be filing for lower rates. However, he said title insurers are not filing for lower rates, and he wonders why they were not. He said this situation has been going on for many years without relief from state insurance regulators. He recommended that state insurance regulators review current state regulations, models, and bulletins to prevent arbitration of rates by credit-related insurers and provide an additional layer of protection for consumers of such insurance products in the future. Amy Bach (United Policyholders) asked why loss ratios for credit-related insurance are half that of regular insurance. Mr. Birnbaum said it is because lender-placed insurance is considered group insurance, so it should be available for less premium unless it has a higher loss ratio rather than provide kickbacks to lenders. Peter Kochenburger (University of Connecticut School of Law) asked if any states have statutory limits. Mr. Birnbaum said Louisiana and Texas are good examples of how credit-related insurance should work. He said Louisiana requires higher rates by statute, and Texas statutes require the insurance commissioner to set the base rates and then allow companies to add only 15%. He said in most states, the minimum loss ratio for credit-related insurance is way too low.

8. Heard a Presentation on When Private Options Shrink for Insuring Properties – Residual Market Entities and Consumer Challenges

Ms. Bach said data charts produced by the Insurance Information Institute (III) provide insight into what happens when private insurance options for insuring property shrink. She said it limits the choices that consumers have to the insurers of last resort, which are the Fair Plans, or the Beach and Windstorm Plans provided by states. She said the tension points surrounding private and public insurers occur because public plans: 1) take all comers so they are treated like a risk pool; 2) have rate caps and provide subsidies; 3) provide greater adequacy of coverage and maximum dwelling limits; 4) post their loss assessments; 5) engage reinsurance through catastrophe funds; 6) have the prevailing view that private coverage should be superior to public options; and 7) engage in recent legislation. She said as climate change reduces private appetite for insuring existing homes, public options can and should provide essential, affordable protection. She said logic suggests that there should be different standards for the pricing and quality of policies on newly constructed homes in regions vulnerable to climate change, which means the insurance industry is distinguishing between coming to the risk prior to any climate change occurrence versus the increase in risk that has occurred during ownership of the home. She said a comparison of how three states are set up for urban risk sheds light on residual market entities and the subsequent challenges to consumers. She said the California Fair Plan (CFP) was established by statute (California Insurance Code sections 10091 et seq.) in August 1968, and all licensed property/casualty (P/C) insurers that write basic property insurance required by Insurance Code sections 10091(a) and 10095(a) are members of the Fair Access to Insurance Requirements (FAIR) Plan. She said the FAIR Plan issues policies on behalf of its member companies, and each member company participates in the profits, losses, and expenses of the FAIR Plan in direct proportion to its market share of business written in the state. She said the basic policy does not match an HO-3 about fire, lightning, internal explosion, or smoke. She said it contained limited loss of use coverage; its coverage for vandalism is optional; the maximum dwelling limit increased from $1.5 million to $3 million in 2021; and it has some options for replacement cost coverage or deductible levels. She said the CFP is a critical financial lifeline for California property owners that recently changed, so the requirement of three turn downs to get a CFP policy is no longer enforced. She said the California Department of Insurance (DOI) and CFP are in litigation over the HO-3 mandate, and that legislature gave the California DOI non-renewal moratorium authority, which has significantly helped maintain stability in the private market and prevent drastic overpopulation of CFP. She quoted CFP President Annelise Bovet as saying, “Jivan urged lawmakers to make other insurers also write more policies in fire-prone areas so that fewer people are having to turn to the FAIR Plan,” and she jokingly said she pretty regularly works in an opposite world. Ms. Bovet said, “I probably run the only company where success is measured by a shrinking portfolio and a shrinking customer base, because that is actually a sign of a very healthy voluntary or private market. At the moment, however, she said that is not the case.”

Ms. Bach said Florida’s Citizens Plan was created by the Florida Legislature in August 2002 as a not-for-profit, tax-exempt, government entity to provide property insurance to eligible Florida property owners unable to find insurance coverage in the private market. She said Citizens is funded by policyholder premiums; however, Florida now also requires that Citizens levy assessments on most Florida policyholders if it experiences a deficit in the wake of a particularly devastating storm or a series of storms. She said Citizens operates according to statutory requirements established by the Florida Legislature and is governed by a Board of Governors that administers a Plan of Operation approved by the Florida Financial Services Commission, an oversight panel made up of the governor, chief financial officer (CFO), attorney general, and commissioner of agriculture. She said Citizens’ basic policy matches an HO-3 form; the maximum available dwelling limits are county-specific ($700,000, $1 million); and its options include code upgrade coverage, sinkhole coverage, and replacement cost on contents. She said Florida law requires that Citizens create programs to help return Citizens’ policies to the private market and reduce the risk of assessments for all Floridians. She said these programs are subject to the approval of the Office of Insurance Regulation (OIR),
and the depopulation program works with private market insurance companies interested in offering coverage to Citizens’ policyholders. She said participating companies must be approved by the OIR, and approved takeout companies can offer to take over your Citizens policy at any time during your policy period. She said the Depopulation Unit works directly with active and prospective Florida insurers and representatives to facilitate the transfer of policies; the Citizens’ policy count had swelled in 2012 to 1.5 million; and Depopulation efforts whittled the count to a low of 419,475 in October 2019. She said Citizens is now on course to see its policy count surpass 1 million in 2022, rising further by the end of the year. One driver of an accelerating rate of policies to Citizens has been reinsurance costs, which have risen considerably for some Florida carriers.

Ms. Bach said Florida residents can purchase Citizens insurance if they cannot find private insurance or a private insurer’s policy is priced 15% above a comparable Citizens’ offering, and state law precludes Citizens from raising renewal rates more than 10%. She said notable in Florida is the Florida Market Assistance Plan (FMAP), which provides a free referral service that helps consumers find personal residential insurance with authorized private market insurance companies. She said the Florida Hurricane Catastrophe Fund (FHCF) is a tax-exempt state trust fund that provides reimbursement to residential property insurers for a portion of their Florida catastrophic hurricane losses. She said it is intended to be self-supporting, with funding primarily from actuariarily determined premiums paid by residential property insurance companies and, in some circumstances, revenue bonds backed by emergency assessments on a variety of P/C insurance premiums.

Ms. Bach said the Louisiana Citizens’ Plan was created by the Louisiana legislature in 2006 (RS 22:1430.2) as a nonprofit organization to provide insurance products for residential and commercial property applicants who are in good faith entitled, but unable, to procure insurance through the voluntary insurance marketplace. She said coverage basics include an HO-3 and other options. She said Louisiana Citizens developed a process in 2008 to “depopulate” whereby new or existing private insurance companies are encouraged to assume policies currently covered by Louisiana Citizens from policies approved for depopulation in accordance with LSA-R.S. 22:2314. Through this process, she said Louisiana Citizens can transfer selected policies back to the private insurance market in accordance with LSA-R.S. 22: 2314. She said Citizens, which covers properties that the private insurance industry will not, is now in its 14th round of depopulation; however, despite three hurricanes and two tropical storms hitting Louisiana during the 2020 season, she said Citizens reported no uptick in home or business owners seeking coverage, a sign of health in the local insurance market. She quoted Commissioner Donelon who said, “[b]y enacting a proactive reinsurance strategy and using modeling to select policies for depopulation, Citizens is in a strong financial position and providing stability to the homeowners market during a turbulent time.” Commissioner Donelon is also quoted as saying, “despite the multiple hurricanes that hit the Louisiana coast last year, Citizens is in a great place to weather these financial storms and continue to support private sector competition in the property insurance marketplace.” Ms. Bach said at present, Citizens is responsible for over 38,600 policies in Louisiana and 0.28% of the state’s homeowners’ market, but it expects to increase its policy count by around 5,000 next year, while at the same time depopulating roughly 100 policies. She said Louisiana Citizens expanded its commercial limits to $10 million on an individual building; $3.2 million for contents; and $20 million in the aggregate, versus previous limits of $5.5 million, $2.2 million, and $11 million, respectively. She said board members noted that the increase would better enable Citizens to accommodate policyholders seeking coverage when they already have an open claim with an insurer during renewals.

Commissioner Conway said it was good to know that the residual markets are available if they are needed, and he asked Ms. Bach which plan she prefers. Ms. Bach said she likes the California FAIR Plan model the best and not just because she lived in California.

9.  Heard a Presentation on the Impact on Demand Surge Post-Disaster on the Labor and Materials Costs of Reconstruction

Ken Klein (California Western School of Law) said he is a law professor who has been researching how natural disasters expose and exacerbate the issues of insurance affordability, insurance availability, and underinsurance. He said his focus is on homeowners’ underinsurance due to demand surge rather than guaranteed replacement but full coverage up to a cap equal to the cost of labor and the cost of goods (e.g., price gouging). He said the primary factors arguably causing significant post-disaster underinsurance is that the insurer inaccurately estimates the reconstruction cost and homeowners accept the insurer’s quote of Coverage A before the disaster. He said after the disaster, the reality of demand surge sets in. He said the cost numbers surge, then level out. He said according to Core Logic, 15% to 30% of the increase in construction costs curbs in six months after a disaster and peaks six months after that (with the location of the neighborhood being the deciding factor of percentage) with it taking many years to reabsorb. He said demand surge is covered in Coverage A limits in a Replacement Cost Value (RCV) policy; an Extended Replacement Cost (ERC) endorsement in a hazard policy; and via optional over insurance in a National Flood Insurance Program (NFIP) policy. He said in California’s 2008 wild fires, of the insureds who had full RCV and ERC, 59% are still underinsured. He said a study of one insurer after the 2017 Wine Country fires found that 94% of homeowners who had full RCV and 50% who had ERC were still underinsured by 10% or more. He said most people do not have total losses, except during catastrophic events, and those are not currently being tracked. He said further research is needed into pre-demand surge, then re-estimation followed by a comparison of guesstimates.
Mr. Klein said state insurance regulators are urged to gather more insights such as: 1) whether Coverage A anticipates or should anticipate demand surge; i.e., a comparison of: a) the percentage of insured homes with a prediction of demand surge included in the estimated reconstruction costs (for purposes of quoting coverage); and b) the percentage total losses that are a result of a catastrophe event; 2) how much demand surge a home actually experiences; i.e., a comparison of: a) early post-disaster reconstruction estimates on a home; and b) a second estimate months later (where the only variable between the estimates is the date the estimate was done); 3) how well Coverage A predicts demand surge; i.e., a comparison of: a) demand surge experienced by a home; and b) the demand surge predictions in the estimate of cost of reconstruction of that home.

Mr. Klein said possible action items for state insurance regulators might be to require: 1) inclusion of demand surge in RCV estimates; 2) disclosure to the state insurance regulator of how demand surge calculations are made; 3) disclosure to state insurance regulators and insureds of what percentage of demand surge is in RCV estimates; 4) toll time period limits on policyholder benefits if demand surge delays reconstruction (e.g., Colorado DOI Bulletin No. B-5.42); and 5) reform Coverage A limits if Coverage A estimates either do not include demand surge or materially underestimate demand surge as measured by historical percentages.

Commissioner Conway said Grand County is dealing with the type of demand surge that Mr. Klein described in his presentation.

Having no further business, the NAIC/Consumer Liaison Committee adjourned.
The NAIC/Consumer Liaison Committee conducted an e-vote that concluded Oct. 19, 2021. The following Committee members participated: Michael Conway, Chair (CO); Andrew R. Stolfi, Vice Chair (OR); Lori K. Wing-Heier represented by Anna Latham (AK); Jim L. Ridling (AL); Alan McClain (AR); Ricardo Lara represented by Lucy Jabourian (CA); Andrew N. Mais represented by Kurt Swan (CT); Trinidad Navarro represented by Frank Pyle (DE); John F. King (GA); Dean L. Cameron represented by Randy Pipal (ID); Vicki Schmidt (KS); Sharon P. Clark represented by Vicki Lloyd (KY); James J. Donelon represented by Jeff Zewe (LA); Anita G. Fox represented by Renee Campbell (MI); Chlora Lindley-Meyer (MO); Mike Causey represented by Tracy Biehn and Kathy Shortt (NC); Jon Godfread and Johnny Palsgraaf (ND); Linda A. Lacewell (NV); Jessica K. Altman (PA); and Scott A. White (VA).

1. **Reaffirmed its 2021 Mission Statement for 2022**

Commissioner Conway said the Committee reaffirmed its mission statement for 2022.

Having no further business, the NAIC/Consumer Liaison Committee adjourned.
The American Indian and Alaska Native Liaison Committee met December 11, 2021. The following Committee members participated: Lori K. Wing-Heier, Chair (AK); Jeff Rude, Vice Chair (WY); Michael Conway (CO); Trinidad Navarro (DE); Grace Arnold and Peter Brickwedde (MN); Troy Downing (MT); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by Chris Aufenthie and Johnny Palsgraaf (ND); Glen Mulready represented by Teresa Green (OK); Andrew R. Stolfi represented by Raven Collins (OR); and Mike Kreidler represented by Todd Dixon (WA).

1. **Announced Reaffirmation of its Mission Statement for 2022**

Director Wing-Heier said the Committee reaffirmed its mission statement for 2022 via e-vote effective Oct. 16 (Attachment Two-A).

2. **Heard a Presentation from MIGIZI on its P/C Claims Experience**

Director Wing-Heier said Kelly Drummer (MIGIZI and Oglala Tribe), will be speaking about her experiences with property/casualty (P/C) insurance following the riots in Minneapolis, MN, the summer of 2020.

Ms. Drummer said MIGIZI means “bald eagle” in her native language and that she followed in the extraordinary leadership of Laura Waterman Wittstock and Elaine Salinas at the organization. During the last three years, she said that she facilitated the MIGIZI capital campaign and subsequent move to a beautiful new space that was lost eight months later to fire in the civil uprising. Ms. Drummer said that today she is working diligently on a campaign for MIGIZI’s new home at 1845 Lake Street that will be a state-of-the-art media production and green jobs training space. She said that she has been instrumental in building the capacity in MIGIZI programming and development of resources to support the 45-year-old American Indian youth organization. Prior to joining MIGIZI in November 2018, Ms. Drummer said she served as founding president and CEO of the Tiwahe Foundation for seven years. She said Tiwahe is an American Indian community foundation that focuses on providing micro grants to American Indian communities, strengthening leadership initiatives, and network building. During her 23 years of philanthropy and nonprofit work, Ms. Drummer said she has worked with the Minneapolis Jewish Community Foundation (JCF), The Family Partnership, Headwaters Foundation for Justice (HFJ), and New Foundations – a Project for Pride in Living (PPL) program. She said she currently serves on the Saint Paul Foundation Community Impact Committee, The Family Partnership board of directors, and other projects that benefit American Indian women and youth. Ms. Drummer said she earned a master’s degree in philanthropy and development from St. Mary’s University of Minnesota and a bachelor’s degree in cultural anthropology from the University of Minnesota (Minneapolis, MN). She said she currently lives in Minneapolis with her husband and five children.

Ms. Drummer said MIGIZI suffered a total loss of its new building during the civil unrest a block from the Third Precinct in Minneapolis. In July 2019, following a $1.7 million campaign, she said MIGIZI purchased and renovated its sacred space only to see it smothered between the seven fires surrounding its block on May 28, 2020. Ms. Drummer said this was just the start of their journey in navigating this loss with their insurance carrier. She said this is MIGIZI’s story and the story of many other small minority-owned businesses in Minneapolis that have had to navigate the insurance system. Ms. Drummer said MIGIZI is still dealing with the process of acquiring payment for its claims for its business expense loss; an increase of insurance costs by 50%; and the fear of rising rates as MIGIZI rebuilds on Lake Street. She said MIGIZI runs three care programs that include working with public schools, which the fires closed, so the children have been out of the school setting for 18 months. Ms. Drummer said the Indigenous Pathways program trains 60 youth every year on social media, resulting in a certification and training program focused on broadcasting and radio. She said the youth are paid to participate in the training program. Ms. Drummer said the Protect the Herd program produced 40 public service announcements (PSAs) on public radio. In June 2008, MIGIZI purchased its prior building and land for $800,000 and then spent $1 million renovating it. When the space was opened in July 019, it was insured for $5 million. She said that the location sustained no damage, no broken windows, and no graffiti during the riots. However, she said the roof caught fire as it jumped from the three buildings next to it. Ms. Drummer said the insurance coverage was up for renewal at this time and that the agency did not renew the coverage even though the organization had maintained coverage with the agency for 44 years. She said the organization secured liability and P/C insurance on May 29, 2020. Ms. Drummer said MIGIZI’s property was declared a total loss. Building code restrictions and the list of property
that had been lost indicated that replacing the furnishings would require $5 million to $6 million. She said this meant the replacement value had increased from $1 million to $6 million and that MIGIZI was underinsured.

Director Wing-Heier asked Ms. Drummer what the most difficult part of the insurance claims process had been thus far. Ms. Drummer said it was such complex problem because MIGIZI shared an adjacent wall with neighboring businesses and that those neighboring businesses were also underinsured. She said the city of Minneapolis did the demolition in September, which saved a lot. However, price gouging at the time contributed to placing most of the risk on MIGIZI and the other business owners. Ms. Drummer said the most difficult lesson learned is that being underinsured resulted from not having the knowledge as a nonprofit to have fine art and ancestral artifacts received as donations from tribal leaders appraised and insured under separate riders. She noted that many of the items were rare, historical items (such as ancient tribal language recordings on tape) and, therefore, impossible to replace at any cost. Ms. Drummer said the furnishings were all brand new, so they were easy to evaluate and determine a replacement cost. However, she said that many of the old items that were lost to the fire, like the antique tapestry donated by the tribe that had not been appraised because such items are one of a kind, rare, and irreplaceable. She said they are still in the claims process with the insurer. Ms. Drummer said some of the business expense losses have also been paid, but others were also still in the claims process. She said as a nonprofit organization, this tragedy had a silver lining as it had led to more gifts being donated to MIGIZI, all of which are currently being given a replacement value through the insurer with the help of an attorney and appraiser. Ms. Drummer said a lease was signed in March 2021 on the new location, with all furnishings and equipment having been donated. Then, on June 16, 2021, the University of Minnesota donated space for MIGIZI. She said insurance increased 50% to 80%, with an overall increase of 26% and a property increase of 51%.

Ms. Drummer said MIGIZI will be rebuilding with solar power and geothermal heating and cooling. She said many of the buildings around them are still damaged, including the shared adjacent wall, which will need another $1.5 million over and above the $2.5 million already donated. Ms. Drummer said they also need a spokesperson to assist while she serves as an advisor to the rebuilding of the programs and to deal with all the stress caused during the insurance process.

Director Wing-Heier said she sympathized with Ms. Drummer, the MIGIZI organization, and all the tribal members affected as priceless artwork is the hardest to value for insurance purposes. She said she hopes the outcome of this disaster will only be good for MIGIZI for the future.

Having no further business, the NAIC/American Indian and Alaska Native Liaison Committee adjourned.
The NAIC/American Indian and Alaska Native Liaison Committee conducted an e-vote that concluded Oct. 16, 2021. The following Committee members participated: Lori K. Wing-Heier, Chair (AK); Jeff Rude, Vice Chair (WY); (Michael Conway (CO); (CT); Trinidad Navarro (DE); Dean L. Cameron (ID); Mike Causey represented by Tracy Biehn (NC); Jon Godfread represented by Chris Aufenthie and Johnny Palsgraaf (ND); and Andrew R. Stolfi represented by Raven Collins (OR).

1. **Reaffirmed its Mission Statement for 2022**

   Director Wing-Heier said the Committee reaffirmed its mission statement for 2022.

   Having no further business, the NAIC/American Indian and Alaska Native Liaison Committee adjourned.